

HCEUSA

**Health Care
Ethics USA**

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for the Catholic
Health Ministry

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A Note on the HCEUSA Publishing Schedule

In an era of constant transformation within healthcare ethics, Health Care Ethics USA (HCEUSA) has remained committed to thoughtful discourse and intellectual exchange. As we navigate the ever-shifting landscape of healthcare and bioethics, we are excited to announce a significant adjustment in our publication strategy.

HCEUSA has historically adhered to a structured quarterly publication model, which has allowed us to share research, essays, and innovative insights on a predictable basis. However, recognizing the evolving nature of ethical discourse and the diverse array of voices contributing to this dialogue, we are embracing a "Content Publishing" approach. We will accept and review pieces as they are submitted and publish an edition when we have enough content. This schedule will also permit more topic specific editions. This shift empowers authors, granting them the flexibility to share their work when it resonates most profoundly, without constraints imposed by a fixed schedule. Ultimately, this evolution underscores our dedication to nurturing intellectual growth and ethical exploration within the realm of healthcare.

HCEUSA started as an electronic newsletter for those practicing ethics within Catholic healthcare, predominantly in the St. Louis area. The journal has seen several shifts

in format and content through the years, expanding its readership along the way. However, we wish to remain a location for continued dialogue among practicing ethicists and those in academia who share our interests and mission. Unlike a peer reviewed academic journal, HCEUSA is not constrained in its publications. We remain committed to the sharing of ideas, even in their early formulation. We believe that this openness to contributions fosters more dynamic discussion. Ethics, as we understand it, is a field that must adapt with new challenges. By embracing this transformation, we are enthusiastic about cultivating fresh avenues for collaboration, dialogue, and discovery in the ever-essential domain of healthcare ethics.

We extend our profound appreciation to the authors, reviewers, readers, and advocates who have played an instrumental role in shaping Health Care Ethics USA. Your steadfast commitment to ethical discourse has made HCEUSA a successful place for the sharing of information and ideas. We know that this commitment to dialogue will continue as we shift towards a new publication schedule.

With sincere appreciation,

NATHANIEL BLANTON HIBNER, PH.D
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Health Care Ethics USA (HCEUSA)

Generating Insights from Catholic Social Teaching: Ethical Guidelines for Artificial Intelligence in Health Care Ministries

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INTRODUCTION

1. In the annals of human history, few innovations have been as transformative as the printing press and the machinery of mass production in the Industrial Revolution. Today, we stand on the precipice of another monumental shift: the rise of generative artificial intelligence (gAI). This technological marvel, with its potential to revolutionize sectors like Catholic health care, beckons us to “read the signs of the times and respond to them in light of the Gospel.”¹ The complexities of gAI are vast, and our aim is to offer some practical ethical guidance on this immense topic. Catholic moral and social teaching has insights that can guide the development, deployment, and evaluation of artificial intelligence in health care. This essay argues that Catholic social teaching (CST) in particular offers insights that shape axioms for generative AI in health care applications.

WHAT IS GENERATIVE AI?

AI, or Artificial Intelligence, refers to the simulation of human intelligence in machines. It's a branch of computer science aiming to create systems able to perform tasks that usually require human cognition, such as decision-making, pattern recognition, understanding language, and problem-solving. When AI is qualified as “generative,” it means that it is a type of artificial intelligence that has the capacity to produce outputs that mimic human-created content (text, images, etc.).

At its core, AI is a tool. Just as a hammer is an extension of the hand for driving nails, AI can be seen as an extension of human cognition for processing data, recognizing patterns, and performing tasks. One may think of AI as a highly advanced cognitive-arithmetic-linguistic-algorithmic tool: AI has multifaceted capabilities from basic arithmetic to complex cognitive tasks like natural language understanding.

Another way to conceptualize artificial intelligence is through its three primary functions: automation, augmentation, and assistance. First, AI's automation capabilities transfer specific tasks from human oversight to algorithmic control, thereby reducing manual labor and increasing efficiency. Second, AI serves to augment human capabilities by enhancing cognitive processes and expanding the collective knowledge base, thereby enabling more informed decision-making and problem-solving. Lastly, AI assists in streamlining operations by providing real-time support and guidance, which in turn lightens the human workload and improves overall productivity.

However, the line can get blurred because of AI's ability to mimic certain human-like qualities, such as conversation, generating digital images, or playing games. Regardless of how advanced or "intelligent" an AI might seem, it does not have feelings, consciousness, or self-awareness. It operates based on the code and algorithms it's been designed with, making it a tool created and directed by humans.

There is a parallel between the rise of AI and the era of industrialization. The following five points suggest this: One, with AI, many anticipate the displacement of jobs. Just as industrialization led to the automation of many manual, labor-intensive tasks (making certain crafts obsolete), AI has the potential to automate many "thinking-intensive" jobs that involve data analysis, customer service, and even some aspects of decision-making.

Two, relatedly, AI could require a skill shift. Industrialization required workers to acquire new skills to operate machines. Similarly, the AI era requires a workforce that understands how

to work with, manage, and even program these new tools. At the time of this writing, a great many early adopters of AI have focused on the art of the prompt: how to get AI like ChatGPT to produce the intended results the user wants by making the prompt "perfect."

Three, many expect AI to increase productivity of certain work. Just as machines increased the scale and efficiency of production of goods, AI can increase efficiency in various sectors, from finance to healthcare, by handling large datasets and performing complex calculations at speeds unimaginable to humans.

Four, many see immense societal implications of AI. The industrial era brought about significant societal changes, from urbanization to changes in work-life balance. Similarly, AI has the potential to bring profound societal shifts, such as changes in how we view privacy, the nature of work, or even what tasks are deemed valuable.

Finally, there are ethical concerns with AI. Industrialization raised concerns about worker safety, fair wages, and working conditions. AI introduces its own set of ethical issues, from bias in algorithms to surveillance concerns.

Just as industrialization transformed societies, economies, and ways of life, AI promises (or threatens, depending on one's perspective) to bring about its own set of transformative changes. The challenge for societies is to harness the benefits while mitigating potential drawbacks and ensuring equitable outcomes. We may think of AI, and generative AI in particular, as marking the industrialization of thought.

This term implies the mechanization and systematic production and execution of cognitive and creative tasks, similar to how industrialization referred to the mechanization of physical labor. For example:

Standardization and Scalability: Just as industrialization led to the standardized production of goods on a large scale, AI allows for the standardized processing of data and decision-making on scales previously unattainable. An AI model, once trained, can be deployed countless times across different devices and platforms, producing consistent results.

Efficiency and Speed: Industrial machines increased the speed of production. Similarly, AI can process and analyze vast amounts of data at speeds far surpassing human capabilities.

Specialization: With industrialization, machines were often designed for specific tasks, leading to specialized production lines. In AI, there are specialized models for various tasks, from image recognition to natural language processing.

Transformation of Human Labor: Just as machines reduced the need for manual labor, AI reduces the need for human cognitive labor in certain areas. Tasks like data analysis, which might take humans hours, can be completed in moments by AI.

Depersonalization: A criticism of industrialization was that it could lead to the depersonalization of work, turning craftsmen into mere cogs in a machine. Similarly, there's a concern that relying too heavily on AI, especially in areas like decision-making, might

strip away the human touch, intuition, or ethical considerations.

Transformation of Skill Sets: As industrialization changed the skills workers needed, AI's rise emphasizes the need for new skills in the modern workforce, such as data literacy and understanding AI ethics.

In many ways, the phrase industrialization of thought aptly captures the transformative impact of AI on cognitive tasks and broader societal functions. However, it is essential to recognize that while AI can simulate many aspects of human thought, it lacks consciousness, emotions, and the nuanced understanding that humans bring to tasks.

Generative artificial intelligence (gAI) represents a significant shift in the realm of computational capabilities. Unlike traditional AI systems that primarily focus on analysis and prediction, gAI is designed to create. This creation can range from generating coherent text to simulating intricate biological processes. The potential applications of gAI are vast, especially in sectors like health care. For instance, gAI can revolutionize diagnostics by analyzing extensive datasets to identify patterns that might be imperceptible to the human eye. This could lead to the early detection of ailments even before they manifest. Additionally, by understanding a patient's unique genetic makeup, lifestyle, and medical history, gAI can offer personalized care, optimizing treatment outcomes. Another promising application is in the realm of research acceleration. The drug discovery process, which traditionally spans several years, could be significantly condensed with gAI simulating molecular interactions, predicting

drug efficacy, and ensuring safety.²

Sara Vaezy explains four strategic domains of gAI applications in health care.³ First, in the clinical domain, gAI has the potential to support clinical decision-making, automate mundane tasks, and assist providers with documentation. Second, from the patient's perspective, gAI could augment patient experience in a highly personalized, precise way based on their unique needs, motivations, preferences, and history. Third, the administrative domain contains numerous gAI opportunities for various tasks such as predictive scheduling, billing applications, etc. Finally, Vaezy points to several gAI applications to back-office functions such as applications that intercept and redirect inquiries to the best channel or outlet to support the specific needs of the patient or consumer.

Generative AI technologies are rapidly maturing and finding applications in various domains, including software engineering. For instance, gAI can be used in software engineering use cases such as translating natural language to code, code translation, and code auto-completion.⁴ However, the introduction of gAI into various sectors also brings forth a plethora of ethical considerations. Concerns range from potential infringements on copyrights due to the replication and production of content by gAI, the risk of job losses due to automation, to challenges in discerning truth from fiction given the ability of AI to create realistic content.⁵

The ethical implications surrounding generative AI are profound. While the technology offers promising advancements, it also underscores the multifaceted ethical landscape that demands

careful consideration and proactive measures as it continues to evolve.⁶

As the above suggests, the issues are vast and many:

1. **Theft of Intellectual Property:** Generative AI can replicate and produce content, leading to potential infringements on copyrights and the devaluation of original creations.
2. **Displacement of Workers:** As AI automates tasks, there's a risk of job losses, especially in sectors reliant on repetitive tasks, potentially leading to economic and social disruptions.
3. **Loss of Autonomy:** Over-reliance on AI recommendations can diminish human decision-making, making individuals overly dependent on algorithms for choices.
4. **Erosion of Human Dignity and Dignity of Work:** Beyond automating tasks, AI can reduce the perceived intrinsic worth of human contributions, undermining the unique value and experiences individuals bring.
5. **Data Privacy and Confidentiality:** AI models, especially those that generate content based on vast datasets, can inadvertently reveal private information or patterns, posing risks to individual privacy.
6. **Bias and Discrimination:** AI models can reflect and amplify societal biases present in their training data, leading to unfair or discriminatory outputs.
7. **Authenticity and Truth:** The ability of AI to create realistic content, like deepfakes, challenges our ability to discern truth from fiction, potentially enabling misinformation.
8. **Economic Inequality:** The concentration of AI capabilities among a few entities can exacerbate economic disparities,

with wealth and power becoming more centralized.

9. **Safety and Reliability:** Advanced AI models can produce unpredictable results, posing risks when deployed in critical sectors.
10. **Depersonalization:** An over-dependence on AI for personal tasks can diminish human-to-human interactions, leading to impersonal and detached experiences.
11. **Transparency and Accountability:** The "black box" nature of some AI models can obscure decision-making processes, challenging accountability and understanding.
12. **Environmental Concerns:** The computational demands of training AI models can lead to significant energy consumption, raising environmental and sustainability concerns.
13. **Over-reliance and Loss of Skills:** Excessive dependence on AI can result in the atrophy of essential human skills, as machines take over tasks previously done by humans.
14. **Anthropological Implications:** AI's ability to create art or philosophical content raises questions about human uniqueness, creativity, and consciousness.
15. **Regulatory and Legal Challenges:** The rapid advancement of AI can outpace legal and regulatory frameworks, leading to potential conflicts and ambiguities.

Each of these points underscores the multifaceted ethical landscape of generative AI, emphasizing the need for careful consideration and proactive measures as the technology evolves. The ethical implications are profound, and the Catholic Social Teaching (CST) offers a beacon.

PILLARS OF CATHOLIC SOCIAL TEACHING

CST, rooted in millennia of theological reflection, provides a moral compass. Drawing from many documents of modern CST, we find that a number of key values, ends, and mechanisms to effectuate change. Each of these, in turn, point to general ethical principles guiding Catholic health care. I will organize our reflections of CST around three pillars – axiological, eschatological, and sociological – to shed light on the key principles these bring to bear on generative AI questions.

Axiological Pillar: The axiological pillar describes essential values at the center of human personhood, communal living, and relationship with God. These are human dignity, the common good, and stewardship.

To begin, human dignity is the inherent dignity rooted in being created in the image and likeness of the divine: "Human persons are willed by God; they are imprinted with God's image. Their dignity does not come from the work they do, but from the persons they are."⁷ As an essential value, human dignity corresponds to two general principles: respect human dignity and respect human life from conception to death. These are interrelated, of course, but distinct principles guiding behavior.

Next, the common good refers to the context and capacity for human flourishing in community. These words describe the common good at Vatican II:

...the sum of those conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfillment,

today takes on an increasingly universal complexion and consequently involves rights and duties with respect to the whole human race. Every social group must take account of the needs and legitimate aspirations of other groups, and even of the general welfare of the entire human family.⁸

Corresponding to the value of the common good we have the general principles of promoting the common good and enabling participation in the common good itself.

A third essential value in CST I will name as stewardship, which pertains to the dignity of work: humankind's participation in God's plan as created co-creators. St. John Paul II had this to say:

Even though it bears the mark of a bonum arduum, in the terminology of Saint Thomas, this does not take away the fact that, as such, it is a good thing for man. It is not only good in the sense that it is useful or something to enjoy; it is also good as being something worthy, that is to say, something that corresponds to man's dignity, that expresses this dignity and increases it. If one wishes to define more clearly the ethical meaning of work, it is this truth that one must particularly keep in mind. Work is a good thing for man—a good thing for his humanity—because through work man not only transforms nature, adapting it to his own needs, but he also achieves fulfilment as a human being and indeed, in a sense, becomes 'more a human being'.⁹

More recently, Pope Francis had this to say in

his encyclical on caring for the Earth:

We were created with a vocation to work. The goal should not be that technological progress increasingly replace human work, for this would be detrimental to humanity. Work is a necessity, part of the meaning of life on this earth, a path to growth, human development and personal fulfilment.¹⁰

In sum, stewardship calls upon us to abide by several general principles: (1) honor the spirituality of work, (2) respect the dignity of work itself and the workers (cf. above), (3) prioritize the worker over utility and efficiency, (4) exercise just use and allocation of resources corresponding to the universal destiny of goods (versus private property), and (5) act to maximize sustainability of resources.

Eschatological Pillar: The eschatological pillar orients humankind to the ends of God's invitation: a transcendent horizon fulfilled by our love for God and for neighbor. This is a 'now and not yet' pillar. The horizon includes ends such as responsibility and religious liberty, social justice, integral human development, and integral ecology.

The eschatological horizon in our tradition calls for responsibility and religious liberty. In the words of *Dignitas Humanae*:

In all his activity a man is bound to follow his conscience in order that he may come to God, the end and purpose of life. It follows that he is not to be forced to act in a manner contrary to his conscience. Nor, on the other hand, is he to be restrained from acting in accordance with his conscience, especially in matters religious.

The reason is that the exercise of religion, of its very nature, consists before all else in those internal, voluntary and free acts whereby man sets the course of his life directly toward God. No merely human power can either command or prohibit acts of this kind. The social nature of man, however, itself requires that he should give external expression to his internal acts of religion: that he should share with others in matters religious; that he should profess his religion in community. Injury therefore is done to the human person and to the very order established by God for human life, if the free exercise of religion is denied in society, provided just public order is observed.¹¹

Thus, in terms of general principles related to responsibility and religious liberty, we have the following. One, persons and corporations should act responsibly and be held accountable. Two, respect for personal and corporate conscience should be established in law within the parameters of the public order. Finally, respect for diversity of views should be a hallmark of communal living.

Social justice is another key component of our eschatological horizon. Lisa Cahill defines social justice as “inclusive participation in the common good.”¹² The Compendium of the Social Doctrine of the Church states, “Ever greater importance has been given to social justice, which represents a real development in general justice, the justice that regulates social relationships according to the criterion of observance of the law.”¹³

The general principles as they relate to social justice include (a) promoting participation in

society, (b) establishing commutative fairness between parties, (c) encouraging contributive fairness of individuals and groups, (d) ensuring proper distribution of benefits and burdens, and (e) exhibiting charity in the absence of justice.

Next, the eschatological component includes integral human development in our horizon. Benedict XVI states,

The truth of development consists in its completeness: if it does not involve the whole man and every man, it is not true development. This is the central message of *Populorum Progressio*, valid for today and for all time. Integral human development on the natural plane, as a response to a vocation from God the Creator, demands self-fulfilment in a 'transcendent humanism which gives [to man] his greatest possible perfection: this is the highest goal of personal development.' The Christian vocation to this development therefore applies to both the natural plane and the supernatural plane; which is why, 'when God is eclipsed, our ability to recognize the natural order, purpose and the 'good' begins to wane.'"¹⁴

The general principles of integral human development include but are not limited to the following. One, design, development, and deployment of technology should be in service to the person, not vice versa. Two, persons should be afforded the opportunity to develop competencies and talents. Three, institutions should cultivate an appreciation of the human person in totality.

Finally, an integral ecology is a component of

the eschatological pillar of CST. In *Laudato Si'*, Pope Francis writes,

Since everything is closely interrelated, and today's problems call for a vision capable of taking into account every aspect of the global crisis, I suggest that we now consider some elements of an integral ecology, one which clearly respects its human and social dimensions. [...] When we speak of the 'environment', what we really mean is a relationship existing between nature and the society which lives in it. Nature cannot be regarded as something separate from ourselves or as a mere setting in which we live. We are part of nature, included in it and thus in constant interaction with it.¹⁵

Ensuring that technology is not “severed” from ethics, at least two general principle(s) apply: (1) understand the interconnectedness of all things, and (2) exercise sustainable development and use of technology.

Sociological Pillar: The sociological pillar provides specific mechanisms to be exercised in social contexts in pursuit of the ends and values mentioned above. First, solidarity, based on the connection and relationship of humankind, is “a firm and persevering determination to commit oneself to the common good. That is to say to the good of all and of each individual, because we are all really responsible for all.”¹⁶ Thus, the general principles of solidarity include (1) embracing a culture of encounter, (2) exercising empathy, (3) build unity with diversity, and (4) engage inclusive practices.

Second, subsidiarity ensures that decision-making should be localized, ensuring

community relevance. Pius XI writes,

Just as it is gravely wrong to take from individuals what they can accomplish by their own initiative and industry and give it to the community, so also it is an injustice and at the same time a grave evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organizations can do. For every social activity ought of its very nature to furnish help to the members of the body social, and never destroy and absorb them.¹⁷

General principles of subsidiarity include (1) shift power to those more proximate to the issues, (2) democratize technology and access to it, (3) disclose information appropriately to exercise due transparency with stakeholders, and (4) obtain consent from appropriate parties as possible.

Third, the preferential option for the poor or marginalized entails concrete actions that are always just and partial to those in need. From the *Church's Compendium* we learn,

The principle of the universal destination of goods requires that the poor, the marginalized and in all cases those whose living conditions interfere with their proper growth should be the focus of particular concern. To this end, the preferential option for the poor should be reaffirmed in all its force. “This is an option, or a special form of primacy in the exercise of Christian charity, to which the whole tradition of the Church bears witness. It affects the life of each Christian inasmuch as he or she seeks to

imitate the life of Christ, but it applies equally to our social responsibilities and hence to our manner of living, and to the logical decisions to be made concerning the ownership and use of goods. Today, furthermore, given the worldwide dimension which the social question has assumed, this love of preference for the poor, and the decisions which it inspires in us, cannot but embrace the immense multitudes of the hungry, the needy, the homeless, those without health care and, above all, those without hope of a better future.”¹⁸

For the preferential option of the poor, we see the following general principles: (1) promote health equity and equal opportunity, (2) invite those marginalized to participate in design and decision-making procedures.

Fourth, the sociological pillar includes corporal works of mercy as a call to help those in need. Again, the *Compendium* states,

The Church's love for the poor is inspired by the Gospel of the Beatitudes, by the poverty of Jesus and by his attention to the poor. This love concerns material poverty and also the numerous forms of cultural and religious poverty. The Church, “since her origin and in spite of the failing of many of her members, has not ceased to work for their relief, defence and liberation through numerous works of charity which remain indispensable always and everywhere.” ... [T]he Church teaches that one should assist one's fellow man in his various needs and fills the human community with countless works of corporal and spiritual mercy. ... [E]

ven if the practice of charity is not limited to alms-giving but implies addressing the social and political dimensions of the problem of poverty. In her teaching the Church constantly returns to this relationship between charity and justice: “When we attend to the needs of those in want, we give them what is theirs, not ours. More than performing works of mercy, we are paying a debt of justice.”¹⁹

To perform corporal works of mercy, these general principles apply: (1) monitor job displacement caused by internal and external factors; (2) provide reasonable access to necessary education and training; (3) measure impact on beneficiaries and on workers, not merely intention alone; and (3) mitigate biases and eliminate all forms of unjust discrimination.

Fifth, liberation through structures of grace, as opposed to structures of sin, forms another sociological pillar from CST. *The Compendium* states,

The moral dimension of the economy shows that economic efficiency and the promotion of human development in solidarity are not two separate or alternative aims but one indivisible goal. Morality, which is a necessary part of economic life, is neither opposed to it nor neutral: if it is inspired by justice and solidarity, it represents a factor of social efficiency within the economy itself. The production of goods is a duty to be undertaken in an efficient manner, otherwise resources are wasted. On the other hand, it would not be acceptable to achieve economic growth at the expense of human beings, entire populations

or social groups, condemning them to indigence. The growth of wealth, seen in the availability of goods and services, and the moral demands of an equitable distribution of these must inspire man and society as a whole to practise the essential virtue of solidarity, in order to combat, in a spirit of justice and charity, those “structures of sin” where ever they may be found and which generate and perpetuate poverty, underdevelopment and degradation. These structures are built and strengthened by numerous concrete acts of human selfishness.²⁰

We might think that the antidote or prophylaxis to structural sin is liberation through structures of grace. Thus, Benedict XVI writes in *Caritas in Veritate*:

The development of peoples is intimately linked to the development of individuals. The human person by nature is actively involved in his own development. The development in question is not simply the result of natural mechanisms, since as everybody knows, we are all capable of making free and responsible choices. Nor is it merely at the mercy of our caprice, since we all know that we are a gift, not something self-generated. Our freedom is profoundly shaped by our being, and by its limits. No one shapes his own conscience arbitrarily, but we all build our own “I” on the basis of a “self” which is given to us. Not only are other persons outside our control, but each one of us is outside his or her own control. A person's development is compromised, if he claims to be solely responsible for producing what he becomes. By analogy,

the development of peoples goes awry if humanity thinks it can re-create itself through the “wonders” of technology, just as economic development is exposed as a destructive sham if it relies on the “wonders” of finance in order to sustain unnatural and consumerist growth. In the face of such Promethean presumption, we must fortify our love for a freedom that is not merely arbitrary, but is rendered truly human by acknowledgment of the good that underlies it. To this end, man needs to look inside himself in order to recognize the fundamental norms of the natural moral law which God has written on our hearts.”²¹

General principles for the liberation of humankind through structures of grace include the following: (1) engage in inclusive, human-centered design, (2) apply structural competency to mitigate the social determinants of disease, and (3) cooperate appropriately with others to promote the common good.

BRIDGING CST AND GAI: FORMULATION OF ETHICAL GUIDELINES

Now, I will attempt to synthesize these insights, particularly the general principles, as ethical guidelines for the design, development, and use of gAI in Catholic health care. While these guidelines’ specificity will be somewhere between principles and concrete moral norms that guide specific behaviors or choices, they should provide practical influence on gAI in Catholic health care. Overtime, additional guidelines derived from CST insights may be warranted; alternatively, the guidelines below may require further specification or elaboration in given circumstances. I have included some

guiding questions to prompt further reflection on these themes, too.

To begin, Catholic health care should engage human-centered design and inclusivity of gAI. Algorithms, data sets, and machine learning applications should reflect our diverse human tapestry, championing inclusivity and ensuring marginalized communities are not sidelined. This could include development of a sense of humanism and a spirituality of gAI and the related work. For example, questions to ask in the design, development, and deployment of gAI could include (1) How can the design process actively involve stakeholders from marginalized communities? (2) What measures are in place to ensure the AI system does not perpetuate existing biases? (3) Does the gAI reflect and enrich integrative human development as a whole (or does it compartmentalize and deconstruct in a way that adversely affects the human experience)?

Next, Catholic health care should aim to empower its workforce and enable continuous learning opportunities. As gAI reshapes work functions and workplaces, continuous training should ensure the workforce remains relevant and the connections among workers strengthened. Minimizing the adverse effects of disruptive technology is also key to the adoption and use of gAI applications. This should include translational skills-building as well as an emphasis on the humanities in AI. What training programs are available for employees to adapt to new AI technologies? How does the organization plan to maintain the relevance of human skills in an AI-driven environment?

Beyond its workforce, Catholic health care

should establish collaborative partnerships and practice community engagement. Collaboration is key. By forging partnerships and engaging communities, we ensure gAI is grounded in real-world needs. Thus, it is important to ask, what partnerships can be formed to ensure the AI system meets holistic, real-world needs and promotes the common good? Moreover, its design, development, and use should not be siloed; rather, it should be done in a truly participatory, synodal way. How is community engagement and feedback integrated upstream and downstream in the development and deployment of the AI application?

To ensure gAI is continuously improved and maintains ethical integrity, Catholic health care should enact ethical deployment protocols and transparent governance structures and processes. Robust governance structures should oversee gAI, ensuring ethical considerations are integral. In addition, advocacy efforts should be aimed at defending the human person and common good. What governance structures are in place to oversee the ethical considerations of AI deployments? How is transparency maintained in the AI system's decision-making processes? Is it clear who trains the AI and how and on which data sets?

In addition, Catholic health care should inclusively develop and collaboratively use choice architecture and enhance a gAI-stakeholder's autonomy. In an AI-augmented world, human agency remains paramount. This entails proper disclosure to appropriate parties of gAI practices, opt-in versus opt-out protocols, and informed consent procedures. Leadership should be able to answer, how are stakeholders involved in the decision-making

process related to AI's choice architecture? And, what mechanisms are in place to ensure that an AI system enhances rather than diminishes user (or beneficiary) autonomy?

In the rapidly evolving realm of artificial intelligence, Catholic health care should clarify proper authenticity and veracity of AI-generated output. To aid this, the delineation between authenticity and truth becomes paramount. Authenticity, in this context, refers to the genuine origin or source of data, ensuring that the foundational elements of AI models are rooted in proper attribution exhibiting coherence and cogency (e.g., hallucinations are identified, studied to understand errors in the AI, and mitigated). Truth, on the other hand, pertains to the accuracy and fidelity of AI outputs. As AI systems increasingly influence decision-making in healthcare, it is crucial to address and actively mitigate biases that might skew these outputs. This not only ensures that the results reflect genuine realities but also guards against the inadvertent perpetuation of existing disparities. Furthermore, a transparent disclosure of data sources, emphasizing their authenticity and representativeness, becomes an ethical imperative, fostering trust and credibility in AI-driven processes. What protocols are in place to verify the authenticity of data used and generated by the AI application? How does the application ensure that AI-generated output is accurate and truthful?

Moreover, the reliability of AI systems transcends their initial accuracy; it encompasses their consistent performance over time. Therefore, as these systems become integral to healthcare, Catholic health care should ensure continuous monitoring and validation to

maintain gAI reliability. Establishing feedback mechanisms, where users, patients, and other stakeholders can report inconsistencies or anomalies, enhances the system's adaptability and resilience. This iterative process of validation and recalibration not only ensures the system's ongoing reliability but also fortifies trustworthiness. Trust, in this domain, is not merely about technical robustness; it's about building and nurturing a relationship of dependability with communities of concern, ensuring that they can confidently rely on AI outputs for critical health care decisions. What are the key performance indicators for assessing the reliability of the AI application? How do these intersect with existing health care related indicators? When and at what cadence should the AI application be audited for performance and compliance with key legal and ethical norms?

Lastly, as AI delves into realms of creativity and innovation, the boundaries of intellectual property and creative rights come to the fore. Catholic health care should exhibit proper attribution of AI output as well as choose open-source versus proprietary models in ways that promote the common good and defend social justice. Especially in cases where AI models generate content or make decisions based on pre-existing works, it becomes ethically and legally imperative to provide clear attribution to the original sources. Respecting the creative rights of individuals and entities ensures that AI does not inadvertently infringe upon or dilute the value of original creations. Moreover, the ethical landscape of AI is further nuanced by the dichotomy between open-source and proprietary models. While open-source models champion transparency and collaborative betterment, proprietary models underscore the

sanctity of intellectual property. Navigating this landscape requires a delicate balance, ensuring that the benefits of AI are harnessed without compromising the rights and contributions of original creators. What guidelines are in place for attributing authorship or artistic credit to the output generated by the AI system? How does the choice between open-source and proprietary models align with the organization's commitment to social justice and the common good? When would a proprietary model be justified for the fiscal security of the organization and under what conditions would this be effectuated?

CONCLUSION

As we stand at the precipice of another technological advancement and ethical discernment, the teachings of the Catholic Church offer a beacon of light, guiding our path. The rise of generative AI, with its transformative potential to ignite an 'industrialization of thought,' calls us to navigate this new frontier with a moral compass rooted in centuries of wisdom. By grounding our approach in the pillars of Catholic Social Teaching, we are better equipped to ensure that AI serves not just as a tool but as an extension of our commitment to human dignity, the dignity of work, the common good, and the overall betterment of society. In embracing these ethical guidelines, we affirm our responsibility to harness the power of AI in ways that uplift humanity, honor our shared values, and pave the way for a future where technology and ethics walk hand in hand. ✚

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Acquisitions and Partnerships Between Secular and Catholic Health Organizations: Navigating the Canonical, Ecclesial and Theological Considerations

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ABSTRACT

Today, one in seven Americans in need of hospital care will receive it in one of over 650 Catholic hospitals in the United States.¹ According to the American Hospital Association, Catholic hospitals represent over 10% of the 6,093 total hospitals in the country.² One in six hospital beds in the United States are now affiliated with a Catholic hospital system.³ These numbers demonstrate the sizeable percent of market share of Catholic healthcare. In an era of fierce competition in healthcare, this is an invitation for secular and Catholic health care partnerships. However, these potential partnerships invite an understanding of deeply held beliefs in the Catholic tradition. This essay encourages secular and Catholic health system mergers, acquisitions and partnerships and will offer a clear guide for navigating the ethical, canonical and ecclesial considerations for such an acquisition. These considerations are “the four Ps”: the principle of cooperation, paper, people

and process.

INTRODUCTION

As the cost of competition for resources, equipment, patient volume, physicians and employees increase, many hospital executives must consider mergers with competitors or end up closing. Since 2011, more hospitals have closed than opened with rural communities often being most affected by these closures.⁴ In 2016, 15 of the 21 hospitals that closed were in rural communities and since 2010, nearly 90 rural hospitals have closed.⁵ Mergers, however, represent an alternative to closure.

In the 20 years between 1998 and 2017, there were nearly 1,600 hospital mergers.⁶ With rural populations shrinking, services shifting to outpatient settings and rural areas experiencing lower incomes and higher rates of uninsured people resulting in higher levels of uncompensated care, some markets are not able to sustain multiple hospitals. In these markets, competing hospitals will either continue the competition until only one entity remains or

they must explore mergers, partnerships or acquisition opportunities. Healthcare executives point to limited capital, technology costs, repairing aging infrastructure and financial performance as reasons to consider merger and acquisition activity.⁷ The tax-exempt nature of religious-based organizations also represent a most attractive advantage.

Catholic hospitals face these same challenges. Believing in their mission, leaders of Catholic hospitals have to confront the same economic and market challenges their secular competitors are facing. Certainly, the shift in care and reimbursement as well as the reduction of women and men religious congregations that have traditionally sponsored these ministries have also had its impact on Catholic healthcare.⁸ While wanting to maintain their Catholic identity, leaders of Catholic healthcare seek opportunities for partnership and even acquisition for similar business and financial reasons. Opportunities for Catholic hospitals to partner or be acquired by a secular health system are increasing. There are growing examples of Catholic hospitals belonging to secular health systems in order to sustain their faith-based mission in the current marketplace.⁹ However, in order for these partnerships to emerge, it is critical to understand the “four Ps”: the principle of cooperation as well as the important paper, people and processes to be navigated.

PRINCIPLE OF COOPERATION

A basic understanding of the moral principle of cooperation in the context of Catholic moral theology is essential in understanding the considerations to complete a transaction in which a secular health system would acquire

a Catholic hospital. At its core, the principle of cooperation considers the moral boundaries of cooperation and partnership in human activities when moral commitments may not align. For example, certain procedures that could be classified as contraception or sterilization might be viewed by some practitioners as essential to the services they provide to their patients whereas other practitioners might view it as a violation of the dignity of the person. The principle of cooperation seeks to describe the complex nature of human activity to determine when one’s actions are considered too proximate or close to a collaborator’s actions such that their participation would constitute a failure to live up to one’s moral commitments.

The principle of cooperation describes the relationship between the “doer” of the action and the “cooperator” with the action. In the framework of Catholic moral theology, the “action” would be that which could be considered a moral “evil”. The “doer” of the action is the one who initiates and directly intends the specific action. The “cooperator” of the action is only involved in the action in some way separate -or at a moral distance- from the “doer” and may not “intend” the evil, but merely tolerates it in order to achieve some specific good.¹⁰ For example, if a secular health system (the “doer” in this case) performed services such as contraceptive procedures that would be prohibited within a Catholic hospital, that could constitute a moral evil from the perspective of Catholic moral theology. The Catholic hospital (the “cooperator” in this case) would have limits related to its participation in this action. An acquisition of the Catholic hospital by a secular health system to achieve some good for the community would need

to ensure that any potential participation of the Catholic hospital in this perceived evil would meet the standard required for morally acceptable cooperation in that act.

The principle of cooperation does not stop this relationship from happening but, rather, serves as a tool for its moral assessment. There are two distinctions to note when considering the principles governing morally legitimate cooperation with an action: the first is between “formal” and “material” cooperation and the second further distinguishes “material” cooperation between “immediate” and “mediate” material cooperation.

First, to the formal and material distinction: if the cooperator participating in the “wrongdoing” intends the wrongdoing, then that cooperation would be considered “formal” cooperation and would be morally wrong. In the example above, if a nurse helping in a sterilization procedure, such as a tubal ligation, wants the operation performed, it would be formal cooperation and would be illicit. It is for this reason, for example, that the Vatican stated no Catholic healthcare facility could ever formally cooperate in providing sterilization.¹¹ If the cooperator does not intend the wrongdoer’s actions, then the cooperation is considered “material” cooperation. Moral theologians have argued that material cooperation can be morally licit pending other issues and distinctions.¹²

To the second distinction between “immediate” and “mediate” material cooperation: immediate material cooperation is when the object of the cooperator is the same as the object of the wrongdoer and, as such, is usually always morally wrong.¹³ However, when the object of

the cooperator’s action remains different and distinguishable from that of the wrongdoer’s then it is “mediate” material cooperation and can be morally licit.¹⁴ For example, if the secular health system provided various procedures intended for the purpose of sterilization, the Catholic hospital should still be able to be part of this secular health system as long as the Catholic hospital’s actions are seen as completely separate from the procedure resulting in the sterilization. Specific steps can be taken to ensure the proper separation is present such as

- separate billing for that procedure
- separate procurement of supplies for the procedure
- the procedure occurring in a space not owned or directly leased by the Catholic entity
- physicians not being employed or paid by the Catholic hospital at the times while performing the sterilization procedure.

These steps ensure that the material cooperation of the Catholic hospital is at an acceptable level, that is, mediate material cooperation.

PAPER

Catholic healthcare follows all applicable civil laws at the municipal, county, state and federal levels. In addition, “church law”, known as Canon Law, governs the Catholic Church around the world, including particular aspects of Catholic healthcare as related to the property and apostolates of the Church.¹⁵ Local countries also have national “conferences” that direct

the life of the Church more specifically in that country. In the United States, the United States Conference of Catholic Bishops (USCCB) has proscribed national guidelines that direct the exercise of Catholic healthcare within the United States.¹⁶ This document, the *Ethical and Religious Directives for Catholic Health Care Services in the United States* (ERDs), along with universal Canon Law, gives guidance in mergers, acquisitions and partnerships between Catholic and secular hospitals and health systems.¹⁷ Finally, original articles of incorporation are important to secure as it will detail the nature of the hospital's property and assets, the "sponsor" of the local Catholic hospital ministry and any "reserved powers" the sponsor may retain. These details are important as it will determine the proper "people" and "process" that will need to be subsequently engaged. In sum, canon law, the ERDs and the original articles of incorporation are three important documents -the "paper"- that will be critical in navigating mergers, acquisitions and partnerships of this kind.

PEOPLE

In these potential arrangements, there are important people in the Church that would be involved in any potential merger, acquisition or partnership with a Catholic hospital or health system including the Bishop, the "Sponsor", the Holy See, the Catholic hospital CEO and the local mission executive who serves as a liaison between all the parties. In addition to both canon and civil lawyers, these four roles are critical in navigating the canonical and ecclesial processes required to achieve such transactions.¹⁸

Bishop

The local Diocesan Bishop is one of the most important persons to engage. The Bishop is the coordinator of all ministries within the Diocese (canon 394),¹⁹ and is to be consulted in matters of import to the Catholic hospitals in the Diocese. The United States Conference of Catholic Bishops note, "the bishop has the right and responsibility to exercise his authority over all apostolates in his diocese including that of health care (canon 678)".²⁰ The ERDs specifically note the role of the local Diocesan Bishop (directive #68, 69).²¹ He may delegate others to assist him in this task.²² In some cases, his permission is required; in other cases, such as that which might be reserved to the Holy See, his nihil obstat, a statement that denotes he has no objection and approves the petition, would be required.²³

In addition to internal matters of the Church in which the diocesan bishop has authority, he has an equally important role in civil matters as well which is critical for any health system to recognize. For example, the IRS' "group ruling" allowing all entities in the "Official Catholic Directory" to be recognized as a "religious (Catholic) organization" - and, therefore, tax exempt is important here. Inclusion in this Directory is at the sole discretion of the Bishop. Therefore, honoring the "Catholic Identity" of the hospital and nurturing the relationship with the Bishop is also critical from a civil law and tax-exempt perspective.²⁴

Sponsorship

Sponsorship in Catholic healthcare is the formal relationship between a Catholic organization and its various entities, including,

for example, its Catholic hospitals. Sponsors are responsible for the viability, mission and life of the ministry they serve.²⁵ Sponsors are not necessarily “owners”.²⁶ Most often, the Sponsor has certain, specific, “reserved powers” including the rights to purchase or sell its apostolates and corresponding property and assets.²⁷ The Sponsor is often the one who can green-light the potential acquisition of one of its hospitals by another health system. Traditionally, sponsors were members of a Religious Institute who, living out the charisms unique to their identity, founded various schools, centers of justice and hospitals (canons 678, 680).²⁸ More recently, there are new methods of sponsorship expressed in various models including lay-formed “juridic persons” who are recognized in the law (canons 315, 676).²⁹

Juridic Persons are created by law or decree to carry out a part of the mission or work of the Church.³⁰ A Public Juridic Person (PJP) can come into existence by decree or by the law itself, can act in the name of the Church and can own ecclesiastical property following all the norms prescribed in the law.³¹ Ecclesiastical property is basically “church property” and many Catholic hospitals might be considered such. A Private Juridic Person does not act in the name of the Church and maintains ownership of its own property but can still offer apostolic work or charity.³² The Juridic Person is often comprised of lay leadership (canon 298§1).³³

The Juridic Person is important when the Catholic partner must navigate matters related to transferring sponsorship, alienating assets or engaging in other matters governed by canon law. For non-Catholic partners, it is important

to identify who the “competent ecclesiastical authority” would be in the respective case (canon 116 §1).³⁴ If the PJP is of “Diocesan Rank”, the competent ecclesiastical authority is the local Diocesan Bishop. However, if it is of “Pontifical Rank”, the authority would be the Holy See.³⁵

The Holy See

The Holy See is the ‘government’ of the Roman Catholic Church in the Vatican. When the Holy See might need to be engaged, the mission executive of the Catholic healthcare organization can serve as intermediary, working with competent civil and canon lawyers as well as the Holy See’s local “ambassador” in the country, called the Nuncio. A petition (that is, a request for an “Indult”) related to alienation of stable patrimony (that is, ecclesiastical property that is part of the Religious Organizations assets dedicated to some service or apostolate) would be directed to one of the dicasteries (that is the particular congregation or office) of the Holy See related to the case in question. In a matter such as the acquisition of a Catholic hospital, the appropriate dicastery would be the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life (CICLSAL).³⁶

Mission Executive

Mission executives are entrusted with guiding administrators of Catholic healthcare institutions in the spiritual, ethical, cultural, moral and canonical issues involved in leading Catholic health care.³⁷ The mission executive would be a key asset in navigating the relationships and nuances of transactions governed by canon law and should, therefore,

have knowledge of the structure and type of Juridic Person that sponsors the ministry in question. The mission executive can help interface between the bishop, the sponsor, the various civil and canon lawyers and the healthcare executives from both parties.³⁸ Key questions the mission executive navigates might include whether the Catholic hospital is part of a public or private juridic person; of diocesan or pontifical rank; the kinds of ecclesiastical goods that are owned by that public juridic person (if applicable); if the assets are part of a stable patrimony; and what inventory of property/ ecclesiastical goods the organization possesses. The answers to these questions determine the course of action, or the 'process' for the acquisition to occur.

PROCESS

After encouraging the mutually beneficial imperative warranting consideration of an affiliation between a Catholic hospital and a secular health system, discussing the principle of cooperation and sharing information on important paper (Canon Law, ERDs, Articles of Incorporation) and people (Bishop, Sponsors, Holy See, Mission Leaders), this essay will now present a basic overview of a process to be followed in order to complete this acquisition.

In order to achieve the endorsement of the local Bishop (his nihil obstat), early and regular communication with his office will be essential. This is often done between the Vicar for Healthcare and the local Catholic hospital's lead mission executive. The bishop will often have two areas of focus that are important – a commitment to the poor and an assurance that the non-Catholic health system will continue to operate the Catholic hospital(s) as Catholic.

Required assurances related to maintaining the Catholic identity of the hospital can be negotiated with the office of the Bishop. Usually, the items to which the Bishop would request include continuing to follow the ERDs, a regular audit (or update) to ensure compliance, the establishment or continuation of the role of the mission executive, the promise to staff the hospital with a qualified chaplain(s), a commitment to serve the poor and vulnerable and an ongoing formation plan to integrate spirituality into the workplace. Ensuring the Catholic culture is the normative culture and moral code of the Catholic hospital is paramount for the Bishop. The provision of funds to sustain a viable Mission Office and Chaplain Services would be a measurable way to confirm these assurances and might be requested by the bishop. Adherence to the ERDs could be ensured by including a provision for compliance in the transaction documents.³⁹

Within these documents, a category listed as "Maintaining Catholic Identity" could include language such as:

- The position of Vice President of Mission will be funded and staffed in perpetuity
- A well-staff Pastoral Care Department with certified chaplains will be maintained
- Adherence to the *Ethical and Religious Directives of Catholic Health Care Services* in the United States published by the United States Conference of Catholic Bishops will be followed within the Catholic entity and by all employees of the Catholic entity with careful attention to the principle of cooperation

- The Catholic Hospital will maintain its commitment to the care of the poor and vulnerable through its charity care function and other community benefit work

Maintaining the Catholic identity of the hospital also has important civil considerations for the health system. Any change in the religious identity of the hospital might risk termination of its exempt status and all the benefits that come with it (property tax exemption, church plan treatment for certain employee pension/benefit plans, ERISA exemptions, etc....)⁴⁰ Attorney Michael DeBoer of Faulkner University wrote a compelling article for the Seton Hall Law Review which encourages religious organizations to lean into their religious identity not only for the sake of their own mission but to ensure governmental and regulatory recognition of that religious identity in order to verify the various tax and other ministerial exemptions claimed to the benefit of the religious organization.⁴¹

Finally, with all this in place, it would be equally imperative to draw up a satisfactory communication plan. Bishops are very concerned with the potential for scandal. Scandal, in this specific context, is an occasion that might lead someone to believe an immoral action is not wrong.⁴² For example, if a Catholic hospital was viewed as participating in a moral evil, it might lead one to believe that the action is not wrong since it is allowed in the Catholic entity. In turn, this might lead someone to participate in that sin, believing the wrong is not, in fact, sinful. So, even if great detail is spent to ensure Catholic identity and ERD compliance of the Catholic hospital, the public, otherwise unaware, might be confused

as to if the Catholic hospital, now part of a secular health system is or is not operating as a Catholic hospital. Communication is essential to assure the community and the Bishop that the potential for scandal has been minimized.⁴³

CONCLUSION

There are urgent challenges confronting health care, including both secular health systems and Catholic hospitals. These challenges invite a new consideration of mergers, acquisitions and partnerships between secular and Catholic health systems. These transactions might better serve the community, advance the viability of both the secular and Catholic hospitals by drawing on economies of scale, improving access to capital and minimizing a mutual self-destruction by continued competition in the community. It also allows the Catholic hospital to continue its sacred mission, a millennia old effort begun by their foundresses, the Women Religious, who came and dedicated themselves to the local community.

Adhering to the principle of cooperation and engaging the important paper, people and processes necessary will allow this acquisition to occur and enable the continuation of a stronger and more vibrant opportunity to serve the local community for generations to come. ✚

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Liberalism, the Catholic Human Rights Tradition and the Involuntary Hospitalization of People with Serious Mental Illness

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In November 2022 New York City Mayor Eric Adams announced a proposal to increase the city’s involuntarily hospitalization of people with serious mental illnesses such as schizophrenia and bipolar disorder when they were found to be dangerous to themselves. Adams touted his proposal as fulfilling a “moral obligation [...] to assist those who are suffering from mental illness” and to reduce the city’s homelessness and crime.¹ Nevertheless, pushback to Adams’s proposal was swift and varied, with concerns about the plan’s feasibility, the city’s lack of structural and systemic support, high rates of burnout among first responders, and exacerbating police violence, especially against Black men.²

Adams’s proposal was met with a still more difficult challenge: the conviction that involuntary hospitalization is unethical precisely because it is done against the will of the person with serious mental illness. As City Councilwoman Tiffany Cabán tweeted shortly after the announcement of Adams’s proposal, “Consent is key [...]”.³ Cabán’s tweet helpfully clarifies that debates about Adams’s proposal are at least as much about ethical

questions such as the meaning and purpose of human rights as they are about psychiatric or social questions about, for example, proper medication and homelessness.

The objection that involuntary care violates the rights of people with serious mental illness fears – sometimes with strong justification – that even the most well-intended interventions can be harmful and that justifying any intervention at all makes it easier to legitimize harmful ones. Invoking human rights would seem to protect people with serious mental illness from harms that are too often and too easily inflicted when consent is rendered unnecessary, but doing so would tie the city’s hands and, thus, to perpetuate homelessness and crime.

I believe that thinking more carefully about the meaning and purpose of rights can provide a way forward from this impasse. Cabán’s defense of consent reflects one way to understand rights, but it does not necessarily reflect the only or the best way to think about these issues. Her understanding of rights reflects that of classical liberalism, according to which the solitary, rational individual is prior to the community or the state, and rights exist to protect the individual’s life, liberty, and property from

interference by others.

A classically liberal assessment of the case at hand yields the conclusions that the individual with mental illness is necessarily the primary unit of moral concern and that the city of New York and the needs of its other residents are of secondary value; that that person with serious mental illness has a right to live life as he or she sees fit, even if those life-plans are not good for themselves (e.g. because they are devised under hallucinations, delusions, or manic or depressive episodes); that those life-plans ought not be interfered with by the city's police or workers, especially when that person does not consent to hospitalization; and that, therefore, involuntary hospitalization is unethical. If liberalism is presumed, Cabán's defense becomes intelligible and even persuasive.

And yet, questions arise. Should liberalism be presumed? How viable or compelling, in fact, are its presuppositions? How helpful is its assessment of this case? Even granting liberalism's long history of shaping social thought in the United States, it is not, in fact, the only resource that Americans have drawn from to think about public life throughout history. As sociologist Robert Bellah and his co-authors famously argued in *Habits of the Heart: Individualism and Commitment in American Public Life*, individualism might be Americans' "first language," but they have also turned to the less individualistic and more communally-centered resources of civic republicanism and biblical religion (including, of course, the Catholic tradition). Liberalism, then, is not our only option for evaluating Adams's proposal.

Nor should it necessarily be, as there are good reasons to challenge liberal presuppositions.

A wide array of resources ranging from the Catholic tradition to Aristotelian philosophy to evolutionary biology to contemporary studies about human loneliness to human experiences such as friendship, marriage, and parenthood cast serious doubt upon liberalism's claim that humans are first and foremost individuals disconnected from one another rather than intrinsically relational creatures.

Furthermore, as philosopher Martha Nussbaum argues in *Frontiers of Justice: Disability, Nationality, Species Membership*, liberalism's requiring rationality casts people with serious mental illness as sub-human. Protecting people with serious mental illness from interference is not entirely meritless, but it also risks cutting them off from loving and being loved in the concrete – precisely the type of relationships and care privileged by the Catholic tradition and its healthcare organizations. By uncritically and necessarily prioritizing the wants of the individual over the needs of the community, liberalism risks justifying the perpetuation of homelessness, crime, and other problems that imperil people with serious mental illness.

The Catholic rights tradition as developed through papal encyclicals like *Pacem in Terris* (1963) and the work of Catholic social ethicist David Hollenbach offers a more helpful way to think about rights for evaluating Adams's proposal. Unlike liberalism's individualistic, rationalistic anthropology, this tradition maintains that humans are intrinsically dignified and relational creatures because they are created in the image and likeness of a relational, trinitarian God. This anthropology suggests that having serious mental illness does not erase one's humanity and commends balance between the wants (and needs) of

the individual and the needs of the wider society. This balance suggests that simply invoking one's "right" to be left alone is not necessarily the trump card that liberalism believes it to be, because people with serious mental illness – like all humans, for that matter – can be mistaken or misled about what is, in fact, good for them. This is especially the case when their illness affects the areas of the brain responsible for recognizing mental illness itself, as this unawareness often leads to medication noncompliance. Rights, therefore, do not so much protect freedom from interference as they do the freedom of each person to participate as fully as possible in the life of the society. Participation includes (but is not limited to) access to psychiatric healthcare as well as the responsibility to contribute as best one can to the common good.

The Catholic rights tradition does not entirely reject the importance of consent, but it can helpfully complicate a singular privileging of consent over other worthwhile ethical issues and resources. It can help us to appreciate more carefully the good that Adams's proposal might enact (while not precluding necessary caution about how well it can and will be implemented on the ground). It can invite us to critically assess the presuppositions upon which our positions depend. And it can remind us that concerns such as Cabán's, though certainly not unimportant, are not the only ones that deserve a fair hearing in our conversations about how best to care for people with serious mental illness, because, ultimately, "do not interfere with your neighbor" falls woefully short of loving one's neighbor as oneself (Matthew 22:34-40). †

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Health Justice Before Charity: Organ Donation in Massachusetts Prisons

Shaun Slusarski, M.T.S

The shortage of organs suitable for transplantation has accurately been described as a crisis. As of early April, there were reportedly 103,913 people waiting for an organ transplant in the U.S., 88,661 of whom were seeking a kidney transplant in particular.¹ Those who wait often depend on costly and inconvenient medical procedures such as dialysis that can significantly impede patients' quality of life. Inequities also persist in access to organ transplants that result in disproportionate impacts upon low-income communities and communities of color.² Increasing the supply of available organs thus continues to be a critical health care issue that requires creative strategies. While such strategies will in part depend on promoting greater participation in postmortem organ donation programs, they will also require mobilizing an expanded number of living donors.

The Catholic Church has offered cautious support for living organ donations. As the procedure first became a possibility in the mid-twentieth century, many Catholic moralists were resistant to endorse living donations due to the Church's long-standing prohibition against mutilation.³ While the principle of totality can be employed to justify surgical procedures that promote the holistic wellbeing

of the individual patient, theologians like Gerald Kelly insisted that the principle could not be used to justify surgical procedures that promote the wellbeing of another patient.⁴ Instead, following the reasoning of Bert Cunningham, the practice came to be justified through the principle of charity. In their willingness to sacrifice a part of their body for the wellbeing of another, the donor imitates the sacrificial love of Christ.⁵ Pope John Paul II affirms that the logic of charity is necessarily at work in all morally legitimate organ transplants. He understands organ donation as "a decision to offer, without reward, a part of one's own body for the health and wellbeing of another person" and he maintains that "love, communion, solidarity and absolute respect for the dignity of the human person constitute the only legitimate context of organ transplantation."⁶ The pope's words indicate that any motivation to donate that is rooted in personal gain instead of love of neighbor is fundamentally immoral. At the same time, John Paul II also suggests that the charitable impulse alone is not sufficient grounds on which to justify organ donations. He insists that "a person can only donate that of which he can deprive himself without serious danger or harm to his own life or personal identity, and for a just and proportionate reason."⁷ While people may wish to donate a part of themselves to help another, they must never do so when

they put themselves at risk of serious harm.

A controversial bill recently proposed by Massachusetts lawmakers seeks to provide another strategy for addressing the organ shortage crisis, but in a way that falls short of Catholic values and wider bioethical principles. Sponsored by Democratic Representatives Carlos González and Judith A. Garcia, the bill would establish a Bone Marrow and Organ Donation Program within the Massachusetts Department of Corrections, empower a committee to oversee the program, and incentivize organ donation among incarcerated individuals by reducing sentences by sixty days to one year.⁸ While the bill faced almost immediate criticism from prisoners' rights advocates, the sponsors contend that the policy could significantly help to alleviate the shortage, and they even frame it as a racial justice issue. Since Black and Hispanic communities endure disproportionate rates of diabetes, heart disease, and other chronic conditions, the sponsors reason that an increased organ supply would ultimately support these communities.⁹

The most controversial part of the bill is undoubtedly the incentive it offers in the form of a sentence reduction. At the legal level, the bill may violate Section 301 of the National Organ Transplant Act (NOTA), which prohibits “the transfer [of] any human organ for valuable consideration for use in human transplantation.”¹⁰ Legal scholar Jamila Jefferson-Jones notes that what constitutes “valuable consideration” is not concretely defined in the law, but in its current form, monetary incentives as well as college scholarships, housing, and payment of household bills are all prohibited.¹¹ South Carolina ultimately failed to pass a similar

“organ-for-liberty” bill in 2007, because lawmakers feared it might violate Section 301 of NOTA.¹²

At the bioethical level, the bill has also sparked debate. Critics of the bill insist that the reduction in sentence constitutes an undue inducement, an incentive so attractive that it prevents prospective donors from adequately considering the risks involved and would thus undermine their ability to make a decision rooted in informed consent.¹³ Beyond the coercive threat to patient autonomy, the incentive also runs afoul of Catholic anthropological claims. In *Donum vitae*, the Congregation for the Doctrine of the Faith (CDF) affirms “the unified totality” of the human person. The CDF insists that because of its substantial union with the soul, “the human body cannot be considered as a mere complex of tissues, organs and functions... rather it is a constitutive part of the person who manifests and expresses himself [sic] through it.”¹⁴ From this firmly held claim, Pope John Paul II deduced that the reduction of human organs to objects of trade or exchange is a clear violation of human dignity. He attests that organ donation “is not just a matter of giving away something that belongs to us but of giving something of ourselves.”¹⁵ The commodification of any part of the body contradicts the Catholic vision of the person, and thus from a Catholic point of view, incarcerated individuals do not have the right to exchange their kidneys for liberty.

In response to pressure from critics, the sponsors of the bill have expressed their openness to amend the bill by stripping it of any sense of quid pro quo. Representative Gonzales indicated that the intended purpose

of the bill has always been to provide a pathway for incarcerated people to donate their organs if they freely choose to do so.¹⁶ Insofar as lawmakers amend the bill so that fears of undue inducement and commodification of organs are assuaged, would it not be morally acceptable to support an initiative that enables incarcerated people to freely donate parts of their body to support the flourishing of loved ones or even strangers in need of organ transplants?

Some bioethicists have suggested that incarcerated people should be precluded from donating organs even for altruistic reasons. When it comes to those condemned to death, Arthur Caplan suggests that organ donation may be immoral because it could undercut the retributive purpose of punishment. In his understanding of retribution, Caplan implicitly suggests that those who commit horrific crimes ought to completely lose their standing in society. He fears that if such individuals are able to donate their organs, they would gain some degree of sympathy or praise from the public for their altruistic actions and risk upsetting the victim's loved ones.¹⁷ While Caplan is right to prioritize the victim's loved ones in his argument, it is difficult to imagine that the majority of the public would be willing to overlook an individual's brutal crimes because they donated their organs.

Moreover, his vision of punishment stands at odds with Catholic convictions about human dignity. Caplan seems to indicate that incarcerated people (specifically those facing the death penalty) lose their humanity and become irredeemable non-persons. This position is completely incompatible with Catholic anthropology. The U.S. bishops affirm that every individual is made in the

image and likeness of God and therefore possesses an inviolable human dignity. This dignity is "not something we earn by our good behavior; it is something we have as children of God." Furthermore, they attest that God's grace "can transform even the most hardened and cruel human beings."¹⁸ Policies that prevent incarcerated people from positively contributing to and deepening their solidarity with the larger human community should therefore be avoided. No human being should be hindered from growing in the practice of love.

While incarcerated people should not be prevented from donating organs for punitive reasons, it may be prudent to avoid implementing living donation policies due to the inadequate health care available in Massachusetts prisons. Through the 1976 Supreme Court ruling in *Estelle v. Gamble*, incarcerated people ironically became the only constituency in the United States that possesses a constitutionally guaranteed right to health care. The mandate to care, however, is frustratingly thin; the ruling only protects incarcerated people from cruel and unusual punishment that comes in the form of the withholding of medical treatment for serious conditions.¹⁹

Despite this mandate and despite the fact that the health of the incarcerated is significantly worse than the health of the general population, medical neglect is rampant in U.S. prisons. The abolitionist coalition *Deeper Than Water* has helped to shed light on the pervasive neglect in correctional facilities throughout Massachusetts. The Massachusetts Department of Corrections has contracted with Wellpath, a for-profit health care company that has

been sued at least 1,395 times between 2008 and 2018 and has left prisons throughout the commonwealth significantly understaffed.²⁰ At MCI-Norfolk, for example, when the medical director recently stepped down, the prison was left with only two nurse practitioners to manage care for 1,100 people.²¹ The company's cost-saving policies have resulted in needless suffering and preventable deaths throughout the commonwealth's prison system. The immunocompromised patient Ziggy Lemanski filed several sick slips for flu-like symptoms, but delays in treatment meant that he died of pneumonia at age 44. Michael Ramsey was diagnosed with atypical migraines and ordered to see a neurologist within a week, but the appointment was never scheduled and clinicians determined him simply to be "med-seeking." When nurses found him in his cell a month later unable to walk, he was quickly hospitalized and shortly died from cryptococcal meningitis at age 36. After an abrupt withdrawal from his prescription drugs, Paul Bulthouse suffered fifteen seizures that were ignored by staff before he died shortly later at 39.²²

These are just a few of the stories that Deeper Than Water has documented. In a survey conducted with a sample of 141 incarcerated respondents, the coalition found that 79% reported that their obvious medical conditions were ignored. Among those with documented health care needs, only 25% found that their treatment plan was followed by staff. Over 80% reported having to wait a long period of time for treatment for a known condition, a trend that the Office of the State Auditor observed in Massachusetts prisons before contracting with Wellpath.²³ Besides medical neglect, respondents commonly reported conditions

inhospitable to health, including insufficient access to food, unsanitary food services, and polluted water.²⁴ Until recently, MCI-Norfolk's polluted drinking water was the object of serious public scrutiny for its dark color, bad smell, and high levels of manganese, a mineral that can cause neurological disorders.²⁵

In an environment characterized by medical neglect and unhealthy living conditions, the implementation of a living organ donation program could be dangerous for incarcerated individuals. While surgeries performed for living donation are usually safe, there is little indication that an altruistic donor would receive the care they need in Massachusetts prisons if complications arise. If provisions were made to ensure expedited care for donors, it would constitute special treatment in a context where timely care is supposed to be a right not a reward. The health conditions in Massachusetts prisons reflect a flagrant disregard for the dignity of the human beings forced to live there, and as such, constitutes an expression of what Pope Francis identifies as "the throwaway culture." His call for "the improvement of prison conditions, out of respect for the human dignity of persons deprived of their freedom" must be heeded in the commonwealth.²⁶ While the supporters of the bill commendably seek to address the organ shortage crisis, which disproportionately impacts vulnerable low-income and BIPOC communities, it is an odd strategy to seek solutions among incarcerated people, who are disproportionately low-income and BIPOC and endure high rates of chronic conditions that make transplantation necessary.²⁷ While incarcerated people motivated by charity should be allowed to donate their organs, justice demands that such a policy must be preceded

by the transformation of health care conditions
in Massachusetts prisons. †

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Book Review: "Losing Our Dignity: How Secularized Medicine Is Undermining Fundamental Human Equality"

Tobias Winright, Ph.D.

Charles C. Camosy is one of the most prolific writers amongst moral theologians today. Since earning his Ph.D. at the University of Notre Dame fifteen years ago, he has published several books and scores of peer-reviewed and popular articles, as well as numerous blog pieces and opinion essays, including for the Washington Post and other national periodicals. Recent books include *Resisting Throwaway Culture: How a Consistent Life Ethic Can Unite a Fractured People* (New City Press, 2019) and, coauthored with Alisha N. Mack, DNP, *Bioethics for Nurses: A Christian Moral Vision* (Eerdmans, 2022). A versatile theological ethicist, Camosy has also published books and articles on ecological and animal ethics, just war theory and nonviolence, politics and civil discourse, and many other contemporary issues. Most of his attention, though, focuses on trends and questions in health care ethics.

At the time he authored and published *Losing Our Dignity: How Secularized Medicine Is Undermining Fundamental Human Equality*, he was Associate Professor of Theological and Social Ethics at Fordham University; now he is Professor of Ethics and Medical Humanities

at the Creighton University Health Science Campus in Phoenix, Arizona. Camosy is not content to write solely to fellow scholars; much of his work aims at reaching wider ecclesial and public audiences. In addition to well-known church-related publishers, such as Eerdmans and Liturgical Press, he writes for New City Press, which is connected with the Focolare movement and seeks to provide “books and resources that enrich the lives of people and help all to strive toward the unity of the entire human family.”¹ Accordingly, Camosy’s audience for *Losing Our Dignity* is not limited to fellow bioethicists, moral theologians, academicians, and health care professionals. This is an accessible and engaging read for students, parishioners, and the wider public.

The book is comprised of seven chapters that are bookended between an introduction and a conclusion. Its main thesis is that “mainstream medical ethics and mainstream medicine” no longer view all human beings as equal “in their very essence” (11-12) and sharing “a common nature that bears the image and likeness of God” (19). Instead, influential medical practitioners and bioethicists increasingly distinguish between “human beings” and “persons,” with the latter being associated with certain

abilities such as self-awareness, rationality, communication, productivity, and the like. When someone lacks the wherewithal to be regarded a "person," they then are viewed as deficient in dignity and no longer deemed to be deserving of the health care that most of us take for granted. This is exasperated by limited medical and financial resources, especially as more Americans are aging and on the verge of becoming "a new, large, and growing set of victims: human beings with late-stage dementia" (15).

In the first chapter, Camosy offers a declension narrative, from the origins of medicine and medical ethics within the Church to their secularization in recent decades. Whereas Christian health care and bioethics cared for the sick and disabled, "especially the untouchable sick and disabled discarded by the dominant culture" (23), now the tables have turned so that the dominant culture has gained the upper hand. Camosy highlights recent articles by philosophers and bioethicists as evidence of this shift: Timothy Murphy's "In Defense of Irreligious Bioethics"; Ruth Macklin's "Dignity is a Useless Concept"; and Steven Pinker's "The Stupidity of Dignity." Yet, Camosy claims that "it is impossible to practice a totally secularized medicine" since "theological concepts nevertheless find their way into the design and practice of medicine in various ways" (39). This is a contention that surfaces a number of times throughout the rest of the book: secular health care practitioners and bioethicists, whether they are aware of it or not, still have "their own particular understanding of the good to bear on these questions" (42). The good, for them, is autonomy, and this is what is eclipsing human dignity.

The second chapter considers the case of thirteen-year-old Jahi McMath, a Black girl who reached puberty in 2014 even as the state of California declared her to be brain dead. For Camosy, medical science has failed to stay in its lane in determining death, a question that is instead philosophical and theological (47). He accuses privileged physicians of exhibiting an ableist attitude toward human beings with catastrophic brain injuries. Camosy adds that the problem concerning the determination of death is compounded by the increasing demand for organ donors. I must admit that when I suffered a traumatic brain injury eleven years ago, I shared Camosy's concerns. At the same time, Camosy is not a vitalist (nor am I), holding that everything must be done to keep someone alive regardless of their circumstances. With advance directives or a surrogate decision-maker, Camosy rightly notes here and in subsequent chapters that such treatment may be forgone or withdrawn if deemed extraordinary. However, human beings with catastrophic brain injury and their loved ones should not be pressured or coerced to do so. Furthermore, Camosy recommends a healthy dose of epistemic humility and erring on the side of caution, concerning human beings with catastrophic brain injuries, a point he makes also in subsequent chapters.

In the third chapter, Camosy discusses Terri Schiavo and the so-called persistent, or chronic, vegetative state. He notes that "a good percentage of people thought to be in PVS are, in fact, conscious and aware" (71) and that "many patients thought to be in a vegetative state can and do recover" (73). As in the previous chapter, Camosy makes clear "that, even in circumstances where there is consciousness, there will be times

that life-sustaining treatment can and even should be withdrawn (especially when the patient can communicate wishes for no extraordinary treatment)" (76). Here, too, Camosy prescribes the precautionary principle: since we "now know that about 20 percent of diagnosed patients can be coaxed into varying levels of conscious states," and that we were wrong about that 20 percent "who we now acknowledge should have the moral and legal equality of persons," we should humbly exercise caution about the other 80 percent, since at some point, "with new technologies, we [may] find that another chunk of those 80 percent can also regain consciousness" (87).

The fourth chapter concentrates on the status of prenatal human beings, abortion, and *Roe v. Wade*. Camosy argues that paternalism rather than feminism fueled that Supreme Court decision. In contrast, he urges respect for the fundamental human equality of pregnant women (109). At the time he was writing, before the *Dobbs* decision in 2022, Camosy expressed his hope that "US practices and law will be pushed to be consistent" (108). But, post-*Dobbs*, there seems to me that there is a lack of careful, consistent thinking amongst many politicians about the dignity of both the unborn and women, especially those women who are experiencing life-threatening circumstances during their pregnancies. I agree with Camosy that "we must absolutely refuse to think of dignity and equality as a zero-sum game where one population can be treated equally only at the expense of another" (111); however, at times there are tragic circumstances in which difficult decisions must be made. Just as in other chapters note when forgoing or withdrawing extraordinary treatment can be morally justified, this one might have at least

acknowledged when an indirect abortion might be, too.

In the fifth chapter Camosy deals opens with the 2018 case of newborn Alfie Evans and neurodegenerative disease.² In Camosy's view, although the medical professionals claimed that they acted in Alfie's "best interests," their assumptions about "quality of life" were the main driving force. As in other chapters, there were conflicting visions of the good (125) in this case, as well as other social factors such as paternalism and classism. Again, Camosy invokes the precautionary principle: "Here's the bottom line: we just aren't sure about a lot of things related to what we think we know about the brain and how what we think we know relates to the (current and/or future) consciousness of a patient with a devastating neurological disease or injury" (119). He also resumes noting that the removal of life-sustaining treatment is sometimes justifiable, but "in this case there are multiple reasons to think this is not what was going on" (121).

The sixth chapter turns to human beings with late-stage dementia and neurodegenerative diseases such as Alzheimer's, Parkinson's, multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS). Camosy worries that philosopher Dan W. Brock's view, that human beings with severe dementia have no claim to life-sustaining health care, will become more prevalent (150). Writing during the early months of the COVID-19 pandemic, Camosy observes that persons with dementia were especially vulnerable and received inadequate care, evidence again of the "powerful ableist forces" that "determine who is in and who is out, . . . which lives are part of a community of equals and which are outside that community"

(154-155), a “deadly medical ableism” (158).

In the seventh chapter, Camosy attempts to engage secular progressives by appealing to their sense of social justice and equality. His medium-term strategy here is to try to “find an overlapping consensus” (173) with those who “may not follow a general commitment to fundamental equality consistently, but they do have one” (174). They are, like many of my undergraduate students who are culturally if not practicing Christians, disquieted about ableism, classism, racism, and consumerism. They vehemently denounce any hint of discrimination or injustice, especially toward the vulnerable. For students and readers who rightly excoriated US police for killing unarmed Black men such as George Floyd, Camosy tries to make plain that “the fundamental value during this racial justice moment is also the fundamental value at the heart of this book” (175). In my experience, such a strategy can be persuasive. Put differently, just as police and the wider public often exhibit an implicit bias toward persons of color, so too perhaps do medical practitioners and bioethicists have an implicit bias of ableism and “quality of life” that unjustly colors their treatment of (or lack of treatment of) human beings who lack certain abilities. In addition, Camosy hopes that those who adhere to Aristotelian or similar philosophical perspectives should be amenable to what he is advocating. He thinks that genuine dialogue about “first principles, chief loves, transcendental values, visions of the good, and ultimate concerns” is possible (178, 181).

In the short-term, Camosy invites fellow Christians to be “a counterculture of responsibility, encounter, and hospitality” in contrast to “a throwaway culture which discards

or otherwise marginalizes human non-persons as having lost their fundamental dignity” (163). He encourages more volunteering in nursing homes, encounters between younger and older generations, making decisions that allow us to care for aging parents and other family members, and other practices that will build and reinforce such a counterculture.

In the conclusion, Camosy asks, “And what if we fail?” And he answers, “If cultural change isn’t on the way, I propose that religious organizations and institutions mobilize for a massive, all-hands-on-deck response of our own” (185). Religious orders, such as the Sisters of Life and Little Sisters of the Poor, as he notes, had such an impact in the past. I would add that something similar has been occurring to address the climate crisis, with women religious leading the way. Maybe they, or comparable groups of Christian laypersons and health care professionals, can establish and operate in the long-term new hospitals, clinics, and nursing homes. Of course, doing so will require a lot of will as well as effort and money. Camosy suggests, though, that such a countercultural witness might be attractive to new converts. ✚

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Charles C. Camosy, *Losing Our Dignity: How Secularized Medicine Is Undermining Fundamental Human Equality* (Hyde Park, NY: New City Press, 2021), 222 pp., paperback, \$22.95.

ENDNOTES

1. For more on New City Press and the Focolare movement, see <https://www.focolaremedia.com/about>.
2. See "Moral Lessons from the Life of Alfie Evans: Two Ethical Perspectives," Health Care Ethics USA (July 2, 2018) for reflections from Tobias Winright, Jason Eberl, and Gerald Coleman, <https://www.chausa.org/publications/health-care-ethics-usa/archives/issues/summer-2018/moral-lessons-from-the-life-of-alfie-evans-two-ethical-perspectives>.

Literature Review: Conscientious Objection & Professionalism

Reviewed by Marissa D. Espinoza

Schuklenk, Udo, and Ricardo Smalling. "Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies." *Journal of medical ethics* 43, no. 4 (2017): 234-240.

Udo Schuklenk and Ricardo Smalling argue that in liberal democracies medical professionals have no moral claim to conscientiously object to the provision of services that are within the scope of professional practice. Accommodating conscientious objection has numerous significant issues. First, we cannot determine the truth of the beliefs that are motivating the conscientious objection and we cannot determine that those beliefs are genuinely held. Because of this, any attempts to draw lines between objections that should be accommodated and those that should not will be arbitrary. Second, conscientious objection disregards the needs of patients and creates inefficiency and inequity in accessing healthcare. Consider a woman in a rural area where abortion is legal, but there are a limited amount of providers willing to provide this service. This may result in the woman having to "depend on the goodwill of volunteering doctors" (237). It is unavoidable that conscience claims will result in suboptimal access to healthcare and arbitrary

service standards. Third, accommodating conscientious objection will also result in an inequitable workload for unobjecting doctors and it is unclear why this unfair burden should be accepted. As medical professionals voluntarily enter their profession, they should be prepared to offer the services that are within the scope of medical practice. If they are not able to offer those services, they do not belong in the profession.

Schuklenk and Smalling's argument provides a compelling account of how accommodating conscientious objection can result in unfair harms for patients. The potential harms patients, especially patients from vulnerable communities, may face should be addressed in all accounts of conscientious objection. It is important to consider ways potential harms to patients can be mitigated. While Schuklenk and Smalling's argument succeeds in highlighting potential harms that may result from accommodating conscientious objection, it operates on a misguided understanding of medical professionalism. Their conception of professionalism requires that an individual's religious beliefs be relegated to the private sphere. They wrongly assume that a person can disregard their own moral starting point and utilize only secular neutral reason. However, secular reason, like religious reason, is not without tradition. Further, professional

identity is not formed in a vacuum. It is the combination of professional and private values. Schuklenk and Smalling overlook how the private values of professionals can help to morally correct medicine when it strays into morally objectionable territory. This is not to say that all conscience claims should be accommodated regardless of the moral reasons for them because of their potential to help medicine morally self-correct. This is only to say that there is more value to accommodating conscientious objection than Schuklenk and Smalling acknowledge.

Symons, Xavier. "Conscientious objection in health care: Why the professional duty argument is unconvincing." *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 47, no. 4 (2022): 549-557.

Xavier Symons responds to what he calls the Professional Duty Argument (PDA), which claims that doctors should set their moral or religious beliefs aside when they are in conflict with what the relevant professional associations have deemed a part of good medical practice. As they enter their profession voluntarily, they should be prepared to offer what has been determined to be a part of good medical practice. Under the PDA, accommodation of conscientious objection should be very limited, if allowed at all because it is at odds with professional duty. Symons raises two objections to the PDA—the fallibility objection and the professional discretion objection. The fallibility objection acknowledges that professional codes of conduct are epistemically fallible ways of determining what is good medicine. Accommodating conscience claims can provide a check on the law and professional associations

that guide the moral conduct of doctors by allowing individual providers to determine whether the guidance of the law and the profession is ethical. The professional discretion objection recognizes the need for medical professionals to be afforded the discretionary space to determine what is best for a patient in a particular situation. The PDA disregards that medical judgments involve both technical and moral considerations. By heavily restricting the discretionary space of the medical professional, we are impeding their ability to better respond to particular needs of each individual patient and act with moral integrity. While this article provides a strong critique of the Professional Duty Argument, it does not consider what limits, if any, should be placed on the professional discretionary space.

Sulmasy, Daniel P. "Conscience, tolerance, and pluralism in health care." *Theoretical medicine and bioethics* 40, no. 6 (2019): 507-521.

Daniel Sulmasy addresses the issue of “how a tolerant, pluralistic, liberal democracy” should handle cases where a professional has an ethical objection to providing a morally controversial service that is legal and is supported by at least some members of the profession. Sulmasy claims that this is not necessarily an issue of conscience, but an issue of how much discretionary space professionals should be afforded to “foster the proper relationship among the state, the market, and the professions in a flourishing, pluralistic, liberal democracy” and how much discretionary space should be afforded to “meet the basic standards of tolerance that all citizens can expect in a flourishing, pluralistic, liberal democracy” (515). While professions establish

the goals and ethics of their practice alongside society, there must be discretionary space for individual professionals. In the same way it is not desirable for political powers to infringe upon the discretionary space of a profession, professions should aim to not infringe upon the discretionary space of individuals. As professional judgment has both technical and moral elements, it is important to respect the discretionary space of individuals to determine what is in the scope of good medicine. Sulmasy argues “forcing individuals to violate their deeply held moral beliefs regarding practices that are not central to their professional activities as a condition of practicing that profession, when the common good is not threatened, is intolerant” (517-518). Tolerance requires that a profession tolerate a diversity of personal characteristics and a diversity of beliefs and practices. However, there are limits to a person’s claims of tolerance. While refusing to perform an action that is immoral has a claim to tolerance, refusing to treat someone you disagree with or whose personal characteristics you do not like does not have a claim to tolerance.

Sulmasy offers a much needed conceptual clarity to important terms in the conscientious objection debate (e.g., conscience, conscientious action, professional medical judgment, conscientious objection, conscience clauses, civil disobedience, and tolerance). As “the bar for not tolerating diverse views and practices, on a Lockean analysis, is quite high—tolerating the view must substantially undermine the common good,” we are left to consider whether difficult cases of conscientious objection, such as those involving gender-affirming care, rise to the level of substantially undermining the common good (518).

SYNTHESIS

While common arguments against accommodating conscientious objection involve the privileging of secularly understood medical professionalism that is at odds with some religious traditions, these arguments remind us of the need to consider how we can better care for vulnerable patients and limit potential harms they may experience. As Catholic healthcare continues to care for patients of diverse backgrounds in an evolving sociopolitical landscape, we should be mindful of how formation efforts are occurring within a particular sociopolitical landscape. As these articles highlight, it is important that we consider what professional identity consists of and what the limits of professional discretion are. ✚

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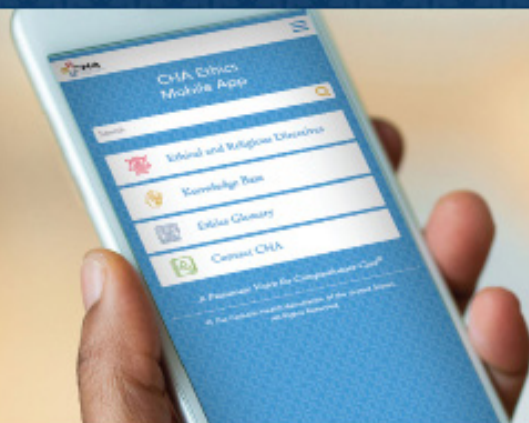


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