

Communicating the *Directives* to physicians

Case scenarios help doctors understand the deeper significance

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During an August 2006 interview on Vatican Radio, Pope Benedict XVI offered this profound observation about the nature of our faith: “Christianity, Catholicism isn’t a collection of prohibitions: it’s a positive option. We’ve heard so much about what is not allowed that now it’s time to say: we have positive ideas to offer.”¹

The idea that our faith and moral teachings are more about the values we are attempting to promote and less about prohibited actions came home to me as I prepared for a presentation on mission and values to new leaders at Sacred Heart Hospital in Eau Claire, Wis. Part of this presentation included an introduction to the *Ethical and Religious Directives for Catholic Health Care Services*. As part of my preparation, I took time to do something which I am embarrassed to admit I had not done for quite a while: I read the *Directives* cover to cover. When I finished reading them, I sat back in my chair, stunned at the document’s wisdom, profundity and insight regarding the human person. The *Directives* are a prime example of what the Holy Father refers to as “positive ideas,” one that those charged with communicating the church’s vision for health care can offer to the world, particularly to physicians.

Too often, however, the *Directives* are utilized when developing institutional policies or receiving an inquiry from a physician for a consultation on a case. As important as these reasons are, the richness and fullness of the *Directives* can be truly appreciated only when looking at the specific norms within the larger context that the bishops

have carefully laid out. It is this context that needs to be the foundation for a full and effective education and formation of physicians and other health care professionals by ethicists, mission leaders, pastoral care experts or anyone else with the responsibility of explaining the *Directives*.

The two-fold rationale behind the *Directives* is to “reaffirm the ethical standards of behavior in health care that flow from the Church’s teaching about the dignity of the human person” and “provide authoritative guidance on certain moral issues that face Catholic health care today.”² Frequently physicians focus on the second of these purposes, that is, the specific restrictions and limitations contained in some of the *Directives*. This article will demonstrate how the detailed guidelines in the *Directives* can be properly appreciated, understood and taught only when viewed through the lens of the underlying principles and values of Catholic health care. This type of education and formation takes time and must be performed in a manner that can be met by some unique and, at times, overwhelming challenges. Nevertheless, this endeavor is fundamental if our institutions are truly to maintain their Catholic identity.



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COMMUNICATING WITH PHYSICIANS

When referencing the *Directives* in a recent presentation on medical error to family practice residents, I encountered two surprising incidents: the initial response was a collective blank stare followed by a resident asking if the *Directives* applied only to our hospital. The need for a good deal of education was evident. It's critical to stress to clinicians that the *Directives* apply to every Catholic health care institution in this country as well as to Catholic professionals engaged in health care services in other settings. Secondly, it's important to emphasize that the values upon which the *Directives* are based flow from natural law and reflect principles and values important to and fundamental for every human person.

The nature of physician training presents another challenge. Unlike ethicists and others charged with explaining the *Directives*, physicians are usually not trained in philosophy or theology. It is imperative that ethicists develop a familiarity with clinical terminology, practices and procedures so they can speak intelligently about how ethical issues are applied to various medical interventions. Failing to use language that physicians are accustomed to runs the risk that they will fail to understand ethical issues relevant to their clinical practice.

At the same time, physicians need to develop familiarity with some basic ethical and moral principles central to a fuller understanding of holistic Catholic care for the patient and family. Physicians and ethicists must learn to appreciate one another's perspective and language to ensure the ethical dialogue will have a solid bioethical footing with an equally sound clinical base. Once this balance is achieved, the next challenge is finding a way to present these vitally important principles in compelling fashion.

The most effective model of teaching ethics in the institutional setting is the case study approach to illustrate various moral and ethical dimensions to patient care. This approach was most effectively demonstrated when our hospital sponsored a bioethics symposium on the development of the patient's relationship with the health care professional. We presented case scenarios, which attendees found not only interesting but also helpful in identifying various ethical issues that typically surface in their daily practice. In this way, we were able to present foundational principles in concrete, practical examples, helping physicians see that ethical discussions and considerations have

a crucial place in their practice. These scenarios also enabled physicians to understand that ethics is not some vague, nebulous subject. Rather, it is a discipline that has a direct impact on patient care, including safety, quality and patient satisfaction.

After effectively engaging physicians' interest in ethics and helping them understand the connection to patient care, the next step is to have them carefully examine the *Directives* in their totality. It's incumbent upon people charged with communicating the *Directives* to get beyond the common misconception that they exist only to let physicians know about the prohibitions in a Catholic institution. Instead, the *Directives* present a well developed and profound vision of the nature of health care and, in particular, Catholic health care. The Preamble reminds physicians and other health care professionals that their work, regarded by the church as a ministry of service, is to be carried out in a way that is conscious and respectful of the inherent dignity of the human person. This belief flows from the Gospel, where we are told that "Jesus' healing mission went further than caring only for physical affliction. He touched people at the deepest level of their existence; he sought their physical, mental, and spiritual healing (*John 6:35, 11:25-27*). He 'came so that they might have life and have it more abundantly' (*John 10:10*)."³

This positive and comprehensive understanding of health care is essential if those of us engaged in fulfilling this ministry are to see our efforts as more than a business or a place for treating medical infirmities. We are called to care for the whole person; the *Directives* present a blueprint so this endeavor may be carried out in a manner that protects the dignity of the human person. The *Directives* rightfully point out, "The dialogue between medical science and Christian faith has for its primary purpose the common good of all human persons. It presupposes that science and faith do not contradict each other. Both are grounded in respect for truth and freedom. As new knowledge and new technologies expand, each person must form a correct conscience based on the moral norms for proper health care."⁴ The *Directives* serve, for both professional and patient, as an instrument critical to that formation of correct conscience.

THE NATURE AND STYLE OF THE *DIRECTIVES*

Physicians and those individuals charged with explaining the *Directives* need to understand sev-

eral points regarding the nature and style of the *Directives*. One is struck by the way the bishops present a wide range of areas that they feel need to be addressed by physicians and others involved in carrying out the apostolate of Catholic health care. Also, people are often surprised that Part One of the *Directives*, "The Social Responsibility of Catholic Health Care Services," does not focus on clinical issues, but rather on the social responsibility of health care services. However, the bishops point out that in an increasingly complex health care system, our society is confronted by "a range of economic, technological, social and moral challenges."⁵ This commitment to a socially just health care system flows from the biblical mandate to care for the human person, to defend the right to life and to care for the poor. Along with this comes a responsibility to be faithful stewards of increasingly scarce health care resources.

Physicians need to pay particular attention to Part Three of the *Directives*, "The Professional-Patient Relationship." Today's health care setting

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often involves a multi-disciplinary team responsible for the delivery of effective health care. This approach makes the relationship between physician and patient more complex. The bishops stress the importance of effective communication between patient and physician, as well as between physicians and other members of the health care team. This is more than just a nice thing to do; it is essential if patient rights and autonomy are to be protected. Issues such as ethics committees, informed consent and advance directives are also discussed in this section and are worthy of study and reflection by physicians.

The sections of the *Directives* that deal with issues related to care at the beginning and end of life address some of the most significant and debated issues in health care. Although this article does not address all of those specific issues, a full education of the *Directives* for physicians will in-

evitably involve significant time explaining the church's teaching on these issues, as well as the underlying principles. Too often, the teachings are presented simply as rules and regulations with little, if any, time spent on the foundation for the church's positions.

Part Six of the *Directives*, "Forming New Partnerships with Health Care Organizations and Providers," describes partnerships with health care organizations and other-than-Catholic providers. As we see more development of relationships and various partnerships between hospitals and

agement is not to be understood as efforts by the bishops to run the hospitals or to intrude upon the physician/patient relationship, but rather as a proper exercise of their responsibilities as chief teachers of the faith in the local church.

Each of the six parts of the *Directives* starts with a thematic statement, which sets the basis for the specific norms covered. These statements deserve reflection. A pastoral understanding of the norms is essential if we are to avoid looking simplistically at the *Directives* as a list of do's and don'ts.

Although the *Directives* are broad in terms of scope, they are far from exhaustive in the sense that they do not address every aspect of church teaching. Therefore, the role of the ethicist is to be familiar with the full scope of the church's teachings and to be prepared to make them understandable to physicians, who are not only looking for answers, but also for a way to explain those teachings to anxious patients and their families.

The image shows the cover of the book "Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition". The title is written in a red serif font, and the subtitle "Fourth Edition" is in a smaller black font below it. The cover has a white background with a black horizontal bar at the top.

Fourth Edition

clinics, related questions will become even more pressing and complex. The most apparent danger is when partnerships are developed solely on the basis of fiscal and clinical considerations, with discussions regarding some of the ethical issues and concerns either missing entirely or delayed until after the partnership has been developed.

Related to this, an important point in this section and throughout the *Directives* is the call for an effective dialogue between hospitals, physicians and the local diocese. Even though most Catholic hospitals are not directly sponsored by dioceses, the hospitals and their sponsoring congregations are asked to remember that "decisions that may lead to serious consequences for the identity or reputation of Catholic health care services, or entail the high risk of scandal, should be made in consultation with the diocesan bishop or his health care liaison."⁶ This is because, "any partnership that will affect the mission or religious and ethical identity of Catholic health care institutional services must respect church teaching and discipline."⁷ Having served as the bishop's liaison for health affairs in my diocese for more than 20 years, I can certainly attest that bishops take this mandate seriously and do not appreciate having learned about various developments or partnerships after the fact. Their need for en-

FINAL CONSIDERATIONS

Three final points are relevant to the challenge of educating physicians and other health care professionals about the *Ethical and Religious Directives for Catholic Health Care Services*.

1. Physicians come from various spiritual and religious backgrounds. The challenge is to help them grow in a fuller understanding and appreciation of the importance of the *Directives*. All physicians practicing in a Catholic institution are called to respect the tradition, moral principles and teachings of the church, while agreeing to abide by the *Directives* as they carry out their practice. This call is not to be viewed as imposing our religious beliefs on others, but rather as being faithful to our religious and spiritual identity.

2. Educating physicians about the *Directives* is a serious task. For instance, physicians should be given appropriate time to discuss the *Directives* during their orientation process. This involves more than handing a copy of the *Directives* to physicians and obtaining their signatures on a document stating they agree to abide by them. Rather, it is important to engage in dialogue, giving physicians the opportunity to ask questions and helping them form a greater understanding of the role *Directives* play.

3. Just as continuing medical education is part of

a physician's development, the need for continuing ethical education is also critical. New cases and situations arise that need to be evaluated and discussed.⁸ Take, for example, the 2007 statement by the Congregation for the Doctrine of the Faith on medically assisted nutrition and hydration and the patient in a persistent vegetative state. This definitive statement by the church is a prime example of a development of doctrine which has real and significant impact upon patient care. Integrating ethical dialogue and education into existing continuing medical education programming, and participation by bioethicists in various patient care conferences, are two ways that continual education of physicians can be achieved.

It is the duty of ethicists, mission leaders and others carrying the responsibility of explaining the *Directives* to help physicians embrace the document's richness and fullness. Ultimately, the care that physicians offer to patients should be fulfilled in accordance with the highest standards of medical excellence and a firm commitment to the essential moral and ethical principles of Catholic health care.

NOTES

1. Pope Benedict XVI, interview by Bayerische Rundfunk, Radio Vaticana, August 5, 2006, interview transcript and audio interview available online at www.radiovaticana.org.
2. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th Edition (Washington, D.C.: USCCB, July 2001), Preamble, www.usccb.org.
3. USCCB, General Introduction, para. 2.
4. USCCB, General Introduction, para. 10.
5. USCCB, Part One.
6. USCCB, Directive no. 67.
7. USCCB, Directive no. 68.
8. USCCB, General Introduction, para. 8.

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