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Noah Dimas

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A New Directive: An Ethical Analysis of the *Ethical and Religious Directives* and Catholic
Healthcare Mission to Promote and Sustain Catholic Healthcare

Noah Dimas

Apr. 29, 2022

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1. Introduction – The Need for Revision of the *ERDs* to Support Catholic HCE Mission

The present state of Catholic healthcare ethics is in something of a state of limbo. Catholic healthcare has always been strong in its moral fervor and presented itself as an alternative to secular healthcare, focusing on the spiritual-physical wholeness of humanity.¹ However, as modern healthcare becomes ever more advanced and expansive, the ways in which Catholic healthcare must engage with these complex issues becomes ever more complex. At the time of writing, American Catholic healthcare, in particular, has only had one authoritative source of ethical discussion, the *Ethical and Religious Directives for Catholic Health Services*. This document, originally published under a different name in 1981, has served as a very robust guide to answer common ethical conflicts within Catholic healthcare.² However, as medical science continues to grow, healthcare as a whole becomes more secular, and the lived experiences of Catholic become ever more complex as a result, the *ERDs* become less authoritative due to their static, directorial nature.³ This is not to say the *ERDs* are currently without value or obsolete. These directives can be useful when quick, direct guidance is needed. However, it fails at aiding healthcare professionals, ethicists, and practicing Catholics in understanding and further applying Catholic teachings onto Catholic healthcare and Catholic healthcare mission.⁴ All these concerns, then, are the cornerstones of this essay. First, this essay aims to provide discussion regarding the history and purpose of mission within Catholic healthcare. Second, this essay will discuss the strengths and weaknesses of the current edition of the *ERDs*. Doing this will then give rise to the third and final point this essay aims to explicate, how a new *ERD* edition can and should be written to align both Catholic healthcare ethics and the current understandings of Catholic healthcare mission with modern understandings of healthcare ethics to provide a more content-full ethical-moral framework for Catholic healthcare.

2. The Role and Purpose of Mission in Catholic Healthcare

Within Catholic healthcare, there exist two concepts that drive the actions of the healthcare system, Mission and Ethics. While these notions may be present in non-religiously affiliated healthcare systems, they can readily be discussed within the context of Catholic healthcare. These concepts will be discussed at length below, but to provide a brief description, it can be said that Mission is what drives the healthcare system to do what it does whereas Ethics is what drives what the healthcare system ought to do.⁵ What is most unique about Catholic healthcare in contrast with secular healthcare are the moral foundations that it is rooted within. This moral framework provides itself some guidelines in what is considered morally permissible and impermissible and informs both Catholic healthcare mission and ethics.⁶ However, despite this apparent rigidity, there is a great deal of room for interpretation and application of said moral understandings. As such, this essay must stress that much of the arguments this essay makes are not the only interpretations that can be made from these founts of Catholic moral teaching. With this preface, this essay can discuss Catholic healthcare mission more thoroughly.

2a. A Brief History of Catholic Healthcare

To best understand Catholic healthcare mission, hereby shortened as Mission, a brief look back into the history of Catholic healthcare as a whole is necessary. It is well understood that some form of sick houses and physicians can be traced back to the time of the Greeks, arguably even further depending on what one interprets as a “healer.”⁷ However, the modern healthcare system that is most prevalent in modern society of hospitals and physicians trained in physical sciences can be argued to have started in Medieval Europe.⁸ These hospitals were known as “hospices” but are not quite the same as their modern counterpart. They are hospices more akin

to their etymology, “hospitality.”⁹ In other words, they were meant to be houses for those seeking hospitality, shelter, and general nursing care. This is more evident when this is combined with the reality that these hospitals were often attached to monasteries and convents where the cloistered religious would open their doors to those who were in need.¹⁰ As this form of hospice expanded and grew, they were slowly aligned with the also growing academy systems that were likewise growing. It is here where one can argue the modern hospital system was truly formed and made common; instructions of learning and healing made common through the growing discipline of medical science.¹¹

What is most notable when contrasting this period of time with the modern state of healthcare is the noted divergence of modern healthcare from its religious roots.¹² Healthcare as a whole, especially that of Catholic healthcare, has historically been rooted within the spiritual and religious convictions of its practitioners.¹³ Yet, when one takes a quick glance at modern healthcare, it is not difficult to see how various healthcare systems are either not religiously affiliated or have begun to distance themselves of such affiliation.¹⁴ This is not to say that this is inherently bad or is fundamentally wrong. Rather, it shows the shift in a society that no longer places high value on religion and religious healthcare. What is even more curious is that the academies of old, the places education for physicians and other professionals, were also tied to religious, often Catholic, institutions as well.¹⁵ This proves an even more curious divergence as many modern academic settings, especially those of medicine, are far removed from any religious affiliation.

This shift of healthcare institutions away from religious affiliation is very much a prevalent phenomenon and not something that can easily be ignored by religious healthcare. Consider the tragic case of the Phoenix healthcare system, St. Joseph’s Hospital and Medical Center and their

abortion scandal.¹⁶ In 2009, St. Joseph's was faced with a very difficult and morally complex case of a female patient in critical condition from complications in her pregnancy. Faced with this critical situation, the healthcare system's ethics team decided that it would be morally permissible to perform a therapeutic abortion to rectify the medical issue as there was no other method to treat the patient. The ethics team justified this as an appropriate usage of the principle of double effect and believed they were still within the moral permissibility granted through the *ERDs* and Catholic moral tradition.¹⁷ However, the healthcare system came under heavy scrutiny and criticism for performing what on the surface, was being considered "an abortion." As such, the local bishop excommunicated the hospital and no longer publicly call itself a Catholic hospital. This essay cannot discuss this case further due to length. But to summarize the general commentary and analysis regarding this case, many Catholic scholars note how the hospital was in appropriate ethical and moral action to do what it did.¹⁸ This case is brought up here to illustrate how Catholic healthcare exists in a very narrow and, at times, uncomfortable position within both secular society and the Catholic community. Some Catholic healthcare systems are even having to forgo their Catholic affiliation due to no fault of their own; simply due to financial stability reasons or lacking the general ability to continue providing care¹⁹.

This is then the underlying ethical dilemma that Catholic healthcare has to contend with in the modern healthcare landscape. What ought Catholic healthcare do in order to preserve its presence in the modern healthcare landscape? Put another way, how must Catholic healthcare adapt its teachings, traditions, and understandings of healthcare to continue its practice of medicine? There are a number of choices, most of which are morally impermissible as they would entail too grave a level of cooperation, such as cooperating with secular healthcare systems and permitting interventions deemed morally impermissible, such as abortion and

euthanasia.²⁰ However, there is one source of wisdom that has guided Catholic healthcare through similar conflicts and can influence this discussion as well as provide a sort of compass moving forward to preserve Catholic identity in Catholic healthcare, Catholic healthcare mission.

2b. The Modern Turn of Catholic Mission

Catholic healthcare has regularly been guided by its strong notion of mission.²¹ However, it is markedly unique compared to other healthcare systems' missions. While there is no direct and authoritative definition of "Catholic healthcare mission," there are common themes among each Catholic healthcare institution's mission that can all be extrapolated into a common definition. At the heart of Catholic healthcare mission, hereby referred to as Mission, is always the desire to continue, further, and sustain the healing ministry of Jesus Christ. In general, this has been associated with the various miraculous healings that Jesus did during his public ministry; regularly healing the blind, the deaf, the lame, even raising the dead.²² It does not take much analysis to realize that this mission is well encapsulated within the modern practices of medicine. As such, Catholic healthcare can say that it is keeping within this aspect of Mission well. However, this surface level of analysis does a deep disservice to properly define Catholic healthcare mission.

The most recent resurgence of mission within the Catholic healthcare sphere is most associated with the continued presence of Catholic healthcare among the growing secular ideology of healthcare. One definition of Mission is specifically to "extend the healing ministry of Jesus Christ."²³ This operative word of "extend" is most crucial as it indicates not only the provision of healing but also carrying it forward in a manner associated with Jesus and the Christian moral tradition. As such, mission within Catholic healthcare must also consider and uphold its continued presence. This what can be considered the modern turn of Catholic

healthcare mission. Throughout its history, Catholic healthcare has had to contend with a number of ethical challenges to its form of medical practice. Throughout the late 1900s, these challenges were the various medical technologies that extended the ability of a human body or hasten the death of a person, to give some cogent examples.²⁴ As such, Mission began to discern and deliberate how these new technologies ought to be adapted into or rejected by Catholic healthcare. Even as the time of writing, there are still questions about these and even more rising/unknown technologies and if they can be truly aligned with Mission.²⁵ However, at the time of writing, one prominent yet least discussed challenges for Catholic healthcare is its continued presence in modern society.²⁶ This certainly is within the realm of Mission and arguably is best answered by it. Referring back to the definition presented earlier, Mission includes the extension, growth, and furthering of Catholic healthcare. This must not be limited to the simple growth of medical technologies. Rather, Mission must explore and discuss how Catholic healthcare as a whole must grow and adapt to sustain itself in modern society. This is the piece of this ethical conflict that Mission must respond to, identifying the morally permissible actions that can be taken to sustain Catholic healthcare.

One drastic method to achieve this continued presence is to allow for the total merger of Catholic healthcare into a non-religiously affiliated healthcare system.²⁷ While indeed an option, it might not be the most appropriate. There is room utilizing the Catholic moral principle of Cooperation to allow for the merging of Catholic healthcare institutions with larger secular healthcare systems.²⁸ However, this does require a great deal of organizational effort to ensure the appropriate merging as all policies, both medical interventions as well as the broader organizational structures of secular healthcare, must require a great deal of attention to ensure the Catholic identity of the Catholic institution is not lost in the merger. However, mergers are not

terribly common. Certainly, they exist and are the only options for some Catholic healthcare institutions. While unfortunate, it is possible to persist the provision of healthcare through these means. Yet still, there exists a deeper issue underlying this need for a merger. Stepping back from the concept of a complete merger between a Catholic and secular healthcare institution, consider the question of why a merger is necessary to begin with. Some might point to the fiscal necessity of Catholic healthcare not being able to maintain margin. Some might point to the general decline in societal demand of religious healthcare as discussed above. Some still might point to the apparent limited nature of medical interventions provided by Catholic healthcare. Given all these reasons, there is an underlying thread that can be pulled upon to bring things into focus, Catholic healthcare does not know its place in the broader healthcare society.

With the shift of healthcare as a whole into a more business-oriented institution, Catholic healthcare, a system that is extremely mission-focused, begins to lose its identity.²⁹ Catholic healthcare is not meant to make money for shareholders. It is not always on the cutting edge of research medicine. It doesn't aim to bring about total societal change or evangelize through medicine. Rather, its goal is and always has been Mission, "to extend the healing ministry of Jesus Christ."³⁰ As such, Catholic healthcare has been in something of an "identity rut" as of late. It has been doing its best to practice medicine as best as it can, but it has been static in its "extension" of healthcare to those who need it. This is not to say that Catholic healthcare ought to adapt the practices of secular healthcare; to "become like any other hospital." Quite the contrary. Certainly, some who are not of religious leaning have questioned and challenged Catholic healthcare's continued presence in society because they are of the understanding that Catholic healthcare is no longer necessary or is self-contradictory and therefore invalid of a moral-ethical position.³¹ However, it is of the author's opinion that these challenges and

questions posed to Catholic healthcare are rooted in a misunderstanding of the goals of Catholic healthcare. As such, this then becomes the avenue for Mission to take hold and clarify these often muddled and confused topics. In other words, Catholic healthcare mission's new goal in the current era of medicine is to make absolutely clear the goals and purpose of Catholic healthcare. Not to change Catholic healthcare, but to put a proverbial stake in the ground to illustrate what Catholic healthcare stands for, how it is different, and what it does better and more completely compared to other healthcare systems.³² This then is the continued goals of this essay, to provide a concrete avenue for Catholic healthcare mission to advocate for, a major revision of the *Ethical and Religious Directives for Catholic Health Services*.

3. The Strengths and Weaknesses of the Current ERDs

To provide some initial information regarding the *Ethical and Religious Directives (ERDs)*, allow a brief discussion on the history of the document and its current authoritative position within Catholic healthcare. Originally published in 1981, the *ERDs* are a set of directives that provide direct guidance on common ethical and religious issues that occur within Catholic healthcare.³³ Each section in the *ERDs* opens with an introduction that help explain the subsequent directives. The directives themselves are typically short, straightforward guidance. This allows Catholic healthcare professionals, Catholic healthcare administrators, and the Catholic faithful to readily answer common questions they may have. This directorial nature allows the *ERDs* to be focused on providing quick guidance in times of great need where deep ethical discussions might not be readily available. Regarding their position in the Church and their moral authority, this requires a short discussion of the ecclesiastical structure of the Western Catholic Church. The *ERDs* were and still are published by the United States Conference of Catholic Bishops (USCCB). Due to the arrangement between bishops and the

authoritative theological bodies of the Church, the directives can exist as a sort of pastoral guidance Catholic faithful of the United States.³⁴ Furthermore, the *ERDs* declare that any Catholic healthcare institution within a US diocese is to abide by the *ERDs* as the sole provider of moral authority.³⁵ This declaration is somewhat dubious as the Catholic Church has rejected the notion that moral teachings are only to be passed down through a hierarchical structure in favor of a communion model.³⁶ As such, the *ERDs* already exist in somewhat questionable waters, despite their general authority being generally upheld. This must be kept in mind going forward as some of the strengths and weaknesses of the *ERDs* are rooted in this tension.

3a. Strong in Principles and Virtues

Having discussed the *ERDs* in general, it will be beneficial and necessary to discuss the current strengths of the *ERDs* to allow better understanding of what can and should be encapsulated in future editions as well as what must be focused on by Mission. As briefly discussed above, the *ERDs* provide a quick and straightforward understanding and guidance of what is typically very complex reasoning and theology. This allows for Catholic moral and ethical teachings to be accessible to everyone who may come in contact with Catholic healthcare.³⁷ Furthermore, despite their brief nature, the *ERDs* are strong in and well equipped to display Catholic principles and values. For example, consider the directives regarding human dignity.³⁸ The Catholic moral tradition is very rich and deep regarding its understanding of human dignity. These understandings in their totality are far beyond what can be discussed in this essay. Yet, despite this depth of knowledge, the *ERDs* are still able to provide brief discussion and guidance on how to approach aspects of human dignity. For most cases, this is often sufficient enough to prime the providers and those participating in care. Any more than what is provided runs the risk of overwhelming all involved and can delay decision-making.

Another strong aspect of the *ERDs* is in their directorial nature. The *ERDs* are written as an authoritative set of directives.³⁹ This might be off-putting for some, especially those who are not of similar religious conviction. However, this aspect of the *ERDs* illustrates how strong the values are in Catholic healthcare and the broader Catholic moral tradition. Within the Catholic faith, there are some medical interventions that are entirely against the Catholic moral tradition, such as euthanasia or physician assisted suicide.⁴⁰ These interventions and their respective rejection on the ground of the Catholic moral tradition are well discussed and explained throughout the *ERDs*.⁴¹ As such, the *ERDs* prove themselves to be strong in their display of Catholic moral principles and virtues, primarily through their authoritative and directorial nature.

3b. Weak in Human Condition and Diversity

However, despite these strengths, there are a number of weaknesses that the *ERDs* possess. What is most prevalent when analyzing the *ERDs* deficits are their strong lack of sensitivity to the complexities of medical ethics. As mentioned above, there exist a number of medical interventions that will always be condemned by the Catholic faith.⁴² However, a great deal of other medical interventions and technologies are far more ethically and morally complex than the *ERDs* demonstrate.⁴³ Consider directive 58 in the 2018 edition of the *ERDs*. In short, the directive states that, in principle, there is a moral obligation for food and drink throughout a patient's life, including the provision of medically assisted nutrition and hydration, even for patients experiencing a persistent vegetative state.⁴⁴ This directive is very narrow in its focus, arguably too narrow and restrictive. This is not because the directive itself is wrong, but rather, the directive is inappropriately understanding the Catholic moral tradition. To illustrate this, allow a careful description of the Catholic moral teaching regarding ordinary/extraordinary care.

For Catholic healthcare ethics, there exist two categories of care; that which is ordinary and, conversely, extraordinary. Ordinary care is care of which is morally obligatory as it is essential to the perseverance of life.⁴⁵ This includes routine medical interventions, life-sustaining interventions, and other care that can be determined as ordinary. However, there are criterion that allow what would be determined as ordinary to be determined as extraordinary. These criterion are care that poses too great a physical, emotional, spiritual, social, or financial burden on the patient and/or community.⁴⁶ This then allows the patient to no longer be morally obliged to receive such care. In other words, the patient can forego these interventions without violating one's own moral obligation to preserve self.⁴⁷ In modern parlance, this concept is known also as proportional/disproportional means of care. However, the Catholic understanding of ordinary/extrordinary is unique in its explicit usage of morality. Due to this complexity of ordinary/extrordinary care, it becomes more clear that no type of care can be determined as always morally obligatory. Somewhat contradictory, this notion of ordinary/extrordinary care is at the heart of directive 59, the directive immediately after the one that determined medically assisted nutrition and hydration as always morally obligatory.⁴⁸

Given this discussion, it becomes clear that the directorial nature of the *ERDs* is highly antagonistic to the nature of Catholic teaching. Catholic teaching does have strong principles and values, especially regarding how one ought to live one's life.⁴⁹ However, this does not mean that these teachings can nor should be reduced down to single-sentence directives.⁵⁰ This method of conducting ethics is far too reductive and oversimplifies what is often a great deal of rich teaching from the Catholic faith. Furthermore, the *ERDs* are also antagonistic to the lived experiences of the Catholic faithful.⁵¹ As much as the Catholic faith would like to think receiving healthcare is a straightforward process, there are often a great deal of complications that prevent

the simplification of a person's care into a concise list of directives.⁵² Consider, again, directive 58 regarding a PVS patient. While the patient may have agreed that MANH is a morally obligatory form of care, the care team might conclude that death is imminent and MANH is only prolonging the dying process and therefore can be considered morally optional, or extraordinary.⁵³ Or consider a patient who is on intensive life-sustaining measures. The patient might have previously stated that all life-sustaining measures should be done and are to never be removed. This is somewhat in line with the notion that life is sacred and could be aligned with directive 56 & 58.⁵⁴ However, the underlying rationale behind the Catholic notion of the sanctity of life and the patient's understanding of this notion might be radically different and extremely complex.⁵⁵ The *ERDs* do not have space for this type of discussion, this facilitation of ethics, this exploration of values and goals. The *ERDs* are, unfortunately, highly specific and lack the ability to engage with the human condition and its never-ending diversity. Again, this is not necessarily a negative. Medical professionals might require a more concise and straightforward definition/directive as they might only be primarily concerned with whether or not the institution is allowed to perform the intervention. But for those in ethics and Mission, a framework presentation of these directives is imperative as without it, there is a gap between what is directed and what is experienced. In other words, there is little room for interpretation and deeper understanding without a proper framework to turn to.

4. The Need for a New Edition of the *Ethical and Religious Directives*

Given the above discussion, it's difficult for ethicists and Mission workers in Catholic healthcare to further guide Catholic healthcare institutions as the broader healthcare landscape changes. As such, there have been some scholars of Catholic healthcare that suggest changes for future editions of the *ERDs* to best serve these two aspects of Catholic healthcare.⁵⁶ These

changes can be categorized into two major groups, the changes for pastoral reasons and changes for ethical reasons. These two are certainly not the only categories that can be made, but they categorize the various reasons well for this essay's discussion. As such, some arguments made by scholars are not well suited for this discussion and must be omitted.

4a. A Pastoral Need

The first major category of changes recommended for the *ERDs* are those of a pastoral nature. To briefly define it, pastoral care or to be pastoral is the sensitivity to the needs of those in care of the leading figure. In the Catholic church, this is generally understood as the duty of the pastor, somewhat self-descriptive. Even more broadly throughout Christianity, the term pastor can be generalized as the leader of a church. It is a pastor's duty to be deeply aware and understanding of the spiritual needs of the faithful.⁵⁷ It then becomes the pastor's duty to realize these spiritual needs through whatever means possible, typically adjusting the spiritual guidance provided during church services or providing spiritual guidance through counseling or events. Within Catholic healthcare, this notion of pastoral care becomes more complex as Catholic healthcare has duties to care for both the physical and spiritual needs of the person. Certainly, secular healthcare can provide spiritual care. But it is not as integrated as a religiously affiliated healthcare system such as that of Catholic healthcare. Catholic healthcare therefore looks at the notion of pastoral care in somewhat of a unique way.⁵⁸ It is the understanding that the care provided within a Catholic healthcare institution must equally consider physical and spiritual needs. It is very much improper if Catholic healthcare were to put one over the other.

What is curious about the current edition of the *ERDs* is their lack of understanding of the uniqueness of the human person and human conscience. The Catholic church has always held that God reveals moral truth through faith and reason.⁵⁹ This has a consequence that the

individual person can form one's own conscience and act on that conscience if it has been well informed.⁶⁰ This understanding of the individual conscience is notably absent from the current edition of the *ERDs*. Rather, they hold that they are the sole source of moral and ethical reasoning within Catholic healthcare.⁶¹ There is even the precedent that all Catholic healthcare institutions are to follow them if they are to be considered Catholic.⁶² This inability to factor the complexity of humanity and the lived experience of humanity creates a great deal of ethical and moral conflict within Catholic healthcare. While one would hope that all moral and ethics conflicts in healthcare are straightforward and with minimal interpretation, this is sadly not the case. Nearly every instance of moral/ethical conflict has multiple stakeholders, multiple values to consider of those stakeholders, even multiple levels of importance of those values.⁶³ As such, the current edition of the *ERDs* is a great disservice to the pastoral needs of patients entrusted to Catholic healthcare. A somewhat amusing consequence of this is that the current edition of the *ERDs* is also in conflict with itself.

By providing explicit directives, the *ERDs* are also in conflict with their own teachings. More specifically, directive 1, that states Catholic healthcare must be modeled after Jesus Christ.⁶⁴ This alone is not very descriptive. But consider again the concept of Mission in Catholic healthcare; "to extend the healing ministry of Jesus Christ."⁶⁵ This conflict might not be as evident as others mentioned in this essay. As such, to clarify, consider the multiple stories of Jesus healing on the Sabbath. In brief, most accounts of this story detail how Jesus came across a sick person in need of healing.⁶⁶ Given the deep need of healing, Jesus provided this healing despite work being forbidden on the Sabbath. Upon seeing this, the elders of the Jewish community came and questioned Jesus on his clear breaking of the Sabbath rest as prescribed in Jewish law. However, this accusation of breaking the Sabbath was not according to the law of God, but rather the laws

created and enforced by man. As Jesus regularly stated, he came to fulfill the law, not destroy it.⁶⁷ As such, these stories serve as reminders that humanity is regularly at fault for creating rules and codes that are not of God, but rather interpretations of God's truth. Therefore, we must not get caught up in doctrine or law that it distracts or detracts from our relationship with God.⁶⁸

Recall then directive 1. The *ERDs* are stating that Catholic healthcare must follow and be modeled after the example of Jesus Christ. Well, Jesus himself taught that manmade customs are not as important to God as one's relationship with God. This then creates a great deal of tension between the entire existence of the *ERDs* and the teachings of Christ. In other words, Christ himself taught that law and custom are secondary to relationship with God, yet the *ERDs* dictate that the directives described must be followed to be considered a "Catholic" healthcare institution. Again, the *ERDs* become almost entirely self-contradictory in their directorial nature and require a great deal of revision to resolve these tensions.

4b. An Ethical Need

The other major category for arguments in favor of another edition consist primarily of reasons from ethicists. The largest of these arguments is that the *ERDs* only have space for minimal ethics facilitation. To best explain this limited nature, consider a contrast between the *ERDs* and a well-known ethical framework such as Principlism. In Principlism, there are a set of principles from which one can analyze the ethics conflict.⁶⁹ From there, the values of all stakeholders can be impressed upon these principles and recommendations can be produced. While ambiguous and somewhat challenging to apply in a concrete fashion, there do exist specific approaches that can facilitate this process and provide more explicit guidance on how the principles ought to be applied.⁷⁰

Consider then the nature of the Catholic moral tradition and the *ERDs*. One can consider the Catholic moral tradition to be similar in concept to that of the principles in Principlism; a necessarily vague set of guiding concepts that can be further operationalized in a set of guidelines.⁷¹ This then could be the understanding that some might have of the *ERDs*. They are a form of directed interpretation of the Catholic moral tradition. However, this is arguably a misguided understanding of the Catholic moral tradition. While there are a number of formalized understandings of the tradition, they are not intended to be taken as the only authoritative interpretation. Rather, the Catholic moral tradition itself is both a moral and ethical framework that can then be applied. The *ERDs* then ought not be reduced to explicit directives when the entirety of the Catholic moral tradition is so rich in and of itself as an ethical framework.

To continue the discussion of the complexities between Catholic and secular healthcare ethics, consider the nature of ethics frameworks themselves. In the broader realm of healthcare ethics, there is no one singular framework that can be utilized as a catch-all framework. Every framework has its own strengths and weaknesses. However, in Catholic healthcare there is only one framework, the Catholic tradition. As such, there is less room for adaptation compared to secular healthcare. Therefore, a more cohesive and holistic understanding of the Catholic moral tradition is necessary for ethicists to properly conduct ethics consultations.⁷² However, the *ERDs* are not conducive to this as it provides only singular explanations of the Catholic moral traditions. This therefore restricts the ability of Catholic healthcare ethicists to conduct ethics facilitation, even within the Catholic moral tradition as discussed above.

Consider the nature of the role of secular ethics in non-religiously affiliated healthcare systems. These ethicists are not bound to a singular model or framework of ethics and can utilize whatever method is most favorable to the individual case, the system as a whole, or even the

method favored by the broader ethics community.⁷³ Secular ethicists conduct ethics based on the individual sets of values and their importance of the patient/proxy, the care team, and the healthcare system.⁷⁴ This is not so in Catholic healthcare according to the *ERDs*. The *ERDs* require adherence to the Catholic moral system through directives as the first level of ethical analysis, with the weighing of values coming secondary.⁷⁵ Again, unfortunately, this is where the shortcomings of the *ERDs* become apparent. Given the approach of the *ERDs* in providing singular interpretations of the Catholic moral tradition, it becomes ethically restrictive to not have a more open, framework-oriented application of the Catholic moral tradition for conducting ethics facilitation. To put this constraint another way, consider a case in a Catholic healthcare facility where an ethics consult is called. The ethicist begins the analysis of the case and refers to the *ERDs* in the deliberation phase of the consult. Given the restricted nature of the *ERDs*, the ethicist is only provided a singular understanding/application of the Catholic moral tradition when there can exist a number of various ethical options within it.

For this essay's discussion, consider a patient that is requesting artificial nutrition and hydration based on directive 58 that states there is a moral obligation to provide such an intervention. A good and wise Catholic healthcare ethicist will notice this and recognize this is a violation of the Catholic teachings regarding ordinary/extraordinary care. As such, when the ethicist meets with the patient and loved ones, there becomes a great deal of confusion on the part of the patient, the loved ones, and perhaps even the care team that are all of the impression that the *ERDs* are authoritative regarding the various ethical options. This then creates unnecessary ethical tensions both from within the institution and without. Certainly, it is acceptable for the USCCB to provide guidance for the Catholic faithful on how to best pursue their healthcare. But it becomes disingenuous for the USCCB to portray the *ERDs* as the only set

of ethical options for the Catholic faithful.⁷⁶ What is even more striking about this reality of the current edition of the *ERDs* is that previous editions did include appendices and discussion to further explain and provide guidance on concepts that were more involved and required deeper explanation beyond single-sentence directives.⁷⁷ As such, it becomes almost a lesson in irony that the USCCB has previously recognized the Catholic moral tradition is far richer and more ethically complex that can be reduced for directives yet refuse to design guidance in such a manner. Therefore, there exists a precedent that the USCCB can revise the current edition of the *ERDs* into a moral-ethical framework as made evident by the appendices of previous editions. This then can allow for not only the ethicists practicing ethics in Catholic healthcare but also the Catholic faithful themselves to engage their Catholic faith more thoroughly and better inform themselves on Catholic ethical decision-making for their healthcare.

5. How Mission and Ethics Must Cooperate to Sustain Catholic Healthcare

Given the discussion throughout this essay, the question posed at the beginning, how must Catholic healthcare respond to the diminishing role of religious healthcare, still stands. One major step proposed to achieve this goal is through a major revision of the *ERDs* that serves the purposes of improved pastoral and ethical practices. However, this revision alone is not sufficient as an individual intervention to sustain Catholic healthcare. It is strong in clarifying Catholic healthcare ethics for those who participate in Catholic healthcare. However, it does not address the broader question of sustainability. This is where a joint effort of Catholic healthcare ethics and mission is necessary. In short, Catholic healthcare ethics can ensure that the assessment of the institution's values are appropriate within medical practice with Catholic healthcare mission ensuring the institution's alignment with the Catholic moral tradition.⁷⁸ In this way, Catholic healthcare can move its position at present from a state of a sort of defensive

position into an offensive position. In other words, rather than framing the issue as Catholic healthcare being under duress or threat of closure, it can instead frame the discussion as Catholic healthcare providing a unique and strong type of care not found in other health systems.⁷⁹ This is a very nuanced but important shift for the identity of Catholic healthcare that must be approached with a great deal of care and caution.

5a. Catholic Values and Ethical Reality

The first point of clarification that must be made with this reaffirming of Catholic healthcare identity is found in the clarifications between Catholic values and ethical reality. While certainly, Catholic morality should not and cannot be compromised, this does not preclude the ability of the Catholic morality to be developed, adapted, and consistently reinterpreted with new information and new insights.⁸⁰ Consider the largest revision of the Catholic church's structures and application of the Catholic morality, Vatican II. This meeting brought a whole host of changes in the Catholic church, from how the liturgy was held to the way fundamental aspects of Catholic theology were to be interpreted and applied.⁸¹ As such, it is a strong disservice to Catholic healthcare to not consistently reevaluate and develop its ethical procedures alongside these ever-changing interpretations of Catholic values.⁸² To provide a concrete example of this, consider the situation of Catholic healthcare and the growing provision of euthanasia in European countries. Some Catholic scholars are of the impression that providing euthanasia is a logical and moral extension of the Catholic value of respect for the human person and the duty to provide care.⁸³ While this interpretation is generally misguided, it still brings a strong example of how Catholic healthcare, and the Catholic moral tradition ought to constantly interact and be in dialogue to face the very complex and difficult realities of healthcare ethics.⁸⁴ Consider the tragic case of an expectant mother that is faced with complications in the pregnancy. As such, the

options are to rectify the complication but risk losing the fetus or proceed without intervention but risk the life of both the mother and fetus. From a secular ethical perspective, the final decision is entirely up to the mother to determine how to proceed, regardless of the ethical approach. By contrast, there are some actions intrinsically wrong and cannot be allowed in Catholic healthcare.⁸⁵ But in this case, there are still a number of options that can be pursued, especially when analyzing the case through the principle of double effect.⁸⁶ Or even consider the case of a patient who is in intractable pain and suffering at the end of life. Some in secular healthcare ethics will argue that assisted death is permissible and obligatory if requested.⁸⁷ On the surface, a Catholic healthcare ethicist might scoff at this suggestion as it is well documented that this is not an option.⁸⁸ But exploring further into the Catholic moral tradition, numerous other options begin to arise that can still provide good end-of-life care without ever going into the realm of assisted death interventions.⁸⁹ All of this discussion has been in service of the point that the Catholic moral tradition is far more complex and rich than much of the publicly facing discussion might imply. Therefore, it becomes a very obvious, self-stating question of why is Catholic healthcare not operating in and promoting this ethically and morally diverse landscape?

Some might find it convenient to take the defensive position that Catholic healthcare ought not to engage at all, even in intellectual dialogue, with traditionally immoral actions/interventions, such as those in favor of euthanasia and other assisted death interventions.⁹⁰ However, this is not nor ever has never been the position of the Catholic Church. The Catholic church has always been in the position that it is a religion entrenched in the lived reality of humanity, in both faith and reason.⁹¹ As stated by John Paul II, “faith and reason are two wings upon which the human spirit rises to the contemplation of truth.”⁹² As such, it is a denial of the Catholic faith to refuse to engage in ethical thought on topics even as well

described, such as euthanasia. Therefore, Catholic healthcare, and the scholars engaged with it, cannot retreat and utilize, “the Benedict option;” shifting from reaching out to an attitude of staying within.⁹³ This is intimidating and requires a great deal of courage and fervor as there are many outside of the Catholic tradition that will challenge and question the Catholic faith on their values and ethics practice. These challenges then must be faced with confidence and tenacity with the full weight of the Catholic moral tradition behind it. It is the position of Catholic healthcare to take a proverbial step back and take a look at its values, provide a new assessment of these values, and realign these values with the present models of healthcare ethics.⁹⁴ This way, Catholic healthcare can present itself as a unique and alternate interpretation of the incredibly diverse and complex ethical reality of healthcare. In this way, this revised understanding of Catholic healthcare ethics can both respond to those who challenge its ethical systems and provide a valuable tool for those within Catholic healthcare to further develop their individual consciences and best participate in ethics without resorting to a restrictive list of directives that run the risk of further muddying and complicating Catholic healthcare ethics.

5b. Ethics Informs Mission and Vice Versa

The second major component and point of clarification for this notion of sustaining Catholic healthcare through ethics and mission is the very intimate relationship necessary between ethics and mission. Many Catholic healthcare systems already have mission and ethics under a single office or division within the institution.⁹⁵ However, there does exist a culture in Catholic healthcare that mission supersedes ethics. This is not intended to detract from the importance of ethics within Catholic healthcare. Rather, it is something of a consequence that has come to be throughout the history of Catholic healthcare.⁹⁶ It can be argued that since the 1970-80s, Catholic healthcare ethics has been under the purview of Mission since Mission was an already

established and well-integrated department of Catholic healthcare. Put another way, ethics for Catholic healthcare was added onto the responsibilities of Mission. As such, there arose a subconscious understanding that ethics was a consequence of Mission; that Mission was at the helm with ethics as its support.⁹⁷ This reality of many Catholic healthcare systems is problematic for a number of reasons.

The first reason of complication of this present relationship is that Catholic healthcare ethics utilizes different methodologies and has different goals from Mission; both divisions will approach and propose answers to the same issue in different ways.⁹⁸ This is not inherently a bad thing. Rather, it is a unique, positive consequence of Catholic healthcare providing two separate avenues when considering the same issue. However, this difference in approach must be well acknowledged and accounted for not only in the nature of their respective works, but also in organizational separation. This is a drastic but arguably necessary change in the organizational structures of Catholic healthcare, Mission and Ethics ought to be separated organizationally to best allow for each arm of Catholic healthcare to focus on its respective work. This is not to say that these two new departments must not communicate after this separation. Quite the contrary. This separation is intended to provide space for each department to more efficiently approach their work that will then allow a greater level of flourishing for future meetings and inter-department projects that otherwise would not be possible.⁹⁹ While it is true that this separation would cause more organizational complication, it is the authors position that this separation, while more complex in nature, is a necessary change due to the divergent natures and goals of these departments as discussed above. Furthermore, it is certainly recognized that not all Catholic healthcare institutions/systems have Mission and Ethics united in a single department. As such, this separation cannot be unilaterally applied to Catholic healthcare as a whole. But this

does not diminish the intent behind this proposed separation, the intended deeper communication of Mission and Ethics to best serve the goals of Catholic healthcare and support its identity.

The second point of complication of the relationship between Ethics and Mission is the very apparent lack of specialization present in each department. It is of little surprise that mission existed in Catholic healthcare long before ethics. It can be argued that Mission has always been at the heart of any Christian that provided any type of care to the sick and dying. This fact is well reflected in the education and specialization of those in Catholic Mission and Ethics. As of 2009, a vast majority of leadership within Mission were trained in Theology.¹⁰⁰ This is well argued as the goals of Mission can be broadly stated to align the actions and policies of Catholic healthcare with that of the Catholic tradition, especially Catholic Social Teaching.¹⁰¹ However, what is arguably more curious is the fact that a significant number of ethicists in Catholic healthcare trained in Theology rather than ethics specifically.¹⁰² On the surface, this seems like a logical consequence of Mission adopting Ethics as Catholic healthcare further professionalized. Put another way, Catholic healthcare utilized those in Mission to perform ethics as they were already trained in moral philosophy and theology, the foundations of the Catholic moral tradition. However, this has slowly become a detriment to Catholic healthcare as not all those working in Mission are equipped to practice ethics. While there are similarities between the Catholic moral tradition and ethics, especially in a Catholic healthcare system, there are still strong differences between Mission and ethics practices. For Mission, as stated above, its goals are to align the institution with the Catholic moral tradition and the example of Jesus Christ.¹⁰³ However, for ethics, its goals are to analyze, elucidate, and facilitate the discussion surrounding all the various stakeholder's values in an ethics conflict.¹⁰⁴ For Catholic healthcare, the moral tradition becomes a major backdrop for ethics practice. However, the methodologies used in ethics are not at all the

same as those in Mission as made clear here. While those trained in Mission can also be trained in ethics practice, they are not the same.¹⁰⁵ Therefore, it is the author's argument that the two departments then should not be staffed by the same personnel if possible. Having staff who are doubled trained in Mission and Ethics is still a possibility, especially considering the resource constraints that are unavoidable at times.¹⁰⁶ However, having ethics being practiced by those who are not trained in ethics can be extremely detrimental to the integrity of the institution's ethics. As such, it is strongly recommended that the departments of Mission and Ethics are to be staffed and run by individuals trained and specialized in their respective department goals. Again, it must be reiterated that resource constraints may limit the level to which this recommendation can be followed. But it does not prevent Catholic healthcare institutions from hiring/training personnel that can be specialized in their respective field of practice. Just as all other specialists of a healthcare system must be certified and trained for the work they are to specialize in, so too ought Catholic healthcare systems specialize its workers.

Finally, it must be reiterated that this distinction between Mission and Ethics is arguably intended to bring about deeper cooperation in Catholic healthcare that leads to the sustainability of Catholic healthcare as a whole. While it is recommended that these two arms of Catholic healthcare be separated into unique departments, this is not to further silo each department's work. Rather, it is this division of labor that allows the specialization of each department, thereby lifting up Catholic healthcare as a fully unique form of healthcare. By providing space for each department to focus on their respective work, it allows for a greater level of resource allocation to that specific department's work rather than having mission leaders try to conduct ethics and vice versa. This separation of these two arms of Catholic healthcare into unique departments echo the "two wings" analogy originally provided by John Paul II; Mission provides alignment

in matters of faith and morality while Ethics provides guidance on values and diversity. It is by these two separate yet still united departments upon which Catholic healthcare can rise and distinguish itself as a unique form of healthcare that cannot be found elsewhere in the broader healthcare society.

6. Conclusion

This essay has presented a challenging, unique, yet necessary critique of the current status of Catholic healthcare ethics, Catholic healthcare mission, and the *Ethical and Religious Directives for Health Care Services*. First, this essay discussed the general history of Catholic healthcare and the modern turn of Mission of Catholic healthcare. This provided a strong backdrop for the larger argument this essay aims to convey; that Catholic healthcare and its Ethics has arguably strayed from its roots and is struggling with its identity. Next, this essay explained the strengths and weaknesses of the current edition of the *Ethical and Religious Directives (ERDs)*. This section provided a strong explanation for how the current understanding of Catholic healthcare ethics, while useful in some cases, is arguably deficient in many other ways, usually to the detriment of Catholic healthcare ethics and those receiving care in Catholic healthcare institutions. Third, this essay explained and further analyzed why the current edition of the *ERDs* need to be revised. Through the analysis of this essay, a new edition of the *ERDs* can benefit both Catholic healthcare's delivery of pastoral care and ethics. This then leads into the final point this essay has made; Catholic healthcare mission and ethics need to be reevaluated and reorganized within the organizational structures of Catholic healthcare if it wishes to sustain itself. While a new edition of the *ERDs* provide a great deal of revitalized fervor and guidance on how ethics ought to be run, these benefits are squandered if Catholic healthcare as a whole is without general guidance on how to best relate to the growing secular healthcare society. This

then is the avenue for future discussion that authors and leadership in Catholic healthcare must take if Catholic healthcare is to persist. Catholic healthcare can help itself by revising the *ERDs* to better fit within modern healthcare ideologies, both internally for those in Catholic healthcare and externally for those critiquing it. However, as a unique entity, Catholic healthcare must still contend with those who question its validity and purpose in the modern era. As such, this is a question best answered by both Catholic healthcare ethics and mission and must not be ignored or else risk the further loss of identity of Catholic healthcare.

Endnotes

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