How Much of What We Do in Catholic Health Care Is Uniquely Catholic?

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There is a presumption that to be competent as an ethicist in Catholic healthcare, a certain amount of expertise in Catholic moral theology is required.[1] What is undetermined, however, is how much expertise? As a clinical ethicist who trained and practiced in non-Catholic institutions before working in Catholic healthcare, I became intrigued by the question: How much of what I was doing now is 'uniquely Catholic'?

My anecdotal experience was that when it came to patient-specific ethics consultations[2], for the vast majority of cases there was no significant difference (and perhaps no real difference at all) in the consultation process itself or in the ethics recommendations. Obviously if a patient, family, or care team member was explicitly Catholic, there was reason to use language related to Catholic moral theory or the Ethical and Religious Directives (ERDs)[3] within the context of the consultation conversations and recommendations. However, knowing when and how to do this would arguably be the same in a non-Catholic institution provided one was a culturally competent clinical ethicist.

Anecdotes being questionable evidence, I decided to review data collected from patient-specific ethics consultations for the previous year within my Ministry Market.[4] While there were limitations to the data available[5], some of the highlights were as follows:

- Over 40% of documented clinical ethics consultations were related to surrogate decision-making (e.g., determination of a surrogate decision-maker, surrogate decision-maker hierarchy, unbefriended patients) and the advance care planning process and interpretation and implementation of advance care planning documents.
- Over 80% of clinical ethics consultations were related to patient-provider relationships more broadly (this includes surrogate decision-making and advance care planning issues, as well as issues of, e.g., informed consent, decision-making capacity, goals of care, confidentiality, risk to self and others, and vulnerable populations).
- Most ERD-related issues were also encompassed by an existing hospital policy or otherwise described using a similar non-Catholic bioethics principle.
- While ERD-related language may have been utilized in conversation during the consultation process, it rarely was documented in the electronic medical record.

Based on the information available, the majority of ethics consultations documented were not the sort that would require significant understanding of Catholic moral teaching or the ERDs, as they could otherwise be fully managed using more general bioethics concepts or hospital policy.

Part of the issue here could be the types of situations that came to the ethics consultation service within the given timeframe at this particular Ministry. In thinking more objectively about what topics or issues *would* be specifically Catholic for clinical consultations, and therefore require a more robust knowledge of Catholic moral teaching and/or the ERDs, the following stand out to me as the more obvious candidates:

Issues in the Professional-Patient Relationship

- One key feature of Catholic healthcare is the strong emphasis on the dignity of the human person. While this may be implicit in the concepts of autonomy or beneficence (i.e., doing good), the ERDs make human dignity foundational and explicit in ways that are less common within a non-Catholic approach.
- Another key feature of Catholic healthcare is the emphasis on caring for those individuals on the margins of society (see, e.g., ERD 3). Again, while this may be implicit in some ways in the concepts of beneficence and justice, it likely carries less weight in non-Catholic approaches to healthcare.

Issues in the Beginning of Life

- Catholic ethics surrounding beginning of life and conception are more likely to be grounded in the sanctity of life and dignity of marriage, rather than the more secular emphasis on patient autonomy, bodily integrity, and maternal-fetal conflict.
- Catholic moral teaching and the ERDs provide specific rules and prohibitions that would not necessarily exist in a non-Catholic institution, such as those surrounding abortion, contraceptives, and sterilization [ERD 45, 52, 53].

Issues Related to the Seriously Ill and Dying

- Catholic moral teaching makes fundamental the position that human life is a gift from God. This can influence ethical decision-making surrounding the seriously ill and dying in ways that are different from a non-Catholic setting, which might otherwise focus more on issues of autonomy and non-beneficence (i.e., non-harming).
- Catholic moral teaching and the ERDs provide specific philosophy, rules and prohibitions that would not necessarily exist in a non-Catholic institution, such as the distinction between ordinary and extraordinary means, artificial nutrition and hydration, and physician-aid-in-dying and euthanasia [ERD 56, 58, 60].

For any of these scenarios, a greater-than-cursory knowledge of Catholic moral theory and the ERDs would likely be helpful, if not indeed necessary. However, if these concerns

do not appear prominent within a particular hospital or healthcare system, should expertise in Catholic moral theology be required? Might it be more efficient and economical to have a competently trained clinical ethicist with minimal understanding of Catholic moral theory and the ERDs, who by virtue of their training and the needs of the Market can perform a sizeable number of clinical ethics consultations that arise in their day-to-day work and need only be able to recognize when assistance from someone with greater expertise in Catholic moral theory is necessary?

Or is there something deeper at play here? Was the predominant absence of Catholic or ERD-related language in documentation and data collection a potential misstep for a professed ministry of the Catholic church? If, in fact, there are relevant values and directives that could be showcased in EMR documentation — regardless of whether the advice could otherwise be provided utilizing only non-Catholic ethics principles and policies — should we? Is this in itself a teachable moment, potent with the capacity to further engender a broader understanding and awareness of our Catholic identity?

And what about the data? If our data collection system tracks largely on more general bioethics principles, and there isn't a clear method for documenting a Catholic emphasis on these principles, are we liable to miss an opportunity to showcase Ethics' role, however subtle, in mission and ministry outreach? If Catholic-specific metrics are either absent or underemphasized, does this downplay their importance in the consultation process, and perhaps even discourage efforts at ensuring Catholic moral teaching and ERDs are part of the ongoing cultural transformation through ethics consultation?

I admittedly do not have answers for these questions. But, if I'm honest, they trouble me.

If indeed there is something special about being a Catholic healthcare ethicist, if there is a true sense of vocation and mission and identity, if we are really the 'hands and feet' participating in the healing ministry of Jesus Christ, shouldn't the answer to at least some of the questions in the preceding two paragraphs be '*Yes*'? And if not, at the end of the day, how much of what we do in Catholic healthcare is actually uniquely Catholic? ✠

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ENDNOTES

1. CHA, Qualifications and Competencies for Ethicists in Catholic Health Care, May 2018.
2. Cases that involve a specific, identifiable patient in the hospital or other healthcare setting.
3. USCCB, Ethical and Religious Directives for Catholic Health Care Services, 6th Edition, June 2018.
4. Nine hospitals and multiple ambulatory surgical centers across Middle Tennessee.
5. Not all consultations performed by ethics committee members were entered into the new database so the data is technically incomplete and analysis is based on existing entries; review of EMR documentation was done as a random sample of Ethics chart notes.