FEATURE ARTICLE

Ethics Consulting for Multiple Catholic Health Care Organizations

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Over the past several decades, health care ethics has become a very important subspecialty, especially in the Roman Catholic context. Numerous scholars in Catholic ethics have accepted positions as ethicists for particular Catholic hospitals or Catholic health care systems. Other scholars have stayed in their academic positions, but focused much of their research and writing on health care ethics. Still others have become ethicists in various research institutions ("think tanks") and related national organizations which address ethical issues in health care.

My own situation, while strongly focused on health care ethics, is somewhat different from any of the health care ethics settings which I have just mentioned. Instead of working for just one Catholic health care organization, over the past 30 some years, I have been serving as a health care ethics consultant to a number of Catholic health care organizations, including hospitals, nursing homes and larger health care systems. Much of this work has taken place in the large metropolitan area where I live (Baltimore-Washington), but some of it has occurred in other parts of the country. My service as a consultant began while I was still a full-time seminary professor, but it has continued since I have moved into my 70s and, as one of my doctor friends says, "allegedly retired." I am certainly not the only Catholic ethicist who works as a consultant to a number of different Catholic health care services, but my experience may be less common than some of the other approaches to work as a health care ethicist.

Some months ago, I received a very welcome invitation from CHA to reflect on my experience as a health care ethics consultant, particularly with a view to seeing whether there are any unique aspects of my experience as compared to those who serve as health care ethicists in one of the more typical settings. In what follows, I will describe five key themes from my decades of experience in health care ethics. Four of these themes strike me as quite common among all of those who serve as Catholic health care ethicists. The final theme is perhaps more specific to my role as a consultant to a variety of Catholic health care providers.

First, to be effective as a Catholic health care ethicist, I have found it necessary to shape my reading and research in a manner which makes me able to address

the wide range of issues which are likely to come up in health care ethics. I continue to read widely in the field of fundamental moral theology and related disciplines. I read many of the books and articles written by other health care ethicists, especially those who work from the Roman Catholic tradition. But I also take the time to read key sections of many of the standard medical publications such as the *New England Journal of Medicine* and the *Journal of the American Medical Association*. Journals such as these often have helpful articles on ethical issues, and are what doctors and other health care professionals are likely to read. As a young priest, I did not anticipate that I would subscribe to these journals, but this is what has in fact happened. While I am always enriched by my knowledge of Catholic moral theology, my reading of these additional sources has clearly enhanced my ability to serve as a health care ethicist. I also take part in local and regional ethics groups, some of which have an interfaith or philosophical focus.

Second, a great deal of what I do as a consulting health care ethicist falls under the rubric of education—education of the total hospital community and all the constituent parts of this community. The Catholic moral tradition is a rich and wonderful tradition, but it is often a sophisticated and complex tradition. My experience is that leaders and other key figures in Catholic health care genuinely want to learn what the Catholic health care ethics tradition teaches about a whole variety of ethical issues. They also want to learn fundamental principles of ethics, principles whose applications often go beyond the realm of health care itself. At this point I could not possibly add up the number of lectures I have given on the *Ethical and Religious Directives for Catholic Health Care Services*, most recently on the revised sections of the ERDs which address artificial nutrition and hydration.

I am not suggesting here that I am the only educator in the places where I serve as an ethics consultant. Often my role is to suggest other resources such as books and articles, online opportunities, guest speakers, etc. So I understand my role as helping create a climate of ongoing education and learning for trustees, administrators, ethics committee members, and the hospital community as a whole.

Third, following from the theme of education, a key element in my approach over the years has been an effort to enable all of those whom I serve— trustees, administrators, doctors, nurses, social workers, pastoral caregivers, etc.—to think ethically for themselves. I do not think of this as trying to put myself out of business, for there always seem to be new ethical questions for which my skills may be needed. But so often the health care professionals have ethical insights which can enhance everyone's approach to an issue, if they can develop the confidence to share these insights with one another. I think anyone who works full-time as a health care ethicist would want to enable the ethical wisdom of those with whom he or she works. But as a consultant, while I visit each of the hospitals I serve very

regularly, and while I try to be present for difficult ethics consults, there are often times when I am not present. This makes the ethical abilities of the ethics committee members and others all the more important. I think the same thing is true in a great many hospitals. These hospitals may have some ethical support but they are often without a full-time professional ethicist. So the effort to strengthen the overall ethical competence of hospital personnel can be a very valuable effort in support of the mission of the hospital.

Fourth, I have found that the ethics program of any Catholic hospital, nursing home, or health care system must include an element of ongoing dialogue with the local church, particularly with the diocesan bishop. Catholic moral teaching on health care is clear but complex. Often difficult decisions are needed in terms of how to apply this tradition in a variety of local circumstances. The need for such decisions can arise in a number of contexts, but the subject of partnerships between Catholic health care entities and other local health care providers is a key example of a theme with many public implications, one which calls for the involvement of the diocesan bishop. Such discussions with diocesan bishops need to take place in a true spirit of dialogue, openness and mutual respect. Many potential problems can be avoided if this climate of respect and trust can be maintained.

Key individuals in Catholic health care such as board leaders, administrators, and sponsors all need to be part of the dialogue with bishops. But so often the issues which need to be discussed are ethical in nature so that the hospital or health system's ethics personnel need to be involved in these discussions, at least indirectly. For my part, I have been involved in direct discussions with diocesan bishops about health care ethics matters on a great number of occasions over the years. The fact that I am a priest, and sometime personally acquainted with a given diocesan bishop, may mean that the Catholic health care leaders whose organizations I support have been more inclined to have me speak directly with a bishop about a partnership or other ethics issue. But the larger point from my experience is that Catholic health care ethicists, in whatever manner, need to support ongoing dialogue between Catholic health care and diocesan bishops.

Fifth, there is the question of the role of confidentiality in the work of a health care ethicist. Surely many issues in health care ethics relate to the common Catholic tradition of faith and ethics. Catholic health care ethicists have a strong and positive custom of sharing insights which are rooted in this common Catholic heritage. Catholic health care ethicists share a desire to see the entire ministry of Catholic health care thrive and flourish. Hence when there are insights which can be shared on complex ethical matters (e.g., nutrition/hydration decisions and decisions about critically ill newborn children), Catholic ethicists share these insights with one another without revealing the identity of specific patients.

This sharing of insights is as it should be, and everyone's ministry of health care is better as a result.

But there are also situations in which local Catholic facilities or the larger Catholic systems are making delicate business decisions on topics such as opening new lines of service, purchasing physician practices, erecting new buildings or entering into health care partnerships. These decisions often have very large ethical implications which call for support from persons with high-level expertise in ethics. While these sorts of decisions are rooted in a commonly shared set of ethical principles, in and of themselves, they are clearly confidential matters. Anyone who would give ethical advice on such matters is unequivocally obligated to observe strict confidentiality.

Health care ethicists who work for only one health care facility or system will normally have confidential information relating to that one facility or system. But for someone like me who provides ethical advice to a number of different Catholic facilities or systems, I may be aware of confidential matters related to several different facilities or systems. This fact raises the stakes concerning confidentiality and calls on me to be especially vigilant never to use any confidential information except in service of the specific facility or system which has asked for my help on a confidential matter. To a certain extent the situation reminds me of the obligations imposed on the priest when he hears confessions: he may never use the specific information he learns in the confessional except to help that individual penitent as part of the confession itself.

I am not suggesting that this situation is impossible. I have always found it possible to keep separate matters separate and to avoid any true conflicts of interest. But I did want to note that the obligation of confidentiality is experienced a bit differently by someone who serves as an ethics consultant to a number of different Catholic facilities and systems. I should also note that from all these confidential situations, there can emerge certain generalized learnings, detached from any specific cases. Sometimes these generalized and detached learnings can be appropriately shared, e.g., reflections on the underlying ethical standards which bishops normally expect to be followed if they are to give approval to a proposed health care partnership.

Over my decades of experience as a Catholic health care ethics consultant, I have been privileged to meet and work with many outstanding leaders and people who are a part of the Catholic health care ministry. My experience with all these persons has made my work as a health care ethicist a source of great and enduring personal happiness. My decision to continue my work as a consultant, even in this later time in life, has been very easy because of the people I have met in Catholic health care.