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Catholic Health Care's Responsibility to the Environment

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Editor's Note: A version of this paper was presented at CHA's Theology and Ethics Colloquium March 11-13, 2020, in St. Louis.

In the creation story, God mandated that humans should be caretakers of the earth (Genesis 1:28) and gave ample provisions to meet the physical needs of all creatures (Genesis 1:29-30).

However, humans have failed to satisfy their duty to care and have threatened the survival of God's creation through environmental exploitation, unjust allocation of resources, and rampant consumption. While all people of good will have a responsibility to care for our planet, Christians have a transcendental obligation to preserve the earth. This obligation extends to all Christians in every vocation.

Health care has its own unique purpose, often envisioned in terms of Christ's healing ministry. Yet, health, healing, and environmental conservation are often thought of as discrete responsibilities. In order to connect these frequently compartmentalized aspects of Christian mission, this article will provide an overview of climate change and its effects, summarize Catholic Social Teaching on environmental responsibility, and offer two ways Catholic health care can continue to take ethical responsibility for the environment. The conclusion highlights the unique opportunity for Catholic health care to practice creation care and medical care in a way consistent with Catholic Social Teaching on the environment.

CLIMATE CHANGE

Climate change is largely a result of human activities that emit greenhouse gas emissions, such as carbon dioxide (CO_2). Climate change causes a number of social problems, including loss of biodiversity, food insecurity, and habitat disruption. Climate change also results in health hazards that increase burdens on health care, dramatically impact the poor, and exacerbate environmental racism.

CLIMATE CHANGE-RELATED HEALTH HAZARDS

According to the World Health Organization (WHO), climate change is estimated to cause approximately 250,000 deaths per year "due to thermal extremes and weather disasters, vector-borne diseases, a higher incidence of food-related and waterborne infections, photochemical air pollutants and conflict over depleted natural resources."[1] Temperature extremes cause higher morbidity and mortality as heat waves become more frequent, intense, and longer, while urbanization creates a "heat island" effect. Rising sea levels contribute to an increase in flooding and coastal erosion,

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storm surges, and damage to infrastructure. Some islands that are habitats for humans will completely disappear.[2] While people are fleeing tsunamis and flooding, injuries occur.

Flooding and drought impact food production through reduced crop yields, increased crop losses, and decreased nutritional content in food that is salvageable. Air quality is compromised through pollution and changes in the levels of pollutants. Altered pollutant dispersal translates to previously immune communities now facing respiratory problems like asthma and lung cancer. The WHO states "air pollution, which is linked to 7 million premature deaths annually, is the world's largest single environmental health risk."[3] Climate change-related health hazards also include wildfires, tornadoes, and hurricanes. Survivors of these and other natural disasters show symptoms of post-traumatic stress disorders, anxiety, and depression.[4] Loss of access to basic elements of life, like clean water and food, cause war and conflict, forced migration, and population displacement. These health hazards disproportionately impact people and communities who are economically and socially insecure.

POOR PERSONS AND CLIMATE CHANGE

As with much ecological degradation, the poor are absorbing the brunt of the problem.[5] For instance, "Socioeconomic factors associated with heat related mortality… include inadequate housing conditions, lack of access to air conditioning, social isolation, chronic illness, as well as psychological and behavioral factors. Many of these factors are found disproportionately in urban areas, particularly among elderly, poor, and non-white individuals."[6] Climate change health hazards are a result of carbon emissions, which do not stay within national borders.

Pope Francis reminds us that "pollution (is) produced by companies which operate in less developed countries in ways they could never do at home."[7] While the rich benefit from the economic gain often associated with this resource use, poor persons are subjected to the noxious externalities of a compromised ecosystem. The compounded pollution and its health effects create an unjust system that exacerbates existing ecological and medical problems.

After a climate event, those without financial means face additional health complications and life disruption because they lack resources to move and are confined to dilapidated, moldy, or uninhabitable neighborhoods. The United States Conference of Catholic Bishops (USCCB) note in their statement, *Climate Change: A Plea for Dialogue Prudence and the Common Good*, that "projected sea level rises could impact low-lying coastal areas in densely populated nations of the developing world. Storms are most likely to strain the

As with much ecological degradation, the poor are absorbing the brunt of the problem.

fragile housing infrastructure of the poorest nations"[8] as well as the poorest people within nations. Climate change health hazards can be considered a form of environmental racism because of the effects on ethnic minorities and developing countries.

ENVIRONMENTAL RACISM

While "the economically well-off can choose to live amid acres of green … poor people are housed near factories, refineries, or waste-processing plants that heavily pollute the environment."[9] Environmental racism is present whenever people are forced to subsist in poverty; when the poor feel the effects — but infrequently the benefits — of an economic system that emits massive amounts of carbon. Environmental racism has been a theological concern since the mid-1980s when "North American churches began turning their attention to environmental racism."[10]

At that time, the United Church of Christ's (UCC) Commission for Racial Justice issued its landmark publication, *Toxic Wastes and Race in the United States: A National Report on the Racial and Socio-Economic Characteristics of Communities with Hazardous Waste Sites*.[11] The document found that environmental threats such as toxic waste sites, municipal dumping grounds, and hazardous waste facilities were clustered in low-income areas where racial and ethnic minorities dwell. Impoverished locations were deliberately chosen since poor people generally lack the political resources to mobilize a constituency to lobby against policies that negatively affect their health. Furthermore, as former World Bank economist Lawrence Summer stated, toxic waste was put in places where poor people live because they "don't live long enough to feel the effects."[12]

A follow-up investigation to the Commission for Racial Justice's *Toxic Wastes Report* made twenty years later found that little had changed.[13] Linked with a history of colonialism and slavery, environmental racism in the United States is no less than, as Womanist theologian Emilie Townes describes, a "contemporary version of lynching a whole people."[14] Victims of environmental racism are subjected to an insidious and obfuscated form of social injustice, which denigrates human dignity.

Environmental exploitation impacts all people, countries, and health care organizations that care for those affected by climate change health hazards. Given that health is intimately tied to the natural environment — as well as other social factors like race, sex, and income — health care has a responsibility for carbon reduction to minimize climate change and climate change health hazards.

CATHOLIC SOCIAL TEACHING ON ENVIRONMENTAL RESPONSIBILITY

Reduction of carbon emissions is an ethical imperative in all areas of life, from transportation, to food consumption, to family lifestyle, to health care. The ecological writings of Catholic Social Teaching (CST) provide the theological rationale to reduce carbon.[15] In

the last 30 years, CST has demonstrated the continuity, coherence, and, at the same time, diversity of approaches to theological ecology, which is instructive for Catholic health care.[16] Several documents have received a significant amount of attention and analysis, including John Paul II's *World Day of Peace Message: Peace with God, the Creator, Peace with All of Creation* (1990); the United States Conference of Catholic Bishops' *Climate Change: A Plea for Dialogue Prudence and the Common Good* (2001); Benedict XVI's *World Day of Peace Message: If You Want to Cultivate Peace, Protect Creation* (2010); and Pope Francis' *Laudato Si': On Care for Our Common Home* (2015). The themes of integral ecology, the common good, and the preferential option for the poor, which are leitmotifs in the aforementioned writings, also emerge powerfully in Pope Francis' 2020 *Post-Synodal Apostolic Exhortation "Querida Amazonia."*

Demonstrating a cohesive approach to environmental problems of the day, Pope Francis recognized that "a true ecological approach always becomes a social approach; it must integrate questions of justice in debates on the environment, so as to hear both the cry of the earth and the cry of the poor."[17] Social ethics, justice and environmental ethics can be synthesized with the foundational commitments of Catholic health care.

ENVIRONMENTAL ETHICS AND SOCIAL ETHICS

First, Pope Francis believes that an ecological approach to sustainability is a social approach. Obviously, ecology is not separate from society — our ecosystem sustains our life and shapes the way we interact with our world. While the natural environment is circumscribed by natural law, humans, who are endowed with freedom, may act in ways that conform to, or rebel from, natural law. Francis reflectively writes, "alongside the ecology of nature, there exists what can be called a 'human' ecology which in turn demands a 'social' ecology. Humanity…must be increasingly conscious of the links between natural ecology, or respect for nature, and human ecology."[18] Humans must yield to natural law in ecology and society.

Likewise, care for people's bodies and care for their souls are interconnected with care for the environment.

To be sure, appealing to natural law as a moral standard for ecological and social activities does not need to lead to a naturalistic fallacy. Natural law upholds the rationality of humans and creative processes thereof. Intelligence, engineering, technological developments, and modern medicine are channels for humans to fulfill our unique imperative to protect and enrich the world. However, rationality is lost when a frantic drive towards progress results in irreparable damage. Thus, an ecological approach has to be a social approach, recognizing that "the care of people and the care of ecosystems are inseparable."[19]

Likewise, care for people's bodies and care for their souls are interconnected with care for the environment. Environmental destruction has negative repercussions on human health. Exploitation of nature reduces access to fresh

water, nutritious and abundant food, the biodiversity of medicinal herbs, and a dynamic landscape. Moreover, the manner in which environmental destruction occurs often comes at a human cost. For instance, people who work in slaughterhouses have higher than average rates of domestic abuse because of the instrumentalization of sentient beings.[20] In *Querida Amazonia*, Francis recognizes that the elimination of the Amazon forests is "purchased with a thousand deaths."[21] This should not only be viewed as a physical death, thus falling into a Cartesian dualism. Rather, there is a spiritual death when one's home is razed; even more so when it is destroyed by one's own hands. Social ecology recognizes this.

ENVIRONMENTAL ETHICS AND JUSTICE

In *Querida Amazonia* Pope Francis also implores, for an integration of "justice in debates on the environment, so as to hear both the cry of the earth and the cry of the poor."[22] Earth justice and social justice are mutually reinforcing, not exclusionary. A healthy society will not only acknowledge the value of nature and seek to preserve wild spaces and wild animals, it will also facilitate the mechanisms to do so.

Pope Francis observes that "the culture of waste is already deeply rooted. A sound and sustainable ecology, one capable of bringing about change, will not develop unless people are changed, unless they are encouraged to opt for another style of life, one less greedy and more serene, more respectful and less anxious, more fraternal."[23] Greed is not only found in malls and restaurants, it is also in luxury medical procedures, hotel hospitals, clinical spas, and lifestyle pharmaceuticals.

The line between greed and progress is thin. Particularly in the hard sciences and in medicine, the never-ending pursuit of "progress" drives the industry. With this mindset, "it becomes almost impossible to accept the limits imposed by reality."[24] One can always look younger, upgrade their body parts, enhance their cognition, and defy mortality for yet another day. Yet, medical greed comes at a cost to patients through redundant treatments that do not meet the goals of medicine, to staff who experience moral distress at futile health care measures, to the poor who suffer in medical deserts, and to our sisters and brothers around the world impacted by the carbon emissions of the medical industry, justified by patient "autonomy."

CATHOLIC HEALTH CARE'S ETHICAL RESPONSIBILITY TO THE ENVIRONMENT

Throughout Catholic Social Thought, the responsibility for creation care and care for the poor are imperatives, not suggestions. Fulfilling these obligations requires a conversion of thought and action where we live, work, and worship. In health care, the responsibility for eco-justice and social justice extends to practices and policies that heal the earth and heal the sick. Fortunately, there are multiple, non-exclusive tactics to discharge the responsibility to respond to climate change, climate change health hazards, and participate in the healing ministry of Christ. With growing consensus that environmental sustainability is an urgent priority that deserves attention and action, and with green hospital practices already proliferating in Catholic health care facilities, environmental bioethics and Green Bioethics offer two ways to pursue responsibility to the environment in health care.

ENVIRONMENTAL BIOETHICS

Environmental bioethics is a subdiscipline within environmental ethics and biomedical ethics. Environmental bioethics developed with two foci: the effects of climate on human health and the effects of health care on the environment.[25] While the former concern is situated within public health, health care organizations, hospitals, and clinics have taken up the latter.

The Catholic Health Association (CHA) has helped make hospital facilities more sustainable and has educated employees about environmental ethics.[26] The CHA continues to innovate and update strategies for sustainable health care, addressing the most pressing environmental issues with a rigorous dedication to the Catholic social tradition.[27] This courage and leadership are laudable. However, environmental bioethics is ultimately limited in its ability to reduce carbon emissions of the medical industry because it only focuses on the structural aspects of health care — buildings, energy, and transportation — rather than the resources used in health care itself.

Health care facilities do produce a significant amount of carbon dioxide.[28] However, a detailed analysis of carbon emission by sector reveals that hospital care and physician and clinical services are the largest emitters in the U.S. medical industry, with structures, equipment and pharmaceuticals at third and fourth, respectively.[29] The environmental impact of health care has been under considered, in part, because of the belief that all treatments are medically necessary and, therefore, carbon emissions are morally irrelevant. Yet, this paradigm circumvents environmental responsibility at the level of the patient-physician relationship and fails to engage the largest stakeholders in medical care — the people giving and receiving treatment. In recognition of this, Green Bioethics was developed.[30]

GREEN BIOETHICS

Green Bioethics proposes four principles for determining the sustainability of the medical developments, techniques, and procedures that doctors offer and patients use. The four principles of Green Bioethics are: distributive justice, resource conservation, simplicity, and ethical economics.[31]

The first principle of Green Bioethics— distributive justice: allocate basic medical resources before special-interest access — begins where Tom Beauchamp and James Childress' principles of biomedical ethics conclude.[31] This continuity provides an avenue for bioethicists to engage with environmental ethics in familiar terms. In particular, distributive justice downplays the biomedical principle of respect for autonomy, while highlighting the value of solidarity.

The second principle — resource conservation: provide human needs before human wants — recognizes that resources must be used, but that they should be used in a way that all people can access them. Resource conservation is firmly entrenched in ecological ethics.

The third principle — simplicity: reduce dependence on medical interventions — is closely identified with the environmental movement. However, physicians practice the principle of simplicity when they act with therapeutic parsimony or diagnostic elegance. Moreover, simplicity connects to the principle

of non-maleficence since unnecessary medical treatments can harm patients.

The fourth principle — ethical economics: humanistic health care instead of financial profit — reinforces the principle of beneficence, since it acknowledges that basic health care should be given to all people regardless of ability to pay. Here, natural resources are directed at greatest clinical benefit, while luxury medical goods are curtailed.

Green Bioethics requires a participatory approach to effectively support environmentally responsible health care. Indeed, a 2012 document published by the Catholic Health Association observes that "health care professionals can lead by example by reducing their personal carbon footprints and embracing sustainable lifestyles and considering the environmental costs at work."[33] Doctors and health care professionals are responsible for their prescribing practices and treatment plans. However, patients must also be cognizant of the environmental impact of their medical care. Both must be supported by sustainable health care organizations and insurance plans.

CONCLUSION

In 2018, the United States Conference of Catholic Bishops (USCCB) reiterated that "throughout the centuries … a body of moral principles has emerged that expresses the Church's teaching on medical and moral matters … has proven to be pertinent and applicable to the ever-changing circumstances of health care and its delivery."[34] Through dedication to sustainable health care, health organizations that are members of the Catholic Health Association can simultaneously maintain the immense worth of individual human life through medical care and the responsibility of environmental stewardship. ✣

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Is the Life-Cycle Principle Justified as a Tie-Breaker in Triage Decision-Making Within Catholic Health Care? Part One

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Editor's Note: The question of the use of the life-cycle principle in triage protocols continues to be debated within the clinical ethics community. In light of the conversation and the presence of this principle in many protocols, Nick Kockler has taken the opportunity to thoughtfully analyze the debate. In order to include as much of the conversation, we the editors of HCEUSA have split the text into two parts. The first, which appears in this issue provides the necessary background information and current discussion. The second part, which will appear in the Fall issue, will apply Catholic moral teaching to the question and provide a concluding analysis.

INTRODUCTION

In the early weeks of the coronavirus pandemic, stories coming from the hard-hit areas of northern Italy generated tremendous moral concern about the role age may be playing in the rationing of scarce critical care resources to meet the needs of patients suffering from COVID-19.[1] Indeed, it seemed that professional guidance affirmed the need for and use of age-based cut-offs in the allocation of critical care.[2]

Public health surveillance data on age-stratified prevalence and outcomes underscore the challenges in justly allocating scarce critical care resources.[3] The cumulative rate of laboratory-confirmed COVID-19 heavily skews toward older persons with 286.9 cases per 100,000 for persons 65 and older. When broken down further, we see this same case rate metric is 207.6 for persons 65-74 years of age, 347.5 for persons 75-84 years, and 535.2 for persons 85 years and older. By comparison, this case rate for persons 18-49 years is 56.5 cases per 100,000. In terms of health outcomes, preliminary data suggest fatality rates highest among patients greater than 85 years of age followed by persons aged 65-84 years, and then persons aged 55-64.[4]

At any time, a surge in prevalence and patients presenting to acute care facilities in respiratory distress may overwhelm capacity. Capacity, in this context, means the finite critical care resources in terms of ICU beds, staff, personal

Therefore, there is a need to allocate resources justly according to sound ethical reasoning, clinical judgment, and the social values of public order, professionalism, and justice.

protective equipment (PPE), mechanical ventilators, other airway management tools, pharmacologic agents, and extracorporeal membrane oxygenation (ECMO) machines. Therefore, there is a need to allocate resources justly according to sound ethical reasoning, clinical judgment, and the social values of public order, professionalism, and justice. Indeed, health care organizations have a duty to plan for and guide decisions in times of contingency and crisis.[5]

To address the confluence of these factors, a model approach to triage decision-making, based on the Oregon Crisis Care Guidance,[6] but adapted for the COVID-19 pandemic, allocates scarce critical care resources IF and ONLY IF a surge overwhelms capacity based on the following criteria:

- Short-term and long-term survival, objectively calculated into a sum/baseline score;
- If necessary: life-cycle-principle if and only if there is prognostic (benefit) equipoise exists; and
- If necessary: randomization.

Health care organizations in the context of the Portland metro area (where the tool was developed) have agreed to approach a surge in a consistent way and share resources to avoid triage decision-making. However, it may still be possible for a surge of patients to overwhelm the entirety of the health care system thereby necessitating the application of a consistent framework for allocating scarce critical care resources.

The Providence Center for Health Care Ethics has had a history of engaging in this work dating at least as far back as the H5N1 (aka, "bird flu") outbreak in 2007[7] and more recently with the Ebola outbreak in 2018. In the COVID-19 pandemic, the Center's ethicists have been engaged internally within the Oregon Region of Providence St. Joseph Health (PSJH), system-wide within PSJH, locally with county public health officials, as well as state-wide with officials in the Oregon Health Authority (OHA).[8]

The community-wide effort within Oregon and especially in the Portland metro area began to mature around the approach to triage decision-making outlined above. As a political endeavor, in the setting of value pluralism, this necessitated tough decisions and questions about the role of Catholic health care in the

Indeed, health care organizations have a duty to plan for and guide decisions in times of contingency and crisis.

public square as well as the tensions potentially created in upholding social solidarity with other health care organizations (e.g., in avoiding rationing in the setting of a surge) and the community at large as well as remaining faithful to our Catholic identity with our special concern for the poor and vulnerable. This tension was acutely felt around the question of a life-cycle principle as a triage tie-breaker. Thus, we are wrestling with the question: Is using the life-cycle principle as a tie-breaker ethically justifiable in Catholic health care?

BACKGROUND

To begin to answer this question, we have been fortunate to draw upon a rich wisdom within the Catholic moral and social teachings. In surveying these resources, I highlight content from the *Ethical and Religious Directives for Catholic Health Care Services*, a Catholic Health Association (CHA) publication, statements from the Pontifical Academy for Life and the United States Conference of Catholic Bishops (USCCB), and commentary from the National Catholic Bioethics Center (NCBC).

Briefly, several Directives[9] are applicable to triage decision-making and other ethical issues of the pandemic. Though no Directive explicitly and specifically address allocation of scarce resources, three Directives seem to stand out with particular relevance. They are (quoted here verbatim):

> 3. In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.
> 6. A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.
> 23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care.

Is using the life-cycle principle as a tie-breaker ethically justifiable in Catholic health care?

Next, with the Institute of Medicine & Humanities, (CHA) previously published a set of principles that should guide rationing of health care and ought to inform health care policies.[10] These principles are:

> 1. The need for health care rationing must be demonstrable.

2. Health care rationing must be oriented to the common good.
3. A basic level of health care must be available to all.
4. Rationing should apply to all.
5. Rationing must result from an open, participatory process.
6. Health care of disadvantaged persons has an ethical priority.
7. Rationing must be free of wrongful discrimination.
8. Social and economic effects of rationing health care must be monitored.

In addition, two source documents informing this discussion come from the Pontifical Academy for Life (PAL) and the United States Conference of Catholic Bishops (USCCB). The PAL note, "Global Pandemic and Universal Brotherhood: Note on the Covid-19 emergency," states

> This applies as well to all the choices made pursuant to a "care policy," including those more closely connected with clinical practice. The emergency conditions in which many countries are finding themselves can lead to forcing doctors into dramatic and painful decisions, with respect to rationing limited resources not available to everyone at the same time. In such cases, after having done at an organization level everything possible to avoid rationing, **it should always be borne in mind that decisions cannot be based on differences in the value of a human life and the dignity of every person, which are always equal and priceless. The decision concerns rather the use of treatments in the best possible way on the basis of the needs of the patient, that is, the severity of his or her disease and need for care, and the evaluation of the clinical benefits that treatment can produce, based on his or her prognosis.** ***Age cannot be considered the only, and automatic, criterion governing choice.*** **Doing so could lead to a discriminatory attitude toward the elderly and the very weak. In any case, it is necessary to formulate criteria, agreed upon as much as possible and based on solid arguments, to avoid arbitrariness or improvisation in emergency situations, as disaster medicine has taught us.** Of course, it bears repeating: rationing must be the last option. The search for treatments that are equivalent to the extent possible, the sharing of resources, and the transfer of patients, are alternatives that must be carefully considered, within a framework of justice. Under adverse conditions, creativity has also furnished solutions to specific needs, such as the use of the same ventilator for multiple patients. In any case, we must never abandon the sick person, even when there are no more treatments available: palliative care, pain management and personal accompaniment are never to be omitted. (Emphasis added.)[11]

The USCCB statement asserts:

> ... in a time of crisis ***we must not discriminate against persons solely on the basis of disability or age by denying them medical care.*** Good and just stewardship of resources cannot include ignoring those on the periphery of society, but must serve the common good of all, ***without categorically excluding people***

> based on ability, financial resources, age, immigration status, or race. // Foremost in our approach to limited resources is to always keep in mind the dignity of each person and our obligation to care for the sick and dying. Such care, however, will require patients, their families, and medical professionals to work together in weighing the benefits and burdens of care, the needs and safety of everyone, and how to distribute resources in a prudent, just, and unbiased way. (Emphasis added.)[12]

Next, the National Catholic Bioethics Center's (NCBC) ethicists cast doubt on the justification of triage protocols that rely on a utilitarian framework. They write, "the Catholic moral tradition does not accept utilitarian principles as an independent or constitutive source of ethical guidance, because such principles can be used to justify actions that undermine the dignity of the human person."[13] While the NCBC ethicists assert that triage teams may be morally justifiable, they also state,

> Patient priority scores for critical care resources allocation should be determined using objective clinical criteria for short-term survival, such as Sequential Organ Failure Assessment (SOFA) or similar criteria. Categorical exclusions based solely on an individual's age, disability, or medical condition (if it does not impact short-term COVID-19 survival) constitute unjust discrimination and are immoral.[14]

When taken alone, this statement would align with the triage tool currently developed within the state of Oregon. However, the next section problematizes prognostication for long-term survival (a component of the model triage tool) and the use of age as a tie-breaker. While not overtly objecting to a life-cycle principle as a tie-breaker, the NCBC ethicists state,

> Each protocol we have reviewed states that age is not an exclusionary factor for receiving critical care. However, in some protocols age actually becomes a factor through "tie breaker" determinations. Certain protocols state that in situations involving a priority score "tie" between two (or more) patients, age becomes the deciding factor for which of them receives critical care. The terminology varies in different protocols ("life-cycle principle," "saving the most life-years," "experience life-stages," "cycles of life," or "equal opportunity to pass through the stages of life"), but the operative principle is the same: decisions about who will, and will not, receive critical care are based on age.[15]

This statement, especially the last sentence, is misleading because it gives the appearance that it is based solely on age, which in the model triage tool, it is not. In a subsequent document, the NCBC ethicists assert (without much justification) that using long-term survival should not be a factor in triage priority and they exclude age-based tie-breakers from the list (again without much justification).

To round out background material, this is also an issue in secular circles. An oft-cited article in this current debate is the article published in *JAMA* by Doug White and Bernard Lo.[16] In their supplemental material (the model policy for the University of Pittsburgh), they incorporate the principle "save life-years" in the primary stratification of priority. Moreover, they write,

> We suggest that life-cycle considerations should be used as a tiebreaker if there are not enough resources to provide to all patients within a priority group, with priority going to younger patients. We recommend the following categories: age 12-40, age 41-60; age 61-75; older than age 75. The ethical justification for incorporating the life-cycle principle is that it is a valuable goal to give individuals equal opportunity to pass through the stages of life — childhood, young adulthood, middle age, and old age. The justification for this principle does not rely on considerations of one's intrinsic worth or social utility. Rather, younger individuals receive priority because they have had the least opportunity to live through life's stages. Evidence suggests that, when individuals are asked to consider situations of absolute scarcity of life-sustaining resources, most believe younger patients should be prioritized over older ones. Public engagement about allocation of critical care resources during an emergency also supported the use of the life cycle principle for allocation decisions. Harris summarizes the moral argument in favor of life-cycle–based allocation as follows: "It is always a misfortune to die; it is both a misfortune and a tragedy [for life] to be cut off prematurely."[17]

Interestingly, the NCBC resources link to an article by the same researchers cited by White and Lo regarding public engagement.

To help with conceptual clarification for the narrow question addressed here, a life-cycle principle is defined as a normative rule prioritizing patients based on stratifying patients who have lived fewer of life's stages. In other words, those who have not had a chance to live more of life's stages should be afforded that opportunity. There is a conceptual connection to a traditional goal of medicine: that physicians should help prevent untimely deaths. (To be sure, these are crude constructs and in any given case warrant caution and nuance.) In a baseball (or cricket) metaphor, commentators appeal to a "fair innings" construct: that patients are prioritized who have NOT had a chance to 'play' a fair number of innings. This is in contrast to prognostication and likelihood of longer-term survival. To continue the baseball metaphor, age in a prognostic rubric is more akin to the pitch-count of a starting pitcher: it serves as a rough metric for how much reserve is left in a person to continue to play. This is a different criterion than whether or not enough innings have been played to count as an official game. In summary, a life-cycle principle would prioritize younger patients over older patients, which opens it up to the charge of ageism and a wrongful discriminatory principle. ✣

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ENDNOTES

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[14] Ibid.
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[17] Ibid. See also: jamanetwork.com, accessed June 24, 2020.

Distributors of Justice: An Essential Quality of Catholic Health Care Leaders

Michael J. Naughton, Ph.D.

This essay was adapted from Chapter 7 of Michael Naughton's "Getting Work Right: Labor and Leisure in a Fragmented World" (Emmaus Road Publishing, 2019).

Twenty-three years ago, my mother died of cancer at the age of sixty-eight. Although it was a good death and a profound experience, it was also a very vulnerable and fragile time for our family. There were two institutions that supported and guided my father and siblings as we coped with the loss of my mother: our parish church with its pastor, and the local Catholic hospital. While there were several people from the hospital who assisted us through this difficult time, Ruby, a hospice nurse aide, stood out with great force.

Ruby cared for my mother during the final month of her life in our home. She was an African American Baptist woman who brought a tremendous amount of joy and consolation to my mother, a traditional Irish Catholic from County Offlay, Ireland.

Ruby came in three days a week to care for my mother, bathing her, changing the bed, massaging her ailing body, and lifting her spirits. She was a natural, both in terms of how she physically touched my mother and how she spiritually engaged her on her impending death. We would hear them laughing together, sharing stories of their children and talking about the Lord in their lives. Ecumenism was alive and well in that room. They would not have made much progress on doctrinal unity, but still, they witnessed a profound spiritual union.

Ruby's work was a great gift to our family, but there was a problem. She was not well-paid. As a nurse's aide for hospice work, she was one of the lowest paid people in the health care industry. They say wages are like shoes: if they are too small, they gall and pinch us, but if they are too large they cause us to stumble and trip. As a single mother with a couple of children, life was not easy for Ruby. Her wages, despite her good work, were galling and pinching.

Ruby was paid according to market value but not according to justice. Many businesspeople and market economists cringe at such a statement. They say that the buying and selling of labor is the same as the buying and selling of any other commodity such as soybeans — its price is determined by the interaction of supply and demand. If Ruby wanted to change her situation and get better pay, she should get the requisite skills and go into another profession.

In part, the economists are right. Ruby — like anyone who works within a market system

— is subject to the forces of the market. For the most part, customers will only pay for the instrumental value of work, that is, they will not pay more than the value they receive for the products and services bought. If the hospital decided to pay Ruby and all the lowest-paid employees higher wages, it would most likely price itself out of the market.

Yet Ruby is one of millions of examples, showing us that markets cannot exhaust our understanding of how we pay people. A market produces a wage, but it cannot ensure the status of the wage's moral worth. Wages, like most things in life, can be either excessive or defective. A labor market that fails to value the physical and spiritual care of the dying enough to give its workers a living wage is defective, just as a labor market that values someone who can hit a little ball with a stick at millions of dollars is excessive.

A market produces a wage, but it cannot ensure the status of the wage's moral worth.

The challenge is knowing how to respond to such excesses and defects. A wage that fails to meet the needs of a full-time adult employee will struggle to carry the weight of a real relationship between employee and employer. Yet to simply raise wages without implementing other changes would be self-defeating. Organizations can find themselves at a competitive disadvantage if the labor costs are significantly higher than those of their competitors.

The last time I saw Ruby was at my mother's funeral. She was like an angel — a messenger from God — whose work offered consolation amidst the profound loss of our mother. There are millions of Rubys in the workforce today. Their labor meets the needs of others, but it does not provide for their own needs. Addressing the situations of the Rubys of the world is a multifaceted problem, but from a business perspective, a key factor is that the pay Ruby receives is dependent upon the wealth generated by the organization.

It is not easy to pay just wages to people like Ruby, who are considered low-skilled, but the logic of exchange used by managers and economists is too mechanical, too neat, and, frankly, too simplistic to deal with a case such as hers. One of the key insights of the Catholic social tradition is that a just wage is a "relationship," which is why the logic of exchange can't capture the richness of what it means to be just in terms of a wage. The very meaning of justice comes from the Latin root of justice that is ius, meaning "right," and in particular, "right relationships." In the Old Testament the Hebrew words *mišpāt* (justice) and *ṣedāqâ* (righteousness) describe the fulfillment of responsibilities between employer and employee, ruler and subjects, God and His people, husband and wife, parent and child.

So what does this mean for Ruby? First, and it may sound harsh, but as wonderful as Ruby is in her work and as a person, she has not developed the skills necessary to get better pay. Her education was poor. She comes from

When an employer receives work from an employee, both participate not only in an economic exchange but also in a personal relationship.

a broken family, and as a single parent, her household is simply under-resourced — she has few familial resources to draw upon when things don't go well. All of these conditions have reduced Ruby's wealth-creating capabilities. None of these conditions were caused by her employer, and for the most part Ruby did not create her cultural context.

Yet, even though the hospital is not responsible for Ruby's lack of skills and poor education, it is responsible for the nature of its relationship with Ruby. And though Ruby is not fully responsible for her situation, she has a job where she can influence the future. This brings us to our second point. When an employer receives work from an employee, both participate not only in an economic exchange but also in a personal relationship. This relationship, if it is to be just, has three convictions that should guide a just wage: *need*, *contribution*, and *order*.

- *Need*: For a relationship to flourish in organization, an employer must recognize that associates, by their labor, "surrender" their time and energy and cannot use them for other purposes. A living wage, then, is the minimum amount due to every independent wage earner by the mere fact that he or she is a human being with a life to maintain and a family to support. A wage that fails to meet the needs of an associate (in particular, a full-time adult) is a wage that will struggle to carry the weight of a real relationship.
- *Contribution*: While the principle of need is necessary for determining a just wage, it is insufficient on its own, since it only accounts for the consumptive needs of associates and does not factor in their productive contributions to the organization. Because of effort and sacrifice as well as skill, education, experience, scarcity of talent, and decision-making ability, some associates contribute more to the organization than others, and are therefore due more pay. An equitable wage, then, is the contribution of an associate's productivity and effort within the context of the existing amount of profits and resources of the organization.
- *Order*: Pay is not only income for the worker; it is also a cost to the employer, a cost that impacts significantly the economic order of the organization. Without proper evaluation of the way a living and equitable wage will affect the economic order of an organization, the notion of a just wage becomes no more than a high-sounding moralistic impracticality. A sustainable wage, then, is the organization's ability to pay wages that are sustainable for the economic health of the organization as a whole.

The key to resolving the tension is invoking the principle of contribution.

In Ruby's case, a tension exists between the principle of need and the principle of order. Raising Ruby's wages could put the economic sustainability of the hospital at risk. The key to resolving the tension is invoking the principle of contribution. Three conditions of relationship are necessary to come to a fruitful resolution.

First, hospital administrators in this case must resist the common practice of passively delegating their responsibilities simply to the mechanical force of labor markets. As managers, they are moral agents, *distributors of justice*, and not mere market technicians.

Second, Ruby has to take responsibility for the fact that she does not have the skills to warrant enough wealth to pay her a living wage. Whatever the circumstances that got her there, she is the one who needs to enhance her skill level. The hospital, however, has to play a role in partnering with Ruby to create development plans that can make her a more valuable member of the organization.

Third, hospital administrators should realize that every action has a reaction, and that raising wage levels without changing the work process would have serious consequences on overall cost structure. To simply pour surplus margins into wages without any consideration as to how the performance of the organization might be strengthened would undermine the hospital's ability to pay sustainable living wages.

What should become clear to the hospital administration is that low wages are merely a symptom of a much larger problem of how the organization structures the work itself. When work is designed to use a wage rate below a living wage, it is difficult to pay a person like Ruby anything more than what she is receiving now, regardless of her talents. Prudence dictates that the living wage cannot come about automatically. It has to come through redesigning the work and giving associates skills. If administrators are going to raise labor rates to pay a living wage, they need to find ways to reduce their labor costs.

My family as well as so many families have been blessed by the Rubys of the world who have profoundly personalized Catholic health care's mission on hospice care. These Rubys meet the spiritual, emotional and physical needs of the dying every day. May Catholic health care leaders find just and prudent ways to pay them and meet their needs. ✣

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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, associate director, supervised the contributions by Valerie De Wandel, J.D. (Ph.D. anticipated 2021), and Shannon Rempe, J.D., M.H.A.

HHS WARNS STATES NOT TO PUT PEOPLE WITH DISABILITIES AT THE BACK OF THE LINE FOR CARE

As the number of COVID cases continues to increase, making it difficult for hospitals to decide how to allocate the limited staff and resources they have, the U.S. Department of Health and Human Services is reminding states and health care providers that civil rights laws are still applicable. This greatly concerns disability groups, who are anxious about rationing or decisions that might exclude the elderly or individuals with disabilities. Roger Severino, the director of the Office for Civil Rights, echoed concern that "crisis standards of care may start relying on value judgments as to the relative worth of one human being versus another, based on the presence or absence of disability. We're concerned that stereotypes about what life is like living with a disability can be improperly used to exclude people from needed care." The HHS guidelines set by HHS are warnings to states. The department's Office for Civil Rights has the authority to investigate health care providers and correct them if they have violated civil rights law. If not corrected, the office can ask the Department of Justice to move forward with prosecuting the perpetrator.

Joseph Shapiro, https://www.npr.org/2020/03/28/823254597/hhs-warns-states-not-to-put-people-with-disabilities-at-the-back-of-the-line-for-care, March 28, 2020.

HOSPITALS, HEALTH CARE WORKERS GIVEN CIVIL IMMUNITY

Executive Order 2020-19, authorized by Illinois Governor J.B. Pritzker, was issued to grant broad immunity from civil liability to "health care facilities, health care professionals, and health care volunteers" who are "rendering assistance" in the state's disaster response. Karen Harris, general counsel of the Illinois Health and Hospital Association, indicated that her organization, along with others, recommended this order to be implemented. She stated, "If you are a retired health care worker in the last couple of years, and want to come help out in this difficult time, you may not have liability coverage. Having assurances that your efforts would not result in a lawsuit is important for making sure we are encouraging those who might want to or be able to come back and help be able to do so." The order specifically defines and distinguishes health care professionals and health care volunteers.

Sarah Mansur, https://www.chicagolawbulletin.com/exec-order-gives-civil-immunity-to-hospitals,-health-care-workers-20200403, April 3, 2020.

TRUMP WILL URGE SUPREME COURT TO STRIKE DOWN OBAMACARE

The Trump administration said it would urge the Supreme Court to overturn Obamacare amidst the COVID-19 pandemic with millions of Americans depending on its coverage. This statement is consistent with the administration's continued legal attacks on the health care law despite Attorney General William Barr's warnings about the potential political blowback of undermining the decade-old health care safety net during this pandemic emergency. The Justice Department had a chance to reverse its position in a case challenging the Affordable Care Act (ACA) brought by Republican-led states. However, President Trump told reporters that his administration would not alter its course. The DOJ's current legal strategy is to have the entire law struck down by arguing that the elimination of the tax penalty in the law rendered the ACA invalid. Previously, the DOJ argued the courts should merely remove the preexisting condition protections of the ACA. This position seems to be more congruent with the wishes of President Trump's current Secretary of Health and Human Services, who opposed a broad attack on the law. Nevertheless, the Trump administration has indicated it intends to continue with their scheme to strike down the ACA that has covered more than 20 million people and is expected to serve as a vital safety net during the economic disaster that has been triggered by the pandemic. The ACA is being defended by a coalition of House Democrats and Democratic state attorneys general in court.

Susannah Luthi, https://www.politico.com/news/2020/05/06/trump-supreme-court-obamacare-240366, May 6, 2020.

INFECTING THE MIND: BURNOUT IN HEALTH CARE WORKERS DURING COVID-19

As a direct result of the stress caused by the COVID-19 pandemic, health care providers across the United States are experiencing occupational burnout and fatigue. In a recently published article in the journal *Anesthesia & Analgesia*, Dr. Farzan Sasangohar, assistant professor in the department of industrial and systems engineering, indicated "the COVID-19 pandemic exacerbated an already existing problem within our health care systems and is exposing the pernicious implications of provider burnout." Doctors and nurses are facing additional stress from a variety of sources, including longer shifts and more patient deaths. Additionally, the fear of exposure is an overriding concern. Sasangohar and his research team identified four main areas of stress as occupational hazards — national versus locally scaled responses, process inefficiencies and financial instability. The purpose behind defining these areas of stress was to identify mitigation strategies to reduce burnout amongst these health care providers. Such identification is imperative, as there will be more world-wide pandemics to come, which is why Houston Methodist Hospital has already begun making changes to increase resilience and prepare for future crises.

Texas A&M University, https://www.sciencedaily.com/releases/2020/05/200513143749.htm, May 13, 2020.

CORONAVIRUS DRIVES HEALTH INSURERS BACK TO OBAMACARE

Due to the COVID-19 pandemic, tens of millions of people are losing their jobs and health benefits. Few individuals will be able to sign up for costly COBRA plans. Insurers are increasingly valuing a marketplace offering government subsidized private insurance to those Americans during this time. The Kaiser Family Foundation recently released a study indicating that insurers who served Obamacare patients continued to see profits last year. However, Obamacare markets or Medicaid are unavailable to much of the vulnerable population in the 14 states that have not expanded the programs under the health law, and programs are at risk for likely cuts as states limit their budgets due to the pandemic. While many states and plans are still constructing rates for the next year, last week Vermont indicated a conglomeration of new proposals from its Obamacare marketplace. Dave Dillon, a fellow of the Society of Actuaries, mentioned that "It does not appear Covid-19 will be a significant variable."

Dan Goldberg and Susannah Luthi , Politico, https://www.politico.com/news/2020/05/14/coronavirus-health-insurers-obamacare-257099, May 14, 2020.

HHS MOVES TO CURTAIL ABORTION, TRANSGENDER HEALTH PROTECTIONS

In early June, the Trump administration finalized a policy that removes women seeking abortions and LGBTQ people from the Affordable Care Act's (ACA) non-discrimination protections. As expected, there is planned legal action and some lawmakers have criticized the administration for this move — calling it "cruel and unconscionable." This new regulation would allow health care workers, hospitals, and insurance companies (that receive federal funding) to refuse provision and/or coverage of services such as abortions or transition-related care. This policy demonstrates the administration's continued effort to preserve "religious freedom," and essentially protect health care professionals from getting penalized for refusal of service based on their moral beliefs. Lambda Legal, the Human Rights Campaign, the Transgender Law Center, Harvard Center for Health Law and Policy Innovation, Transgender Legal Defense and Education Fun, and the National Women's Law Center all plan to challenge the rule. The Human Rights Campaign has alleged that this rule exceeds the administration's authority in defining sex discrimination under the ACA and undermines the ACA's goals of expanding access and eliminating barriers to care. In finalizing this policy, the administration has not actually changed the law, but instead has created an HHS rule, but its impact has and will continue to cause a lot of confusion and hurt in LGBTQ communities.

Shira Stein, https://news.bloomberglaw.com/health-law-and-business/hhs-moves-to-curtail-abortion-transgender-health-protections, June 12, 2020.

IF YOU'VE LOST YOUR HEALTH PLAN IN THE COVID CRISIS, YOU'VE GOT OPTIONS

The loss of employment for over 21 million Americans has come with many challenges. However, one of the biggest problems is that it also means the loss of insurance during this pandemic, an obviously important time to be covered. Many people do not know of their insurance options when they lose their

employer-sponsored insurance. The Affordable Care Act is an important safety net to people who have been recently let go from their jobs. Under this law, people who are experiencing certain "life events" like moving, getting married, having a baby, or losing their job and health insurance qualify for a special enrollment period. While the Trump administration increased scrutiny of people trying to prove they qualify, these requirements have been loosened because of COVID-19. However, it is important to note that people only have 60 days after they lose their coverage to qualify under the ACA special enrollment. Finally, if someone missed the 60-day window, they may still qualify for extended time if they were sick or caring with someone who was ill. Another option is for people who have lost their jobs to apply for coverage under Medicaid. Medicaid doesn't require a special enrollment period and eligibility is based largely on income. Maximum income levels vary, but the weekly $600 unemployment benefits do not count toward the Medicaid income calculus.

Finally, staying on a former employer's plan is a possibility for some under the federal COBRA law. However, this could be expensive because people must pay the full cost of the premium unless their employers agree to share the cost.

Julie Appleby,
https://khn.org/news/if-youve-lost-your-health-plan-in-the-covid-crisis-youve-got-options/,
June 12, 2020.

Literature Review:
Stewardship or Caritas? On the Economics of Catholic Health Care Ministry

Jordan Mason

Increasing economic pressure on Catholic health care ministries in recent decades has inspired renewed conversation regarding the theological bases of our financial decisions. The concept of stewardship has risen to prominence as a foundational commitment guiding our use of limited resources. However, Therese Lysaught argues that an older commitment — *caritas* — is more theologically fruitful. While most agree that a broad array of values is necessary to guide economic decisions in Catholic health care, *caritas* and prudence-infused-by-charity rightly encompass that broad array, and thus, get us much farther in demonstrating our Catholic identity in economic matters than mere stewardship.

M Therese Lysaught, "Beyond Stewardship: Reordering the Economic Imagination of Catholic Health Care," *Christian Bioethics: Non-Ecumenical Studies in Medical Morality,* Volume 26, Issue 1, April 2020, 31–55, https://doi-org.ezp.slu.edu/10.1093/cb/cbaa002.

Stewardship has become one of the foundational commitments of the Catholic health care ministry in recent decades. The Catholic Health Association's "Shared Statement of Identity for the Catholic Health Ministry" lists stewardship as a core commitment, as does much of the USCCB's literature, including the *Ethical and Religious Directives for Catholic Health Care Services*.[1] Catholic bioethics literature contains references to stewardship at seemingly every level: patient care, allocation of resources, analysis of novel technologies, organizational ethics, personnel, budgeting, and more. While the USCCB states that stewardship is essential to Christian discipleship, Lysaught is concerned that "Christian discipleship appears to have become yet another form of management, reduced to performing the techniques of accounting, resource management, and maximizing returns."

What's wrong with the concept of stewardship for Catholic health care? Lysaught provides a genealogical analysis of stewardship's rise to prominence in Catholic thought that is quite compelling. From the early days of the Catholic Church, the theologically robust concept of *caritas* — charity, grounded in theological conceptions of the immanent and economic Trinity — was the foundational Christian virtue and the basis of the Christian life. Starting in the thirteenth century, however, the concept of stewardship began to supplant charity as the

model for handling and distributing limited resources. Such a process was furthered as the Roman Catholic Church was dispossessed by the English Reformation in the sixteenth century, concurrent with the rise of modern capitalism. Once the altars were stripped and ecclesial assets seized, the poor were left without large-scale assistance; "stewardship" as an element of good Christian discipleship became a necessary tool to induce individuals to give to the poor. But this is no costly discipleship;[2] rather, stewardship and capitalism are quite natural bedfellows. Unlike charity, stewardship lives comfortably within the bounds of capitalist class structures. It involves unidirectional giving without disturbing the causes and institutional structures behind inequality and poverty. "It is a principle for those with social and economic power," writes Lysaught.

Inherent in Lysaught's project is a desire to attend to the invisible assumptions and structures that distort Catholic theological commitments and contribute to modern dilemmas in the clinic. Putting aside the symptoms, she cuts to the root. Stewardship hinders, rather than enables, the moral imagination of Catholic healthcare. *Charity* is a much more faithfully Christian basis on which to build a just economic structure — but not just "charity care," a legal obligation for tax exemption. What contemporary Catholic healthcare needs in this historical moment is a reconstruction of charity (as solidarity, a charity with teeth) as the basis for our work, Lysaught argues. This reconstruction would employ Scripture, tradition, and magisterial teaching to put charity in its rightful place: as the theological reality underneath all we do. Charity, and prudence infused by charity, must displace stewardship as the guide for economic decision-making. Through prudence-infused-by-charity we participate in the mercy and creativity of God, profligate and abundant, disrupting and transforming existing personal and structural relationships to the benefit of the poor and vulnerable.

Slosar, J.P., Repenshek, M.F. & Bedford, E. "Catholic Identity and Charity Care in the Era of Health Reform." *HEC Forum* 25, 111–126 (2013). https://doi.org/10.1007/s10730-013-9212-6.

While Lysaught proposes recovering the theological concept of caritas as the primary lens through which to address economic concerns in Catholic healthcare, Slosar, Repenshek, and Bedford believe the question of if/how/when to limit uncompensated care cannot be addressed by one overriding moral consideration. Rather, it must be tackled using various principles as guides to a holistic understanding of the Church's health ministry. Their article, published 7 years before Lysaught's and shortly after the implementation of the ACA, attends to what they call the "tension between three intersecting primary values, namely, a commitment of service to the poor and vulnerable, promoting the common good for all, and financially sustainability." Within this tension, it is difficult to know whether it is justified to limit charity care. They argue it is justified, but it is vitally important how we do so.

Slosar, Repenshek, and Bedford point out that while Catholic hospital systems have an obligation to charity, and to their identity as part of the Church, they are not excused from their need to operate like a business to remain

economically sustainable. Thus, questions of *limits* on charity care immediately arise, because health ministries are beholden not just to individuals but also to the common good. The authors embrace the theologically considered concept of stewardship as a way of standing in the breach between individuals and the collective; unlike Lysaught, however, they understand stewardship to require both management techniques and a social justice element. Yet it is not clear how they develop this understanding of stewardship — theologically, historically, or otherwise. Their description of stewardship, including allocation of resources to promote human rights, equity, and the common good, seems less like a prophetic voice for social justice and more like something that works toward Catholic values within the current system. It is Lysaught's critique that stewardship-based approaches like this one perpetuate capitalist class structures, instead of subverting them.

But their project, of course, resonates with hers. If the common good requires that healthcare be available to everyone, then no one can have access to *all* healthcare — and this is the basis on which we must build a "theology of limits." By acknowledging limits, and determining where they should lie, we can achieve the common good. For these authors, while caritas requires indiscriminate provision, concern for the common good can help us set limits and thus sustain our health ministries for the long haul. This constrains the proper exercise of charity. In essence, Slosar, Repenshek, and Bedford are saying charity alone does not help us decide where to devote our limited resources. What we have here, as is so often the case, are competing goods; we must balance our obligations such that our charity is sustainable. When conflicts between goods arise, it is crucial that we analyze them from the angle of each obligation, including human dignity, distributive justice, stewardship, participation, the common good, and solidarity. But isn't this just prudence, after all? It seems Lysaught's proposal still stands: caritas and prudence-infused-by-charity can replace stewardship.

Slosar, Repenshek, and Bedford object, saying caritas works well in cases where $n = 1$, but our healthcare institutions are operating at a much larger scale. They believe that caritas and prudence, while important obligations, cannot on their own guide us in large scale economic decisions. So, while Lysaught proposes prudence-infused-by-charity as the basis on which to set limits on spending, Slosar, Repenshek, and Bedford believe only an interplay of various principles can guide us through this complexity.

Gremmels, Becket. "Can Catholic Hospitals Still Be Catholic? A Virtue Theory Response." *Christian Bioethics*, Volume 25, Issue 1, April 2019, 17-40, https://doi.org/10.1093/cb/cby017.

Gremmels attends to a question beneath the economic concerns around charity care and limited resources: whether Catholic hospitals can retain their Catholic identity (what Lysaught might call a commitment to caritas, and which Slosar, Repenshek, and Bedford locate in an interplay of principles) amidst the various shifts happening in our country, our institutions, and our Church. He offers virtue ethics as a way of attending to this question, as it provides a framework for understanding the

development of our moral character through our actions and decisions, both as individuals and as organizations.

A Catholic hospital's economic decisions help define it. "Either a hospital's actions, decisions, policies, etc., will lead it toward becoming or maintaining the nature of a Catholic hospital, or they will lead it away from it toward something else ... Every leader's decisions collectively shape who and what the organization is ... " writes Gremmels. Through a virtue ethics lens, we see that Catholic identity is teleological: our final purpose is to be perfected in Christ. As healthcare organizations, just as for individuals, we will fail in our attempts to be "perfect" and yet we continue to strive for increased virtue as we imitate Christ. Shifting factors like consolidation and economic shortfall means the setting for our decision-making and action will look different. And because of their complexity, Catholic organizations may sometimes fail to enact all elements of their identity. From this perspective, Slosar, Repenshek, and Bedford are right to point out the tension between our core values of service to the poor, the common good, and financial sustainability. But is it really fair to pit those against each other?

This is where practical wisdom, or prudence, comes in. Gremmels offers, per virtue theory, that the right action is the one properly tailored to the situation. Lysaught would agree. Prudence entails deliberation and discernment prior to action. The question is not whether Catholic hospitals can live out their identity amidst economic pressures, but how to adapt the expressions of our identity within the bounds of their fundamental tenets. Like Slosar, Repenshek, and Bedford, Gremmels believes that, "An accurate conception of Catholic identity reveals a broad array of values and ideals rather than a narrow vision that focuses primarily on one or two elements." What Lysaught calls us to consider, however, is that caritas might just encompass that broad array of values, and prudence-infused-by-charity may get us much farther in demonstrating our Catholic identity in economic matters than mere stewardship. I think she is right, and a broader moral vision will help us escape the weeds of our economic pressures.

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ENDNOTES

[1] Catholic Health Association, "Shared Statement of Identity for the Catholic Health Ministry," https://www.chausa.org/mission/a-shared-statement-of-identity.; US Conference of Catholic Bishops, "*Ethical and Religious Directives for Health Care Services*," 2018, Directive 6.
[2] Dietrich Bonhoeffer, The Cost of Discipleship (New York: Touchstone, 1995).

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