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The Principle of the Double Effect as Preserving Integral Goodness: A Brief Historical Overview

Peter J. Cataldo, Ph.D.

A common decision-making experience that cuts across ordinary life and specific areas such as health care is the choice of an act that has both good and bad effects where there is not merely a general awareness of a risk of the bad effect, but where the bad effect is foreseen yet unintended, and is something that under different circumstances the person would ordinarily avoid as impermissible (a “double effect act”). Historically, as philosophers and theologians in the Catholic moral tradition reflected on the elements of human action and double effect acts, an implicit moral principle gradually developed for evaluating such acts, which became explicitly formulated as the principle of the double effect (“PDE”).¹ This article will identify those components of human action that were historically presupposed by the PDE in the Catholic moral tradition and will suggest that the PDE is best understood and applied as a guide for ensuring what the Catholic tradition comprehended as the integral goodness of a double effect act.

THE PRINCIPLE

The permissibility of double effect acts is morally evaluated through the PDE by the application of four conditions. Each condition depends upon and is best understood within the structures of human action and existence as articulated within the Catholic moral tradition. The historical antecedents of the PDE are usually acknowledged to begin with St. Thomas Aquinas’ treatment of the ethics of self-defense in his *Summa Theologica* culminating in the explicit articulation of the principle’s fundamental conditions in the work of the classicist theologian Joannes P. Gury, S.J., in 1850.² This article will suggest that the antecedents of the PDE originate in Aristotle and gain essential definition in multiple sources from Aquinas. The traditional four conditions of the PDE are the following:

1. The moral object of the act must good or at least not be intrinsically immoral.
2. The good effect must be intended, even though the bad effect is foreseen.

3. The good effect cannot be caused by the bad effect.
4. The good effect must be proportionate to the bad effect.

As will be shown, in the Catholic moral tradition each condition represents an integral part of a whole. All four conditions, therefore, must be fulfilled and must be applied with the appropriate virtues for a double effect act to be justified. The structures critical for a historical understanding of the four conditions of the principle that will be briefly reviewed here are the natural moral law, voluntary human action; the traditional three sources of the human act; the relation between means and ends; and the responsibility for foreseen and unforeseen consequences.

THE FUNDAMENTS OF MORAL ACTION

The PDE is historically and ontologically conditioned by what in the Catholic moral tradition is known as the first principle of practical reason within the natural moral law, namely, that all things are ordered toward the good.³ Given this principle, our practical reason is able to recognize the most fundamental obligation of morality: "Good is to be done and pursued, and evil is to be avoided."⁴ The reality of human action is such that this obligation is not fulfilled simply by either doing good *or* avoiding evil when doing so is uncomplicated, but that the obligation is also in force when the pursuit of good is inextricably tied with evil in double effect acts. Thus, a fundamental moral goal of the PDE is to guide the moral agent *to pursue and achieve good* even though this effort is inseparably connected with evil that is foreseen as likely.⁵

As with any moral obligation, fulfilling the first rule of the natural moral law presumes voluntary moral agency where there is adequate knowledge and free choice of the will.⁶

However, there are situations and actions in which the voluntary status of the act may not be clear, in particular the intent of the agent. Aristotle recognized this in his classic example of a ship in a storm: "Something of the sort happens also with regard to the throwing of goods overboard in a storm; for in the abstract no one throws goods away voluntarily, but on condition of its securing the safety of himself and his crew any sensible man does so"⁷ Here, Aristotle recognized that an act that has a good effect (e.g., saving life) may also have a bad effect (e.g., destruction of goods), which considered in itself is not permissible and as such is not intended. Such an act is voluntary but has a "mixed" status because the good effect cannot be obtained without the foreseen but unintended bad effect. Thus, the essential elements of the PDE — a good or indifferent act with good and bad effects, foreseeing but un-intending the bad effect, and a proportionality between the good and bad effects — are present in Aristotle's account of voluntariness.⁸

The historical antecedents of the PDE are also found in Aquinas' example of the part-whole relationship and in his view of lethal force. In his ethical analysis of causing physical injury to oneself or another, Aquinas explains that

. . . a member of the human body is of itself useful to the good of the whole body, yet, accidentally it may happen to be hurtful, as when a decayed member is a source of corruption to the whole

body. Accordingly so long as a member is healthy and retains its natural disposition, it cannot be cut off without injury to the whole body.⁹

The implication of this argument is that a decayed member may be cut off to preserve the whole of the body.¹⁰ This is permissible even though the bad effect of losing a member is foreseen. The surgical act of amputation is not immoral because while a human limb is intrinsic to the good of the whole body, in particular cases that intrinsic status is accidentally altered by disease. Hence, even though the bad effect of losing a limb is foreseen, the loss *qua* particular part within the whole need not be intended and in fact is not what is intended.¹¹ Moreover, the good effect of preserving the health of the whole is proportionate to the bad effect of losing a limb.¹²

Aquinas' account of the ethics of self-defense highlights the components of intention, nature, and proportionately found in the PDE:

. . . the act of self-defense may have two effects, one is the saving of one's life, the other is the slaying of the aggressor. Therefore this act, since one's intention is to save one's own life, is not unlawful, seeing that it is natural to everything to keep itself in "being," as far as possible. And yet, though proceeding from a good intention, an act may be rendered unlawful, if it be out of proportion to the end. Wherefore if a man, in self-defense, uses more than necessary violence, it will be unlawful: whereas if he repel force with moderation his defense will be lawful . . .¹³

An act of physical force taken in self-defense can have the good effect of saving one's life and the bad effect of killing the aggressor. Such an act is good in itself (*per se*) consistent with the natural moral law. The good effect of saving life is intended and the killing of the aggressor is incidental to the act of self-defense. To confirm that the killing is an incidental effect, Aquinas includes a proportionality test to ensure that no more violence than is necessary is used. If disproportionate force is used, then this is evidence that the killing is not an incidental effect of the act and is itself intended.¹⁴

This attention to due circumstances in the ethical evaluation of self-defensive actions points up that the traditional three determinants of a moral act are another fundamental factor for understanding the traditional version of the PDE. These determinants or fonts are the moral object of the act, the intention of the agent, and the circumstances of the act. When each of these elements achieves its own good, the moral goodness of an act forms an integral whole. For an act to be completely good, all three fonts must be good, but a defect in only one component is enough to make the act morally bad. This is a principle of human action recognized by Aristotle and used throughout the Catholic moral tradition.¹⁵ The moral integrity of an act is actually reflective of the way it exists on an ontological level. As all things have a potential for what Aquinas calls "the fullness of being" (*plenitudo essendi*), so also does the human act possess a fullness or wholeness of its being as constituted by its object, intended ends, and its due circumstances.¹⁶ No one moral font by itself can account for an act's fullness of being, but

only together do they constitute its fulness. As will be shown, the PDE is best understood as a guide to preserve the unity and integral goodness or fullness of being of a double effect act.¹⁷

The moral object of an act in the Catholic moral tradition refers to the act's delimited moral content that constitutes its moral nature or species within an objective moral order; for example, theft, self-defense, murder, adultery, or lying.¹⁸ Intention is an act of the will that tends in an ordered relation toward something as its terminus (or "end") guided by reason. An intermediate terminus toward which the will tends is known as a means and is also known as the proximate or immediate end which is ordered to an ultimate terminus or remote end.¹⁹ Moreover, to intend a remote or ultimate end is necessarily to intend the means to that end.²⁰

Intention should not be conflated with foresight. Traditionally, these were regarded as operations of two different powers: intention as an act of the will, foresight as an act of the intellect.²¹ Therefore, to foresee a bad consequence in a double effect act is not necessarily to intend it. Related to intention but distinct from it in assessing responsibility is any additional willingness for an effect. For Aquinas, the consequences of an external act can increase or decrease the goodness or badness that an act already has from its object depending on whether the effects are foreseen, and if unforeseen, whether they are incidental or should have been foreseen when the consequences follow from the nature of the act.²² The conditions of the PDE in part help to ensure the overall integral good of a double

effect act by determining whether the act truly has a double effect or whether the foreseen bad effect defines the nature of the act.²³

Aquinas defines the circumstances of an act in this way: "Whatever conditions are outside the substance of an act [moral object], and yet in some way touch the human act, are called circumstances."²⁴ How the circumstances of an act are configured with each other is important for its ethical assessment: "Everything that is directed to an end should be proportionate to that end. But acts are made proportionate to an end by means of a certain commensurateness, which results from the due circumstances."²⁵ Assessing the voluntariness of an act is also determined by knowledge or ignorance of its circumstances.²⁶ Circumstances are categorized as "who, what, where, by what aids, why, how, and when" and touch the act itself, the cause of the act, and the act's effect.²⁷

ENSURING INTEGRAL GOODNESS

The PDE implicitly integrates all tenets of the Catholic moral tradition identified here: the first principle of the natural moral law — to do good and avoid evil; the voluntary status of acts in which pursuing good is inextricable with avoiding evil; and the centrality of an act's object, intention, and circumstances. The PDE is best understood as designed to preserve the integrity of the goodness of an act in its three fonts where there are both foreseen good and bad effects.²⁸

This is evident from the way in which the three traditional determinants of a moral act overlay with the four conditions of the PDE.²⁹ As with any human act, the moral nature of a double

effect act is derived from its object. The first condition of the PDE ensures that the act's object is good or at least is not immoral. For a double effect act to be good, the agent must intend a morally good object in the proximate end or means, a remote end that is good, and only particular effects that are good (second condition). Foreseeing the bad effect(s) does not disrupt the integrity of the act because foreseeing a consequence does not necessarily entail that the effect is intended, and because the nature of the act is such that it has multiple effects both good and bad.

Finally, the third and fourth conditions of the PDE pertain to the third font, the circumstances of the act, and specifically those circumstances that correspond to the act's causes, its effects, and the act itself. Among the circumstances relating to the effects of the act, the bad effect cannot be a cause of the good effect in any way, either as a final, material, or efficient cause. With respect to the circumstances relating to the effects and the act itself, for example, there must be a due proportion among the nature of the effects and their moral status and among circumstances such as the timing of the act and how or in what manner the act is performed. Understood against the backdrop of the notion of the integrity of goodness and in light of other fundamental structures of human action, the PDE was never designed as a comprehensive moral principle but as a threshold test for the moral wholeness of a double effect act.³⁰

The three-font foundation of the PDE ensures that all circumstances touching upon object, intention, foresight, causality, and effects of a double effect act achieve an overall

commensurateness with the ultimate end of the act and thereby preserve the integrity of its goodness and the fullness of its being.³¹ Hence, by applying the PDE through the lens of an act's integrity it can be shown how, for example, the PDE preserves the integral goodness of removing a gravid cancerous uterus threatening the life of the mother.³² The act's integral goodness is evident in the status of the following components: Removing the threat of cancer as the act's object is morally good; the good effect of removing a diseased uterus and the remote end of preserving life are all intended; the death of the fetus is foreseen but not intended; the death of the fetus is not the cause of the good effect of removing a diseased uterus; and there is a relational circumstance between the goodness of the good effect and the wrongness of the bad effect such that the good effect is proportionate to the bad effect. The good of saving the mother — the only life that can be saved under the circumstances — through a procedure that conserves the lives of both mother and child to the extent possible and is not defined by the killing of the child, represents a proper proportionality of the good effect in relation to the bad effect.

The understanding of the PDE articulated here as being conditioned by the classical view of the three moral determinants of an act provides a helpful hermeneutic to interpret both contemporary views of the traditional principle and contemporary reformations of it. As a guide for preserving the integral goodness of a double effect act, its central thesis is not focused on one element of action, such as intentionality around the bad effect. Thus, the main purpose of the PDE is not to block the transfer of the impermissibility of other (non-

double effect) acts that have bad effects similar to the bad effect in a double effect action.³³ Given the multifactorial foundation of the PDE, it is not reducible to any one relation within the structure of human action or to any particular traditional condition or combination of conditions. For example, the PDE is not reducible to the epistemological relation between foreseeable and intended effects,³⁴ or to its second and third conditions, or to a principle about intentionality.³⁵ Similarly, the PDE cannot be reduced to a psychological relation between foreseeable and intended effects.³⁶

The PDE emerged from the multifaceted nature of human action within the Catholic moral tradition. Among the various components of this view of human action is the fundamental recognition that the goodness of action forms a unified, integral whole. Given these historical sources of the principle, the essential purpose of the PDE is best understood and applied as a principle for ensuring the integrity of goodness of double effect acts.³⁷ ✚

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ENDNOTES

1. All uses of "PDE" will refer to the traditional formulation and understanding of the principle, unless otherwise specified. I also use the definite article, "the," in the title of the principle because this was the traditional form used and because it captures the thesis of this analysis that the PDE is not a principle for assessing side effects but for assessing the unified integral goodness of double effect acts.
2. For an authoritative history of the PDE, see Joseph T. Mangan, S.J., "An Historical Analysis of the Principle of Double Effect," *Theological Studies* 10, 1 (February 1949): 41 – 61; see also T. A. Cavanaugh, *Double-Effect Reasoning: Doing Good and Avoiding Evil* (Oxford: Clarendon Press, 2006); and T. Lincoln Bouscaren, S.J., *Ethics of Ectopic Operations*, Second Edition (Milwaukee, WI: The Bruce Publishing Co., 1944): 30 – 38.
3. Aristotle first articulated the core of the natural moral law in his *Nicomachean Ethics*: "Every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim": Aristotle, *Nicomachean Ethics*, tr. W.D. Ross, (Oxford: Clarendon Press, 1925), I, 1 (1094a 1). St. Thomas Aquinas, building on Aristotle, described the essence of the natural moral law in this way: ". . . every agent acts for an end under the aspect of good. Consequently, the first principle of practical reason is one founded on the notion of good, viz. that "good is that which all things seek after." Aquinas, *Summa Theologica*, trs. Fathers of the English Dominican Province (New York: Benziger Bros., 1947), I-II, q. 94, a. 2.
4. *Summa Theologica*, I-II, q. 94, a. 2.
5. For an excellent examination of the role of the natural moral law in the PDE, the causal structures of the moral act, and their relational significance as they function in the PDE, see Jean Porter, "Choice, Causality, and Relation: Aquinas's Analysis of the Moral Act and the Doctrine of Double Effect," *American Catholic Philosophical Quarterly* 89, 3 (June 2015): 479-504. See Alison McIntyre, "Doing Away with Double Effect," *Ethics* 111 (January 2001): 233, ". . . it [PDE] is addressed to well-intentioned agents who wonder what they may do to further a good end." McIntyre introduces six "constraints" on the application of the PDE to address what she argues are problems with the way that proponents of the PDE treat the difference between intentionality and foresight.
6. *Summa Theologica*, I-II, q. 6, a. 1. A voluntary act is described as a human act as opposed to an act of a human; see *Summa Theologica*, I-II, q. 18, a. 8.
7. Aristotle, *Nicomachean Ethics*, III, 1 (1110a 5). Aristotle

describes this case as an example of acting out of fear of greater evils. This description can be understood as later becoming the principle of lesser evils, which is related to the PDE.

8. Consistent with Aristotle, the voluntary status of a double-effect act was categorized in the manualist tradition as “indirectly voluntary”; see, for example, Dominic M. Prümmer, O.P., *Handbook of Moral Theology*, trs. G.W. Shelton, S.T.L. (Cork: The Mercier Press, 1956): 13 – 14; John A. McHugh, O.P. and Charles J. Callan, O.P., *Moral Theology*, Vol. 1, Edward P. Farrell, OP, ed. (New York: Joseph F. Wagner, 1958): 16 – 17.
9. *Summa Theologica*, II-II, q. 65, a. 1.
10. See *Summa Theologica*, II-II, 64, 2: “For this reason we observe that if the health of the whole body demands the excision of a member, through its being decayed or infectious to the other members, it will be both praiseworthy and advantageous to have it cut away.”
11. Aquinas’ analysis shows an additional foundational element for understanding the PDE; namely, the distinction between the per se nature of something and its per accidens state, which was pervasive throughout classical thought. For an example of how this distinction is relevant for understanding the PDE, see Mangan, S.J., “An Historical Analysis of the Principle of Double Effect,” 49, 53, 55, 57 – 58.
12. The manualists in the Catholic moral tradition generally recognized five standards for assessing the proportionate gravity of the reason(s) for tolerating the bad effect in double effect acts: the degree of badness of the effect; the degree of dependence of the bad effect on the act; the proximity of the effect to the bad act; the degree of certainty that the bad effect will occur; and the degree of obligation to prevent the bad effect. See, for example, John A. McHugh, O.P., and Charles J. Callan, O.P., *Moral Theology*, 38 – 39.
13. *Summa Theologica*, II-II, q. 64, a. 7.
14. In the same article (as well as a. 3), Aquinas argues that it is morally permissible for a public authority to intend to kill as a means to preserve the common good. This is not a double effect situation insofar as the killing is deemed morally good.
15. See Aristotle, *Nicomachean Ethics*, II, 6 (1106b, 28 – 35): “Again, it is possible to fail in many ways . . . while to succeed is possible only in one way . . . For men are good in but one way, but bad in many”; Aquinas, *Commentary on Aristotle’s Nicomachean Ethics*, trans. C.I. Litzinger, O.P. (Notre Dame, IN: Dumb Ox Books, 1993), II, 7, 319 – 321 (pp. 107 – 108): “. . . good results from a united and complete cause but evil from any single defect. . . . ‘goodness will be present only when all the circumstances are rightly ordered’; see also Aquinas, *Commentary on Aristotle’s Nicomachean Ethics*, I, 12, 139 – 140; see Aquinas, *On Evil*, trs. John A. Oesterle and Jean T. Oesterle (Notre Dame, IN: University of Notre Dame Press, 1995), II, a. 4, ad 2 (p. 62): “And hence it is that an evil act cannot become good, for from whichever [of these defects] the act is evil, it cannot be an integral good; but a good act can become evil because it is not required that it be an integral evil, but it is sufficient that it be evil in some particular respect”; see also, for example, Aquinas, *On Evil*, VIII, a. 4; X, a. 1; XVI, a. 6, ad 11; see also *Summa Theologica*, I-II, q. 19, a. 6, ad 1; and see *Summa Theologica*, I-II, q. 18, 4, ad. 3: “Nothing hinders an action that is good in one of the way[s] mentioned above, from lacking goodness in another way. And thus it may happen that an action which is good in its species or in its circumstances is ordained to an evil end, or vice versa. However, an action is not good simply, unless it is good in all those ways: since ‘evil results from any single defect, but good from the complete cause,’ as Dionysius says (Div. Nom. iv).” Christopher Kaczor in “Double-Effect Reasoning from Jean Pierre Gury to Peter Knauer,” *Theological Studies* 59 (1998): 299, recognizes that Aquinas’ analysis of self-defense in *Summa Theologica*, II-II, q. 64, a. 7 presupposes his examination of the principles of human action earlier in the *Summa* at II-II, q.18, but he does not make the additional point that for Aquinas these principles are integral to the unity of a good moral act.
16. See *Summa Theologica*, II-II, q. 18, a. 1-3; articles 4 – 11 also indirectly address the fullness of human action as good. See Jan A. Aertsen, “Thomas Aquinas on the Good: The Relation between Metaphysics and Ethics,” in Aquinas’s *Moral Theory: Essays in Honor of Norman Kretzmann*, eds. Scott MacDonald and Eleonore Stump (Ithica, NY: Cornell University Press, 1999): 243 – 247. Analogous to the unity of the goodness of a moral act is the unity of a human act in its operations; see *Summa Theologica*, II-II, q. 17, a. 4. See also Ralph McInerney, *Aquinas on Human Action: A Theory of Practice* (Washington, D.C.: The Catholic University Press of America Press, 2012): 69: “. . . a single human act contains many parts which are only potentially many; some of them actually come to be separate wholes when something goes wrong.”
17. The preservation of this unity of a double effect act through the application of the PDE is why the PDE is appropriately described as a principle. Cavanaugh, *Double-Effect Reasoning* (p. xx, n.) uses “double-effect reasoning” rather than referring to the principle of the double effect because he regards it as being more a set of criteria than a principle, and because use of “principle” reinforces the erroneous reduction to one of the criteria. However, given that preserving the integrity of goodness is the central purpose of the PDE, the principle is not simply about the reasoning of an agent but also pertains to the moral and ontological wholeness of a double

- effect act.
18. *Summa Theologica*, I-II, q. 18, a. 2.
 19. *Summa Theologica*, I-II, q. 12, a. 2, a. 3, a. 4.
 20. This follows from the very structure of intention as an ordering of one terminus to another. See *Summa Theologica*, I-II, q. 12, a. 4: “. . . the will is moved to the means for the sake of the end: and thus the movement of the will to the end and its movement to the means are one and the same thing. For when I say: ‘I wish to take medicine for the sake of health,’ I signify no more than one movement of my will. And this is because the end is the reason for willing the means.”
 21. There are other differences as well; see Cavanaugh, *Double-Effect Reasoning: Doing Good and Avoiding Evil*, 97, 107.
 22. *Summa Theologica*, I-II, q. 20, a. 5. Even though to foresee is not necessarily to intend, in some cases one can still be responsible for foreseen effects, even if they are not intended; see G.E.M. Anscombe, “Modern Moral Philosophy,” *Philosophy* 33, 124 (January 1958): 11. See Gareth B. Matthews, “Saint Thomas and the Principle of Double Effect,” in *Aquinas’s Moral Theory: Essays in Honor of Norman Kretzmann*, eds. Scott MacDonald and Eleonore Stump (Ithaca, NY: Cornell University Press, 1999): 72 – 74 for a critique of the view that, unlike double effect actions, Aquinas held that when one’s act has one bad effect that follows from the nature of an act it need not be intended.
 23. Willingness based on the status of whether the consequences of an act are foreseen can be said to pertain to other operations of the will in addition to intention; namely, counsel, consent, and choice. See *Summa Theologica*, I-II, q. 13, 14, 15.
 24. *Summa Theologica*, I-II, q. 7, a. 1.
 25. *Summa Theologica*, I-II, q. 7, a. 2.
 26. *Summa Theologica*, I-II, q. 7, a. 2.
 27. *Summa Theologica*, I-II, q. 7, a. 3.
 28. On this interpretation, the PDE is not adequately characterized as a moral rule arising from a consideration to avoid doing moral evil as is argued, for example, by Alexander R. Pruss, “The accomplishment of plans: a new version of the principle of double effect,” *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 165, 1 (August 2013): 49, 58.
 29. See Peter J. Cataldo, “The Principle of the Double Effect,” *Ethics & Medics: A Catholic Perspective on Moral Issues in the Health and Life Sciences* 20, 3 (March 1995): 1 – 3; see also Peter J. Cataldo, review of P.A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle* (Notre Dame, IN: University of Notre Dame Press, 2001) in *The National Catholic Bioethics Quarterly* (Summer 2004): 436.
 30. For an account about what ought not to be expected from the PDE, see Heidi M. Giebel, “The Limits of the Double Effect,” *Proceedings of the American Catholic Philosophical Association*, ed., Mirela Oliva (Houston, TX: American Catholic Philosophical Association): 143 – 157. G.E.M. Anscombe, “Medalist’s Address: Action, Intention, and ‘Double Effect,’” in P.A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle*, 64 – 65 argues that additional principles are needed “on which to judge the unintended causing of death.” An example of such a principle might be the “intrinsic certainty of the death of the victim.” Anscombe’s observation is true insofar as it pertains to whether an effect defines the nature of the act, and I would submit that such subprinciples are implicitly present in the conditions of the PDE that account for the due proportion of circumstances.
 31. See *Summa Theologica*, I-II, q. 18, a. 3, where Aquinas relates the circumstances of an act to the fullness of its being: “Now, everything that is directed to an end should be proportionate to that end. But acts are made proportionate to an end by means of a certain commensurateness, which results from the due circumstances. In natural things, it is to be noted that the whole fullness of perfection due to a thing, is not from the mere substantial form, that gives it its species; since a thing derives much from supervening accidents, as man does from shape, color, and the like; and if any one of these accidents be out of due proportion, evil is the result. So it is with action. For the plenitude of its goodness does not consist wholly in its species, but also in certain additions which accrue to it by reason of certain accidents: and such are its due circumstances. Wherefore if something be wanting that is requisite as a due circumstance the action will be evil.”
 32. For a defense of the PDE against critiques in the context of other typical issues in medical ethics see Daniel P. Sulmasy and Edmund D. Pellegrino, “The Rule of Double Effect: Clearing Up the Double Talk,” *Archives of Internal Medicine* 159 (March 22, 1999): 545 – 550. While Sulmasy and Pellegrino correctly present the PDE, they mistakenly hold that the PDE cannot be used together with other traditional principles, such as the principle of ethically proportionate and disproportionate means of sustaining life, to morally evaluate actions such as physician assisted suicide and terminal sedation.

33. See Joseph Boyle, "Intention, Permissibility, and the Structure of Agency," *American Catholic Philosophical Quarterly* 89, 3 (2015): 461 – 478; Germain Grisez, *The Way of the Lord Jesus: Christian Moral Principles*, Volume 1, (Chicago: Franciscan Herald Press, 1983): 299.
34. See Neil Delany, "To Double Business Bound: Reflections on the Doctrine of Double Effect," *American Catholic Philosophical Quarterly* 75, 4, (Fall 2001): 561 – 583; David S. Oderberg, "The Doctrine of Double Effect," in *A Companion to the Philosophy of Action*, eds. Timothy O'Connor Constantine Sandis, (Oxford: Wiley-Blackwell Publishing, 2010): 324-330; Lawrence Masek, "In Defense of a Minimalist, Agent-Based Principle of Double Effect," *American Catholic Philosophical Quarterly* (June 2015): 521 – 538; Michael S. Moore, *Causation and Responsibility: An Essay in Law, Moral, and Metaphysics* (Oxford: Oxford University Press, 2009): 42 – 51; Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Sixth Edition (New York: Oxford University Press, 2009): 162; Philip A. Reed, "The Danger of Double Effect," *Christian Bioethics* 18, 3, (2012): 287 – 300; Reed also makes the claim that the PDE is abused because its conditions are inherently disposed for abuse. This claim can in part be countered by an adequate understanding of the central components of human action within the Aristotelian-Thomistic tradition, including the integrity of goodness, and how they form the conditions of the PDE and are preserved by the PDE in double effect action.
35. For views that reduce the PDE to its second and third conditions see, Joseph M. Boyle, Jr., "Toward Understanding the Principle of Double Effect," in P.A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle*, 7 – 20; Philip A. Reed, "How to Gerrymander Intention," *American Catholic Philosophical Quarterly* (June 2015): 441 – 460. For views that reduce the PDE to a principle of intentionality see, Timothy E. Quill, Rebecca Dresser, Dan W. Brock, "The Rule of Double Effect – A Critique of Its Role in End-of-Life Decision Making," *The New England Journal of Medicine* 337, 24 (December 11, 1997): 1768 – 1771; Warren S. Quinn, "Actions, Intentions, and Consequences: The Doctrine of Double Effect" in P.A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle*, 23 – 40; Jonathan Bennett, "Foreseen Side Effects versus Intended Consequences," in P.A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle*, 85 – 118; Nancy Davis, "The Doctrine of Double Effect: Problems of Interpretation," in P.A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle*, 119 – 142; Philippa Foot, "The Problem of Abortion and the Doctrine of the Double Effect," in P.A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle*, 143 – 155; Donald B. Marquis, "Four Versions of Double Effect," in P.A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle*, 156 – 185.
36. See Neil Sinhababu, "Unequal Vividness and Double Effect," *Utilitas* 25, 3, (September 2013): 291 – 315.
37. For an important study of the historical sources for Jean Pierre Gury's formulation of the PDE, see Julia Fleming, "Jean Pierre Gury's Sources: A Missing Chapter in the History of Double Effect," *Theological Studies* 74 (2013): 420-441. In my view, Fleming correctly concludes that "For Gury and his sources, the critical question regarding the indirect voluntary [e.g., a double-effect act] was not whether an action was direct or indirect, but whether a particular indirect action was licit or illicit" (p. 441). The historical reason for this view by Gury and his sources is that their principles crucially assumed a unity of the three fonts of a moral act which preserves its integral goodness.

Jacks and Jills of All Trades, Experts of Some: Process Skills Training for Ethics Programs

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CASE REFLECTION

Case 1: One of the first ethics consultations I (Steven) witnessed as a novice left me confused. An attending physician had me observe a family-provider ethics consultation meeting. The patient was a woman in her thirties who was hit by a car while walking. Multiple opportunistic infections from advanced AIDS exacerbated her injuries. She was quite ill but not actively dying yet and she lacked decision-making capacity. Providers wanted to meet with her sister, who was the patient's statutory, default surrogate decision-maker, to suggest palliative care rather than aggressive treatment for her sister. Three chairs were in the middle of a medium-sized institutional room with half-filled bookcases on the sides. The patient's sister arrived with the patient's two children, who looked to be approximately seven and nine years old. They gingerly sat down. The attending physician, who had been standing at the doorway, left and returned with some resident physicians, all of whom were White

and wore white lab coats. They filed in and stood surrounding the seated Black family. The rest was a worsening nightmare, from providers talking to — not with — family members to doctors younger than the children's mother making an abrupt and unabridged disclosure, far too blunt for little ears, as the children's eyes widened and welled with tears.

Case 2: Many years later, ethics consultation team members asked for my (Steven) help in a provider-family ethics consultation meeting. I was requested because of my ethics expertise after a provider-family ethics consultation meeting had already occurred. The patient's husband and children asked to have a second ethics consultation with an expanded group after concerns about providers' advocacy of their and the patient's interests in the wake of the first ethics consultation. I entered the meeting room where chairs were arranged in a large circle. Something seemed off when just over a dozen participants found their chairs. My thoughts periodically drifted to a former consult (Case 1), but I was confused why. Discussion reached a crescendo. As voices raised, the back-and-forth between the care team and family resembled a tennis

volley. Only then did it occur to me that the patient's family members, all of whom were Black, were seated on one side of a huge circle. The caregiver and provider team, all of whom were white, were seated on the opposite side of the circle. Chairs arranged in a circle were meant to create closeness, be therapeutic, and remove barriers such as tables. Yet the participants' seating choices made it an oppositional cross-examination. I sought a place in the conversation to mention this, but someone else did first. A family member rightly called attention to the seating choices, so then everyone switched seats.

Reflection: Hindsight is 20/20. During Case 2, I didn't understand why I thought about Case 1, because the consults' topics and substance bore no semblance to one another. My reflections shortly after Case 2 clarified the cases' similarities. Too many caregivers were present at the consults. Family members were clearly overwhelmed. Participants' choices for placement and arrangement, seated or standing, aligned with ethnic differences and differences in relationship to the patient (care providers vs. family). The care team and I, failed to notice and call attention to arrangements early in the meeting. Failure to do so likely elevated us-vs.-them tensions.

It was much later, after supervising chaplains and understanding pastoral care, that I better realized why it took me years of working with health care professionals from different fields to understand my role and the facets or layers in these cases. On one level, I reflected on my and other consultants' proficiency in addressing diversity and inclusion. On another level, my reflection was about recognizing and managing

my own thoughts and emotions while actively listening to others. I didn't reflect until years after these cases, so I pondered how to foster intentionality around reflection and make connections among cases and myself. Perhaps on the deepest level, it was about my and others' education and training in ethics, which didn't include these skill sets that are basic to other fields.

OPPORTUNITIES FOR PROCESS SKILLS DEVELOPMENT IN ETHICS

The American Society for Bioethics and Humanities (ASBH) has emphasized process and knowledge as core competencies for clinical ethics consultants.¹ ASBH recently launched a credentialing program, and the requirements are currently limited to an exam. The launch of this program has received criticism for its lack of attention to the process dimension of ethics consultation.² Knowledge of theory pertaining to process skills for ethics consultation is necessary but not sufficient. Although these efforts are a good start, we need to augment our existing knowledge-oriented training programs with process learning. Specifically, we need process learning tools oriented toward effective facilitation when emotions are high and power dynamics related to social identities (e.g., race, gender, immigration status, religion, or culture) are magnified. We need the skill to address these power dynamics in real time while managing our own emotions. This is essential for building trust and eliciting honest responses from participants, which are both core competencies for ethics consultants according to ASBH.

This gap can be filled by engaging a phenomenological approach to ethics consultation. In a 2011 issue of *Bioethics*, Andrea Frolic shared an analysis of her qualitative research on the profession of bioethics.³ She observed that most ethics consultants did not consider their own embodiment in their interactions during consultation, suggesting to her a lack of reflection on the micro-politics involved in ethics consultations. They regarded themselves as “talking heads,” oblivious to the emotional, social, and political work they did with their embodied presence. Building on Frolic’s observations, Ellen Bernal recognized a deficiency in self-awareness when considering the way bioethicists discuss moral distress.⁴ She argues that we fail to acknowledge our own moral distress in difficult cases. Both Bernal and Frolic recommend the work of Richard Zaner as particularly helpful for considering how the ethics consultant affects (and is effected by) an ethics consultation. We agree that too little attention is given to the personal formation required for an embodied practice of ethics consultation that respects the dignity of the people involved in a case consultation. We recommend ongoing process learning for ethics consultants that includes self-reflective tools.

The field of bioethics is inherently interdisciplinary, assimilating knowledge from medicine, philosophy, law, theology, and more. Bioethicists already draw on multiple disciplines for methods of analysis. For example, a key resource for ethics consultants is *Bioethics Mediation: A Guide to Shaping Shared Solutions* by Nancy Dubler and Carol Liebman. Their chapter on techniques for mediating bioethics disputes in the revised and expanded edition

includes reality testing, reversing roles, allowing silence, and stroking. These are basic counseling techniques found in texts such as *Counseling Strategies and Interventions* by Sherry Cormier and Harold Hackney.⁵

We can continue to draw on other disciplines for tools to implement in process learning. Such learning would not only help ethics consultants build process skills for consultation but would also provide an opportunity for ethics consultants to process their own emotions about their work. As we develop a credentialing program in ethics consultation, we should look to the tools of other professions that achieve similar learning goals. Frolic and Bernal recognize the need for reflective tools that engage ethics consultants in self-reflective processes. An example of this kind of training can be found in Clinical Pastoral Education (CPE). Although pastoral care interventions are directed to different goals than ethics consultation, the process skills of building trust and values solicitation are necessary to both professions. CPE provides a model of the kind of training ethics consultants need.

CPE arose out of a need to complement knowledge training in the seminary with skills training in ministry.⁶ The early CPE movement was driven by a belief that ministers learned plenty about doctrine in school; what they still needed to learn to be effective ministers was how to work with people. One of the founders of CPE, Richard C. Cabot, was a physician who had taken the chair of ethics at Harvard University. In 1925, he wrote a plea for ministers to have a clinical training year. Decades later, clinicians sought out philosophers to help them answer difficult

questions about morality in clinical decision-making.⁷ Over time, pastoral care has become the realm for addressing patients' feelings, and ethics has been the realm for analysis of values.⁸ This divide isn't exact, nor is it sufficient to our work. Good spiritual care and good ethics consultation require integration of head and heart; we need collaboration to help each other grow more effective in our roles. Pastoral Care is an older profession than ethics consultation and thus has had more time to cultivate and implement tools for process learning. The plea for a clinical year that Cabot made one hundred years ago has been resonating for ethics consultation training in recent decades, and the call sounds even louder as ASBH has begun credentialing ethicists with an exam.

Rather than starting from scratch in developing tools for process learning, ethics consultants should build variations on existing tools that have proved effective in pastoral care. One such tool is the verbatim. A verbatim includes a transcript of a consult (from memory) with notes on context, nonverbal communication, the consultant's mood, the consultant's read on the interlocutor(s)' mood(s), and interpersonal dynamics. The verbatim allows for reflection on one's own performance, including the micro-politics and emotional factors that influence analysis and communication. These reflections are not simply private writing experiences; they are presented before a group of peers for discussion and evaluation. They invite others to broaden the consultant's self-awareness, bringing attention to habits or styles of communication that may not serve the goals of the consultation. Implementing the verbatim in the training of ethics consultants will address

the gaps in process learning that the profession currently experiences to improve ethics quality.

Having an experience without considering or processing emotions, sensitivities, motivations, or character misses the mark.⁹ This illustration may assist: ASBH mentions knowing a clinical context with "awareness of the grieving process and psychological responses to illness" in *Core Competencies for Healthcare Ethics Consultation*, second edition. One can know Elisabeth Kübler-Ross' stages of grief, but identifying what stage someone is in is a different matter. Supporting someone is another matter still. Guidance about what to do and what to avoid in response to grief requires much more skill and precision.

Ethics colleagues express a range of difficult experiences from the coronavirus pandemic: These include moral distress, moral injury, and burnout. Many ethics consultants *are* frontline health care professionals although their services are classified as ancillary. The same ethics consultants who experience moral distress and injury may also facilitate moral distress and moral injury interventions for their colleagues. Practicing the services that we provide to others and modeling self-care can be difficult for ethicists.¹⁰ Ethics consultants need help processing our own experiences in the clinic. Chaplains have tools to help, and they have cultivated a culture of emotional processing by encouraging activities such as journaling, making notes, taking quiet time, and spending time with family and friends.¹¹ We can borrow these tools and adapt them to our work to help us practice better self-care.

OTHER OPPORTUNITIES INCLUDE EQUITY, DIVERSITY, AND INCLUSION TRAINING

Other fields also have transferrable skills and tools for bioethics. The following true story highlights the need for equity, diversity, and inclusion training for ethics consultants:

Susan Moore, the patient, said the White doctor at the suburban Indianapolis hospital where she was being treated for COVID-19 had downplayed her complaints of pain. The doctor told her that he felt uncomfortable giving her more narcotic and suggested that she be discharged. “I was crushed,” Moore said in a video posted on Facebook. “He made me feel like I was a drug addict.” In her post, which has since circulated widely on social media, she showed a command of complicated medical terminology and an intricate knowledge of treatment protocols as she detailed the ways in which she had advocated for herself with the medical staff. She knew what to ask for because she, too, was a medical doctor. But that was not enough to get her the treatment and respect she said she deserved. “I put forth and I maintain if I was White,” she said in the video, “I wouldn’t have to go through that.” After Dr. Moore, 52, complained about her treatment, she received care that she said “adequately treated” her pain. She was eventually sent home, and on Sunday, less than three weeks after posting the video, Dr. Moore died of complications from COVID-19, said her son, Henry Muhammed.¹²

As a hypothetical, assume that Dr. Moore requested an ethics consult when she first experienced a care disparity. The on-call consultant would need recognition, skill, and comfort working with the patient and providers on this overt discrimination that is intensely uncomfortable to discuss.

Not all diversity and inclusion issues in ethics are as overt. Some are subtext within other discussions. Consider the patient who moved to the United States, could not access appropriate health care, and then once accessed, the level of care appears ... *different* ... than care received by others. These narratives may not have occurred in the current setting, but they impact current perceptions and plans, nonetheless. Physician ethicist Kelly Stuart’s simple and helpful rubric is that less has always been less for people who have experienced health disparities.¹³ In other words, clinicians and ethics consultants often express the view that less invasive treatment is better for the person.

Responding to overt or implicit care disparities in a consult can be awkward for White ethicists. These situations bear a remarkable resemblance to addressing adverse events, such as medical errors, especially for clinicians, lawyers, and risk managers. The fairness of disclosure (or delving into disparities, in our case) to respect autonomy hangs in the balance with worries about organizational nonmaleficence after the disclosure (discussing disparities). Do ethics consultants have the tools and training to effectively navigate situations? What are the ways the organization helps consultants process their anxieties and fears around these tough topics? Professionals in health equity, diversity and inclusion (HEDI) have the skills and training to help.

ETHICS CONSULTANT CONTINUING TRAINING AT CHRISTUS HEALTH

Ethics consultants appreciate and invite periodic skills retraining, especially if consultants are the point person for only a couple to a half-dozen consultations a year (i.e., they experience long intervals between consults). After reformatting initial ethics consultation training, a small planning team's attention focused on skills retraining for consultants who have taken the initial, which focuses mainly on process and basic skills. Two key questions emerged: 1) Can content, methods, and skills from other fields and professions benefit CHRISTUS Health ethics consultants, and 2) can involving experienced, talented professionals and leaders from those fields and professions benefit CHRISTUS Health ethics consultants by their involvement in ethics consultant training? The answer to both questions was yes.

The planning team considered when and how health care and ethics consultations can go wrong. A litmus test for technological and treatment appropriateness developed by neurologist Bryan Jennett was used in a different manner to sort issues: Anything inappropriate may be unnecessary, unsuccessful, unsafe, unkind, or unwise.¹⁴ Although safety issues are usually referred to other departments, ethics consultants are frequently called into situations where these five issues arise.

Bryan Jennett's definition of unwise involves justice, which is another area where healthcare delivery and ethics consults may fail. Dr. Martin Luther King Jr. inherently linked injustice with unkindness during a press

conference outside the second convention of the Medical Committee for Human Rights in 1966 with, "Of all the forms of inequality, injustice in health is the most shocking and the most inhuman." Chaplains and HEDI professionals have unique skills and resources to bolster ethics responses to what is unkind and unwise. Opening conversations with an acknowledgement of historical and social injustice is a helpful way to respond in situations when a patient experiences care disparities. An approach resonating with HEDI professionals was introduced by Kelly Stuart during Awkward Moments in Ethics Consultation training in 2019 at a different organization. She recommends inviting a patient or their family members to the table with something such as, "We know healthcare doesn't always meet everyone's needs. Please share any concerns if you have any. It helps us meet your needs better."¹⁵ This short script addresses the needs of individuals while still being comfortable for the organization. The focus is on problem-solving for all stakeholders.

A mid-sized workgroup of chaplain leaders, HEDI professionals, and ethicists are currently designing the training and the workgroup will also be involved in the rollout. Involving human resources, the experts said, in the training's construction and practice increases the chances of identifying and attending to root problems rather masking their signs and symptoms. An observant Ph.D. ethicist, for instance, could assess whether training participants use the five R's of effective listening — repeating, restating, reflecting, responding, and respecting.¹⁶ Seasoned chaplains, chaplain leaders, or CPE supervisors are more likely to evaluate the totality of active

listening and engage why a participant is not listening.

We are also leveraging the rarest of healthcare professionals — those who have expertise in two professions, such as this article's co-author Andrea Thornton, who has extensive training in ethics and pastoral care. CHRISTUS Health has an exemplary chaplain ethicist, Jeff Matsler, who was the only uniformed ethicist in the Department of Defense for approximately 15 years. Some HEDI professionals have experience with ethics and are uniquely suited for this work. Social worker ethicists also have knowledge and experience with diversity and inclusion issues in addition to their ethics expertise. Those with feet in two professional worlds have insights that can only be seen at the intersection of two disciplines.

The pastoral skills component of ethics consultant training at CHRISTUS Health focuses on three things:

1) Emotional awareness: Chaplains and care ministers should be adept at knowing how they are before entering a visit. This applies to ethics consults as well. Emotional checks include: "How do I feel today? How do I feel about going in this visit? Do I have any strong feelings about something else that might preoccupy me today?"¹⁷ Ethics consultants may want to add or adapt questions: "How might the case context or characteristics remind me of my emotions from similar cases? How does this situation mimic illness narratives and family dynamics with my own friends and family members? What are my feelings when someone already reminds

me of an acquaintance?" This is called countertransference, and we should be more attentive to it in ethics consultation.

2) Being pastoral: Ethicists should be cautious about rubrics and formulas without practice and expert engagement. The devil is in the details and attempts to help can quickly become vapid, armchair "how-to" lists or, even worse, inadvertent techniques for manipulation and intimidation. Appearing to actively listen and actual active listening are light-years apart. Looking present, interested, and engaged is different than being present, interested, and engaged.¹⁸ Other skills include an appreciation for the toll of pain and illness on the mind, body, and spirit and how to accompany those who suffer:¹⁹

People in pain don't need to hear: "It can't be that bad, can it?" "Don't worry, everything will work out." "I know what you are going through." "I had that operation once, too." "I've had a really bad day." When working with people in pain, remember: Don't touch without permission. Don't lecture. Don't back away. Don't try to make it all better.²⁰

3) Debriefing with others: A pastoral skill discussed previously is processing encounters for content, process, and feedback. Emotions and communication are not accessory to a debrief; they are central. Inviting others to share in this reflection helps us see our blind spots. The verbatim provides a template for debriefing ethics consults with others.

The CHRISTUS Health team looks forward to piloting the program and receiving participants' feedback for refining and improving this training. It is our hope to report back about this intervention's effectiveness. We also look forward to hearing about different cross-disciplinary and interdisciplinary ethics trainings that others develop. ✚

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ENDNOTES

1. Materials on ASBH certification are taken from two documents, The Core Competencies and the HCEC Certification Commission's document on the HEC-C exam. Anita Tarzian et al., "Core Competencies for Healthcare Ethics Consultation" (American Society for Bioethics and Humanities, 2011), <https://asbh.org/>. The documents are available at ASBH.org. For additional information on the credentialing effort, see also Eric Kodish et al., "Quality Attestation for Clinical Ethics Consultants: A Two-Step Model From the American Society for Bioethics and Humanities." *Hastings Center Report* 43, no. 5 (September 2013): 26–36, <https://doi.org/10.1002/hast.198>.
2. Claire Horner, Andrew Childress, Sophia Fantus, Janet Malek. "What the HEC-C? An Analysis of the Healthcare Ethics Consultant-Certified Program: One Year In." *American Journal of Bioethics* 20, no. 3 (March 2020): 9–18. <https://doi.org/10.1080/15265161.2020.1714794>.
3. Andrea Frolic. "Who Are We When We Are Doing What We Are Doing? The Case For Mindful Embodiment in Ethics Case Consultation." *Bioethics* 25, no. 7 (September 2011): 370–82. <https://doi.org/10.1111/j.1467-8519.2011.01913.x>.
4. Ellen Bernal. "Health Care Ethics Consultation: Personal Knowledge and Apprenticeship." *Tradition & Discovery* 42, no. 4 (October 2016): 34–54.
5. Many mediation and dispute resolution techniques appear in the sections on responses to cognitive content and responses to affective content in: Sherry Cormier, Harold Hackney, *Counseling Strategies and Interventions*, fifth edition (Boston, MA: Allyn and Bacon, 1999), 80–84, 99–104.
6. For more on the history of CPE, see Edward Thornton. *Professional Education for Ministry; a History of Clinical Pastoral Education* (Abingdon Press, 1970).
7. Richard Zaner tells this history in *Ethics and the Clinical Encounter* (Prentice Hall, 1988).
8. For a critique of how modern pastoral care has drifted from the moral and religious dimensions of spirituality, see H. Tristram Engelhardt Jr., "The Dechristianization of Christian Hospital Chaplaincy: Some Bioethics Reflections on Professionalization, Ecumenization, and Secularization," *Christian Bioethics: Non-Ecumenical Studies in Medical Morality* 9, no. 1 (April 2003): 139–60.

9. Kelly Morton et al., "Defining Features of Moral Sensitivity and Moral Motivation: Pathways to Moral Reasoning in Medical Education," *Journal of Moral Education* 35, no. 3 (2006); Elena Mustakova-Possart, "Education for Critical Moral Consciousness," *Journal of Moral Education* 33, no. 3 (2004).
10. Jonathan Friday, "Education in Moral Theology and Improvement of Moral Thought," *Journal of Moral Education* 33, no. 1 (2004): 23–33.
11. Glen, Kofler, O'Connor, *Handbook for Ministers*, 42–43.
12. John Eligon, "Black Doctor Dies of COVID-19 After Complaining of Racist Treatment," *New York Times*, December 23, 2020, <https://www.nytimes.com/2020/12/23/us/susan-moore-black-doctor-indiana.html> (accessed August 15, 2022).
13. Kelly Stuart, personal communication, August 16, 2022.
14. Bryan Jennett, *High Technology Medicine, Benefits and Burdens* (London, England: The Neuffield Provincial Hospitals Trust, 1984).
15. Steven Squires, Kelly Stuart, Awkward Moments in Ethics Consultation (Bon Secours Mercy Health, ethics consultant training, 2019); Kelly Stuart, personal communication, August 16, 2022.
16. Glen, Kofler, O'Connor, *Handbook for Ministers*, 17–20.
17. Genevieve Glen, Marilyn Kofler, Kevin O'Connor, *Handbook for Ministers of Care*, second edition (Chicago, IL: Liturgy Training Publications, 1997), 21, 39.
18. A chaplain colleague illustrates this with a TEDx talk by Celeste Headlee titled "10 Ways to Have a Better Conversation" for teaching active listening, conversational competence, and respectful disagreement. Although the title seems hypocritical (a rubric), Headlee's modes are for being and doing, not for look or appearance. Additionally, they are about setting parameters and boundaries rather than regimented prescriptions and methodological edicts. Headlee advises entering every conversation as a continuous learner, assuming that you have something to learn and that you can set yourself aside, in the words of M. Scott Peck. Celeste Headlee, "10 Ways to Have a Better Conversation" (TEDxCreativeCoast presentation, Savannah, GA, May 2015), https://www.ted.com/talks/celeste_headlee_10_ways_to_have_a_better_conversation?language=en.
19. Glen, Kofler, O'Connor, *Handbook for Ministers*, 56–57.
20. Ibid, 57–59.

Legal Lens

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, executive director, supervised contributions by Caela M. Camazine (J.D./M.P.H. anticipated 2024) and Mary Schnellmann (J.D. anticipated 2024).

DRAFT BILL WOULD BAN CDC, NIH FROM FUNDING LAB RESEARCH IN CHINA

Jocelyn Kaiser, Science, July 12, 2022. <https://www.science.org/content/article/draft-bill-would-ban-cdc-nih-funding-lab-research-china>

Following the speculation that the Wuhan Institute of Virology (WIV) released the coronavirus that started the current pandemic, as well as objections to other potentially risky biomedical experiments, Congress is looking to bar the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) from funding research laboratories in China, Russia, or any country the U.S. government has designated a foreign adversary. If signed into law, the measure could cut off millions of dollars of U.S. funds flowing to collaborative research projects in several areas. These include HIV/AIDS, cancer, mental health, and flu surveillance. Supporters say that “taxpayers shouldn’t be forced to fund ... cruel, wasteful, and dangerous animal experiments in hostile countries ... where there’s no real transparency and accountability.” Though, the proposed measure does not mention

animal studies. Some scientific organizations are concerned by the proposal’s expansive scope, calling it extreme, and say there may be better ways than blocking all NIH funding to foreign countries. International collaboration is essential for scientists to understand disease threats and protect public health. The ban’s potential impact isn’t clear because WIV is largely funded by the Chinese government, and researchers there have not received U.S. funding since July 2021. But the NIH supports other research in China, with grants totaling \$5.6 million this year, making some projects headed by Chinese investigators vulnerable. The ban would need to survive in the Senate to become law.

HOUSE PASSES BILL TO EXPAND HEALTH BENEFITS FOR BURN PIT EXPOSURE

Stephanie Lai and John Ismay, The New York Times, July 13, 2022. <https://www.nytimes.com/2022/07/13/us/politics/burn-pits-veterans-care.html?searchResultPosition=2>

The House of Representatives passed a bill that is one of the largest expansions of veterans’ benefits. The bill would put forth a projected \$285 billion over the next decade to streamline veterans’ access and cover their treatment for burn pit exposure. This legislation would presume that any American service member stationed in a combat zone for the last 32 years could have been exposed to toxic substances by being near trash burn pits on U.S. military

bases. Open-air burn pits were standard on American military bases in Afghanistan and Iraq. When existing sanitation services were destroyed by combat, soldiers would use jet fuel to burn all unneeded items. These fires, as well as contaminated drinking water on bases in the United States, have been estimated to have exposed 3.5 million veterans to toxic substances, leading to many conditions, respiratory illnesses, and cancers. The legislation would modify the definition of “toxic exposure” to determine veterans’ eligibility for medical care, nursing home care, and mental health services. It would require the Department of Veterans Affairs to recognize dozens of cancers and respiratory illnesses linked to toxic exposure. It would also order the department to include such exposure in patient questionnaires to reach patients unaware that their conditions could be linked to these burn pits. Opponents of the legislation objected to its cost, complaining that due to the expensive nature of the bill, there would be cuts to other programs to compensate. However, they have cut a deal to phase in the benefits over a series of years, meaning that those who served earliest would be eligible for care in 2024.

THE NEW 988 MENTAL HEALTH HOTLINE IS LIVE. HERE'S WHAT TO KNOW

Rhithu Chatterjee, NPR, July 16, 2022
<https://www.npr.org/sections/health-shots/2022/07/15/1111316589/988-suicide-hotline-number>

Starting July 16, individuals can call or text the National Suicide Prevention Lifeline’s 988 phone number for crisis assistance as an alternative to calling 911. The purpose of the lifeline is to connect people in crisis

with appropriate mental health services, rather than deploying 911 to the scene of each call. Mental health crises are unique among medical emergencies because they overwhelmingly result in a law enforcement response, which is not always appropriate. The 988 initiative was signed into law in 2020 by then-President Trump and is a joint initiative by the Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Veterans Affairs. The lifeline will be funded as a joint federal-state partnership, with the Biden administration contributing more than \$400 million to help bolster crisis call centers, many of which have closed due to lack of funding or labor. Additionally, the legislation permits the addition of a small fee on cellphone bills as a permanent source of funding for 988 and associated mental health services. The lifeline comes as the United States is grappling with an unprecedented rise in suicide rates. Currently, the rate of suicide is highest in middle-aged White men. As of 2020, suicide is a leading cause of death for people ages 10 – 14 and 25 – 34.

CONSERVATIVE BLOCS UNLEASH LITIGATION TO CURB PUBLIC HEALTH POWERS

Lauren Weber and Anna Marie Barry-Jester, Kaiser Health News, July 18, 2022. <https://khn.org/news/article/conservative-blocs-litigation-curb-public-health-powers/>

Conservative and libertarian think tanks, Republican state attorneys general, and religious liberty groups have been attacking

public health mandates and the government agencies charged with protecting community health, rolling back public health authority at the local, state, and federal levels. Through lawsuits or simply wielding the threat of legal action, these loosely affiliated groups have targeted individual counties and states, and in some cases, set a broader legal precedent. The Wisconsin Institute for Law & Liberty has filed a flurry of COVID-related litigation. It won a Supreme Court case stripping local health departments of the power to close schools to stem the spread of disease. The Missouri state attorney general levied dozens of cases against school mask mandates and set up an email address where parents could report schools that imposed such mandates. In California, religious groups challenged a health order that limited the size of secular and nonsecular in-home gatherings and drew in religious liberty groups that gained traction after Amy Coney Barrett was confirmed as a U.S. Supreme Court justice. By no means have the blocs won all their challenges. The Supreme Court declined to hear a lawsuit on behalf of employees challenging a vaccine mandate for health care workers in New York that provides no exemption for religious beliefs. For now, the legal principles that for nearly 120 years have allowed governments to require vaccinations in schools and other settings with only limited exemptions remain intact. However, all of these lawsuits have chipped away at the power of federal and state authorities to mandate COVID vaccines for employees or a governor's ability to declare emergencies. Public health experts say these groups have altered the government response to this pandemic and have endangered the fundamental tools public health workers have used for decades.

BGOV BILL SUMMARY: H.R. 8373, CONTRACEPTION ACCESS

Christina Banoub, Bloomberg Law, July 19, 2022.
<https://news.bloomberglaw.com/health-law-and-business/bgov-bill-summary-h-r-8373-contraception-access>

In response to the Supreme Court's decision to overturn *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organization*, the U.S. House of Representatives created House Resolution 8373, which provides a statutory right to obtain contraception and to engage in the use thereof. The legislation also protects a health care practitioner's right to provide and counsel on contraception; empowers the Justice Department, individuals, and entities to take civil action against parties carrying out state or local law in violation of the measure; and prohibits (1) limitations on access to contraception and (2) restrictions on facilities and practitioners providing contraception. If passed, state laws are preempted by H.R. 8373, and federal district courts have jurisdiction over such disputes and, as such, would be instructed to "liberally construe" the bill's provisions. Under H.R. 8373, states' and officials' immunity from 10th Amendment suits is removed, as are similar protections for such parties under the 11th Amendment. The bill comes at a time when twelve states have laws allowing practitioners to refuse to provide contraception, and several other states have attempted to block access to contraceptives. When introduced by Rep. Kathy Manning (D-NC 06) on July 14, the bill had 55 Democratic cosponsors. The measure is further supported by the National Women's Law Center, NARAL Pro-Choice America, Planned Parenthood Federation of America, and the National Family Planning and Reproductive Health Association.

BGOV BILL SUMMARY: H.R. 4040, MEDICARE TELEHEALTH AUTHORITIES (1)

Christina Banoub, Bloomberg Law, July 26, 2022.
<https://news.bloomberglaw.com/coronavirus/bgov-bill-summary-h-r-4040-medicare-telehealth-authorities>

Medicare could continue to offer telehealth services through Dec. 31, 2024, under a modified version of House Resolution 4040. Originally authorized during the COVID-19 public health emergency, telehealth service use is growing among elderly and rural populations. The bill's sponsor, Liz Cheney (R-WY At-large District), is optimistic that this legislation will “permanently cut burdensome red tape” and allow Medicare to adapt to “ever-changing innovation in medical technology.” H.R. 4040 aims to reduce the Medicaid Improvement Fund trust by nearly two million dollars and will allow: (1) Medicare patients to receive authorized telehealth services regardless of location; (2) federally qualified health centers (FQHCs) and rural clinics to continue providing telehealth services; (3) telehealth for mental health services, including audio-only services for office visits and office psychiatry services; (4) hospice physicians and nurse practitioners to use telehealth services in emergency situations; and (5) occupational and physical therapists, as well as speech language pathologists and audiologists, to provide telehealth services. Ultimately, supporters of the legislation, including the American Medical Association and the Connected Health Initiative seek to address disparities in health care that persist between urban and rural communities, as well as in elderly populations.

WHAT'S IN JOE MANCHIN AND CHUCK SCHUMER'S RECONCILIATION DEAL ON CLIMATE, HEALTH AND TAX POLICY?

Amara Omeokwe and Siobhan Hughes, The Wall Street Journal, August 5, 2022. https://www.wsj.com/articles/whats-in-joe-manchin-and-chuck-schumers-reconciliation-deal-on-climate-health-and-tax-policy-11658973323?mod=Searchresults_pos3&page=1

After months of negotiations over a crucial piece of President Biden's agenda, two Democrats have created the Inflation Reduction Act of 2022. Senate Democrats report that the measure would reduce the budget deficit by roughly \$300 billion over a decade. The nonpartisan Congressional Budget Office found the package would reduce the deficit by about \$102 billion over a decade. The proposal would implement a 15% corporate minimum tax aimed at large companies that report significant profits but pay little or nothing in income taxes. The deal would dedicate \$64 billion to extending the Affordable Care Act subsidies, sparing nearly 13 million people who get federal subsidies from higher health-insurance premiums. The measure would also allow Medicare to negotiate the cost of some prescription drugs with pharmaceutical companies, predicted to save the government \$288 billion. More than 100 economists are in support, saying the proposal “addresses some of the country's biggest challenges at a significant scale by cooling inflation by reducing aggregate demand in the economy. Republicans have argued the deal would have little impact on inflation, pointing to an analysis from the Penn Wharton Budget Model. GOP lawmakers have said this would hurt American families and companies. Democrats hope to approve the bill in the Senate via reconciliation, allowing it to

pass with a simple majority. Republicans are likely to oppose the measure unanimously.

NEW WEIGHT-LOSS DRUGS CAN FATTEN DRUGMAKERS' PROFITS

David Wainer, The Wall Street Journal, August 5, 2022.
https://www.wsj.com/articles/new-weight-loss-drugs-obesity-treatment-obese-11659646078?mod=Searchresults_pos5&page=1

Novo Nordisk and Eli Lilly have repurposed drugs developed for diabetes into weight loss drugs. Although Eli Lilly's tirzepatide hasn't been approved for weight loss yet, Novo Nordisk's Wegovy received Food and Drug Administration (FDA) approval last year for obesity. In studies, tirzepatide helped obese people lose as much as 22.5% of their body weight. Expecting similar results in future studies, Eli Lilly is working with the FDA to assess whether it can submit the drug for approval earlier based on the current data. Novo Nordisk's approved Wegovy, which mimics the effects of gut hormones that work to increase satiety, shows patients can lose about 15% of their body weight. However, usage is limited due to supply constraints and reimbursement challenges since many insurers hold that weight loss is a vanity project rather than a legitimate medical treatment. With 40% of American adults being obese, government-sponsored insurance plans deciding to cover these drugs would be pivotal. Morgan Stanley analysts expect Congress to pass a bill in the future that would expand Medicare and Medicaid coverage of prescription drugs for obesity. Ultimately, private insurers will take their cue from Medicare and Medicaid.

CONGRESS POISED TO EXTEND ENHANCED MARKETPLACE SUBSIDIES THROUGH 2025

Katie Keith, Health Affairs, August 9, 2022.
<https://www.healthaffairs.org/content/forefront/congress-poised-extend-enhanced-marketplace-subsidies-through-2025>

On August 7, 2022, the U.S. Senate approved the Inflation Reduction Act (IRA). The bill aims to bolster investment in health care, climate change, and deficit reduction through a \$740 billion budget reconciliation package. The IRA includes policy implications for Medicare and for marketplace subsidies enacted under the American Rescue Plan Act (ARPA). Changes to Medicare include (1) a new requirement for federal officials to negotiate some prescription drug prices, (2) a cap on overall out-of-pocket spending for seniors, (3) a copay cap of \$35 on all insulin products, and (4) rebates if drug prices rise too quickly. Additionally, the IRA extends the temporary marketplace subsidies adopted under ARPA to make premium tax credits (PTCs) more available. Under ARPA, individuals are eligible for PTCs if the cost of premiums exceeds 8.5 percent of their household income. Previously, individuals and families above 400 percent of the federal poverty level were not eligible for PTCs, leaving many middle-income individuals — especially those who are older and live in rural areas — with high premiums. This policy ensures that self-insured middle-income people do not pay more than 8.5% of their income toward premiums. Moreover, the IRA keeps enhanced subsidies for insurers available under the Affordable Care Act (ACA) available. Insurers that assumed the ARPA subsidies

would expire may have set their rates higher than what will be true of the actual risk pool now that the IRA has extended ARPA subsidies for another three years. Allowing insurers to proceed with the ARPA subsidy rates will drive down out-of-pocket premiums for individuals. Without the ARPA subsidy rates, out-of-pocket premiums will be higher. This may lead some enrollees to disenroll in coverage, leaving a sicker — and therefore costlier — marketplace risk pool.

U.S. ALLOWS ALTERNATE MONKEYPOX VACCINE INJECTION METHOD TO BOOST SUPPLY

Ahmed Aboulenein and Ankur Banerjee, Reuters, August 9, 2022. <https://www.reuters.com/business/healthcare-pharmaceuticals/us-fda-authorizes-bavarian-nordics-jynneos-emergency-use-against-monkeypox-2022-08-09/>

To respond to growing concerns about monkeypox and low vaccine supplies, the U.S. Food and Drug Administration (FDA) has authorized intradermal injection of a monkeypox vaccine, instead of subcutaneous

administration. This change comes after the United States and the World Health Organization (WHO) declared monkeypox a public health emergency. This change is to maximize availability of the monkeypox vaccine, because the intradermal method only uses a fraction of a subcutaneous dose but provides the same protection. Bavarian Nordic's JYNNEOS monkeypox vaccine is approved for use in adults and people younger than 18 years if they are determined to be at high risk of infection. With the intradermal method, the standard protocol will be two doses of the vaccine given four weeks apart. Currently, the United States has 441,000 vials of the vaccine in the strategic national stockpile, which translates to more than 2.2 million intradermal doses. To support the response, the U.S. Centers for Disease Control and Prevention (CDC) will provide training and educational support to health care workers on how to administer the vaccine intradermally. The first case of monkeypox was reported in the United States on May 18, 2022. Since then, there have been more than 10,700 cases reported in the country.

Literature Review:

The Metaphysical Turn in Clinical Ethics Consulting

Reviewed by Julie D. Gunby, BSN, MSN, Ph.D.(c)

Malek, Janet. “The Appropriate Role of a Clinical Ethics Consultant’s Religious Worldview in Consultative Work: Nearly None.” *HEC Forum* 31, no. 2 (September 18, 2019): 91 – 102. <https://doi.org/10.1007/s10730-018-9363-6>.

For any person of faith who has ever wondered about the place of their religious commitments in the work of clinical ethics, Janet Malek has provided an answer — nearly none. Although many of the earliest bioethicists were theologians, recent decades have shown a trend toward non-confessional ethics in the presentation topics of the American Society for Bioethics and Humanities (ASBH) and the articles routinely published in *HEC Forum*, *American Journal of Bioethics*, and *Bioethics*, but Malek is among the first to offer an explicit critique of “the role of a clinical ethics consultant (CEC)’s religious worldview in the context of clinical ethics consultation.”

Malek argues that a CEC’s personal beliefs should never influence the content of their ethical decisions nor how they frame an ethical recommendation. Instead, if the CEC’s religious commitments are to play any role at all in their ethics consultations, they might on

occasion, and with great caution, be used as a means of building rapport with a patient or family.

Malek’s case studies clarify her meaning. If a patient asks a CEC what they personally would do when faced with a medically complicated pregnancy, a religious CEC cannot answer if that answer would reflect a view of abortion drawn from the CEC’s religious tradition. If a terminally ill patient’s family cites religious reasons for not implementing a do-not-resuscitate order, a religious CEC cannot use language from their shared tradition to reframe the discussion. Instead, the only time a CEC can draw on religion might be if, for instance, the CEC shares religious dietary practices with the patient and bringing up this point of similarity might help establish friendly relations for their decision-making.

The argument for seriously limiting the role of religion in clinical ethics proceeds as follows: 1) There is a bioethical consensus. 2) The bioethical consensus can be used without appeal to any tenets other than universally accepted, mid-level moral principles. 3) Appealing to principles, such as religious beliefs, that fall outside that consensus is bad, and it is bad for three reasons: a.) it imposes the CEC’s views, contra patient autonomy;

b.) it yields inconsistent results, as opposed to a standardized consult; c.) it requires religious expertise outside the CEC's scope. Therefore, 4) CECs should use the bioethical consensus without appeal to religious principles except in very marginal, rapport-building ways.

For Malek, religious beliefs are “commitments and preferences” that “describe how the individual wants the world to be” and that might guide an individual's decision-making but “cannot be drawn on in conversations with others.” This account of religion comes closer to describing a cross between Wittgensteinian private language and Freudian wish fulfillment than it does any standard account of orthodoxy or orthopraxy, and few religious practitioners are likely to recognize themselves in it. Nonetheless, many religious CECs who read Malek's article may find it hard to articulate what they find unsettling about her view.

Kornu, Kimbell. "Policing the Sublime: The Metaphysical Harms of Irreligious Clinical Ethics." *Christian Bioethics: Non-Ecumenical Studies in Medical Morality*, Volume 28, Issue 2, (August 2022): 109 – 121. <https://doi.org/10.1093/cb/cbac005>.

The physician and theologian Kimbell Kornu has recently criticized Malek's argument by taking her position at face value and exploring its theological and philosophical implications. Kornu asks what would happen if ASBH and the HEC-C certification commission adopted Malek's view and “prohibited CECs from drawing on their own religious worldviews in the work of clinical ethics consultation.” Kornu coins a phrase to describe the potential danger — to implement such a position would

cause "metaphysical harm" to clinical ethicists, to patients, and to clinical ethics consultation as an institution.

Understanding the phrase "metaphysical harm" requires understanding the notion of ontological violence, of which Kornu takes it to be a particular, concrete species. "Ontological violence" is a category that occurs in the work of Heidegger and Žižek, among other critical theorists, but to develop his account, Kornu turns to the work of theologian John Milbank, who lays out the history of the invention of the secular. On Milbank's reading of Nietzsche and the history of the modern West, Malek's proposal to require clinical ethicists to check their metaphysical commitments at the door may seem benign, but it is anything but. Any claim to normative secularity is an act of violence, asserting one metaphysics to supplant another — in this case, the nihilism of secularity forcibly replaces the theologically grounded ontology of peace.

Kornu's examples of metaphysical harm clarify his meaning. To insist on bracketing religious beliefs is to harm *the ethicist* by insisting they function as “a disengaged, buffered self,” whereas with Malek's view, a CEC's job might be done just as well, if not better, by an artificial intelligence such as the prototype medical ethics advisor, MedEthEx. To deny validity to the transcendent metaphysical claims of a patient's religious beliefs is to harm *the patient* by silencing what may be their most important need as they face death and debility. To close off clinical ethics discourse from any metaphysical claims not grounded in secularism is to harm *the institution* by formalizing an obligation that sharply and dangerously curtails the limits of ethical discourse.

It is not always clear what mechanism of action causes metaphysical harms to occur, but the suggestion throughout is that any normative secularity that mistakenly believes it is devoid of metaphysical commitments smuggles in its commitments and foists them on others under the guise of neutrality. Given the magnitude of this harm, Kornu insists that an alternative constructive account of the role of religious belief in clinical ethics is necessary.

Brummett, Abram. "The Quasi-Religious Nature of Clinical Ethics Consultation." *HEC Forum* 32, no. 3 (January 3, 2020): 199 – 209. <https://doi.org/10.1007/s10730-019-09393-5>.

One of the most nuanced constructive proposals for the role of religious beliefs in clinical ethics consultation comes from secular bioethicist Abram Brummett, who argues against both Malek and the physician-ethicist Clint Parker. Like Kornu, Brummett thinks little good could come of implementing Malek's anti-religious injunction. But neither does Brummett want the bioethical community to consist of CECs who regularly invoke and disclose their deepest religious commitments as Parker recommends. As an alternative, Brummett proposes a metaphysically self-aware form of clinical ethics that he calls "quasi-religious" or a "moral-metaphysical proceduralism."

Brummett's most heated disagreement with Malek centers on her contention that it is possible to conduct bioethics without appeal to anything beyond purportedly "universally agreed upon" mid-level moral principles, and the most constructive elements of his proposal

are modifications of her premises that there is a bioethical consensus and that there is a need to delimit the scope of metaphysical argumentation in clinical consultation.

When Malek argues that to cite a religious rationale imposes the CEC's views and contravenes the bioethical principle of patient autonomy, Brummett finds Malek's account of bioethics as thin as her definition of religion. Instead Brummett reminds us that clinical ethics consulting consists of more than fostering patient autonomy — there are guidance and intervention principles that dictate terms when patient preference must be overridden. Furthermore, there is no ethics apart from metaphysics. The central principle that allows ethicists to intervene in a plan of care is the harm principle, but even that archly clinical criterion includes tacit beliefs about what counts and doesn't count as a harm, and thus carries force in all those "aspects of human life deeply intertwined with religious belief, such as birth death, suffering, child-rearing, and human sexuality." The denial of metaphysical claims is itself a metaphysical claim, and Malek's argument falls prey to her own critique.

Debates within bioethics are often about the nature of bioethics itself, leading many who have engaged with Malek to reject her premise that there is a bioethical consensus. Brummett does not. However, he contends that the current consensus cannot function without formalized transparency as to what counts as consensus and without systematizing the process by which that consensus is achieved. Anything short of this risks the kind of metaphysical harms Kornu condemns.

Brummett also modifies Malek's claim that substantive religious discourse falls outside the scope of clinical ethics. Instead, he tells CECs who hold religious commitments at odds with the bioethical consensus, "Disagree but obey, and know where to make your case." That is, Brummett highlights the need for a distinction between the clinic and the academy in terms of metaphysical discourse. Just as athletes must follow the rules of the game on the court, they can also petition the sport's governing body for changes if the current guidelines seem unfit. The insight here is that proceduralism is important for standardization, but unreflective proceduralism goes awry and requires the protective effect of metaphysical reflection.

SYNTHESIS

In any argument about the role of religious beliefs in clinical ethics, it is important to recognize that religious commitments are being "bracketed," not erased. In fact, it is precisely the nature of religious and metaphysical commitments to govern when such bracketing is permissible. Recognizing the perdurance of metaphysical commitments suggests the need for a conversation about conscientious objection not just in clinical medicine, but in clinical ethics consultation as well.

By focusing on the role of religious commitments in "secular" clinical spaces, the argument suggests that no such complications would arise "in an environment where a specific religious perspective shapes institutional policies and the commitments of individual providers." Nonetheless, religious commitments are rarely uniform within traditions, and it is possible, for instance,

for Catholic CECs to have moral qualms about the content of the *Ethical and Religious Directives (ERDs)*. Brummett's "disagree but obey" solution suggests a potential framework for this in-house moral quandary as well, reminding religious CECs of their obligation both to practice in accordance with existing moral directives and to work conscientiously to influence the underlying theological discourse.

In a time of increasingly polarized debate, it is all the more important that ethicists identify the root causes of our disagreement. All three articles point to the profound significance of the metaphysical turn in clinical ethics. If religious clinical ethicists feel a tacit marginalization in professional bioethics, and if they find themselves self-policing their beliefs in their clinical work, Malek's forthrightness enables an open debate about whether and to what extent that circumscription should be the case. The fact that Kornu, a theologian in the radical orthodoxy tradition, and Brummett, a professed atheist, argue to the same conclusion suggests that the turn to metaphysics offers promising ground where thoughtful clinical ethicists can engage with the issues of greatest importance. ✚

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