SAFEGUARDING PATIENTS' DIGNITY

The Revised Directives Discuss Spiritual and Professional Considerations

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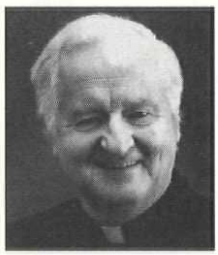

CHA and the Center for Health Care Ethics at the St. Louis University Health Sciences Center are collaborating to publish a series of articles on the Ethical and Religious Directives for Catholic Health Care Services. *This article is the third in the series, written by Sr. deBlois, CHA's senior associate for ethics, and Fr. O'Rourke, director of the Center for Health Care Ethics.*

Summary The Catholic health ministry recognizes that caring for the spiritual nature of a person is a high priority. The rights of patients and residents in their relationship with care givers are also important. These topics are treated in Parts 2 and 3, respectively, of the *Ethical and Religious Directives for Catholic Health Services*. This article focuses on those directives.

Directive 10 says pastoral care should be available to all persons in a Catholic healthcare facility, no matter their religious affiliation. Directives 12 to 20 are concerned with the reception of the sacraments of baptism, penance, anointing, and communion by Catholics. Directive 21 discusses the appointment of priests and deacons to the pastoral care staff.

Directive 23 reminds care givers that respect for human dignity must inform all Catholic healthcare. Directives 24 and 25 discuss norms for responding to advance directives and the responsibilities of surrogates. Directives 26 to 28 are concerned with free and informed consent on the part of patients and surrogates. Directives 29 to 30 say care givers have a moral obligation to preserve a patient's anatomical and functional integrity. Directive 31 discusses the ethical limits on medical research, and Directive 33 discusses therapeutic procedures likely to harm the patient.

Directive 34 says care givers must protect patients' privacy. Directive 36 discusses the care of women who have been raped, including treatment that would prevent ovulation as a result of the rape. Directive 37 says ethical consultation should be available to all Catholic facilities, usually through an ethics committee.

This, our third article in a series about the revised *Ethical and Religious Directives for Catholic Health Care Services (ERD)*, examines the principles underlying the spiritual care of patients and residents and the safeguarding of their rights. The article also discusses the particular directives involved.

PRINCIPLES

Catholic healthcare services are concerned with all dimensions of the human person: the physical, psychological, social, and spiritual.[1] For this reason, the Catholic health ministry recognizes that caring for the spiritual nature of the person is a high priority. Part 2 of the *ERD* discusses the spiritual or pastoral care of persons. The rights of patients and residents in their relationships with care givers are also important. These rights are treated in Part 3 of the directives. Because both parts seek to enumerate rights and activities which assist "those in need to experience their own dignity and value,"[2] we shall treat Parts 2 and 3 together in this article.

Although the documents of the Church enumerate four dimensions or functions of the human person, the four dimensions are united integrally in any one person. Every human act or event expresses all four dimensions. Eating, for example, primarily fulfills a physiological need and is associated with that dimension of personality. But eating affects the psychological function as well; no one wants to eat the same food at every meal, and good cooks present food in a visually attractive manner. Moreover, there is nothing like shared food and drink to help people develop social relationships. Finally, our spiritual dimension—especially our ability to think and love—is sustained by a healthy constitution, which is partly the result of eating well. Assisting people to integrate or balance the four dimensions of their personalities is one way of describing healthcare dedicated to the "whole person." This is the manner in which healthcare professionals strive to fulfill their mission: to help people "experience their own dignity and value."[3]

The unity of the human person should be a watchword for the Catholic health ministry. Care givers should never think that their sole responsibility is to provide spiritual care. However, care givers must realize that providing for the spiritual

needs of persons must have a priority equal to that of providing high-quality medical care.

Commentary on Directives in Part 2

As in our previous articles on the *ERD*, we shall assume that readers have access to the full text of the document and comment only on those directives that need further explanation or are difficult to apply.

Directive 10 Pastoral care should be available to all persons in Catholic healthcare facilities. In the introduction to Part 2, such care is described as follows: "Pastoral care encompasses the full range of spiritual services, including a listening presence, help in dealing with powerlessness, pain and alienation, and assistance in recognizing and responding to God's will with greater joy and peace." Because there is a wide range of such services, the directive addresses only a limited number of specific pastoral activities.

Clearly, Directive 10 mandates adequate pastoral care for all patients or residents of a Catholic healthcare facility, no matter their religious affiliation. In staffing a pastoral care department, organizations should consider the religious affiliations of persons in the community served. Directive 22 states that the non-Catholic members of the pastoral care team should be named in accord with the diocesan policy regarding such appointments. However, few dioceses have such a policy in place. In the absence of a policy, discussion with officials of other denominations are in order before ministers are appointed.

Directives 12 to 20 These directives are primarily concerned with the reception of the sacraments of baptism, penance, anointing, and communion by Catholics. The few exceptions to the norm that only Catholics may receive the sacraments, with the exception of baptism, are contained in Directive 20. Since Directives 12 to 20 are addressed mainly to priests and deacons representing the Catholic Church, and remind them of several points contained in canon law, it does not seem necessary to consider them explicitly in this commentary, addressed as it is to the general public associated with Catholic healthcare.

Directive 21 The appointment of priests and deacons to the pastoral care staff of a Catholic facility must have the explicit approval of the local bishop, but the administration of that facility is "to collaborate" in making the appointment. This procedure is reversed in appointing the director of the pastoral care staff: The administration of the facility makes the appointment "in consultation with the diocesan bishops." The director of pastoral care should be a Catholic (Directive 22); exceptions to this norm must be approved by the diocesan bishops. All personnel assigned to pastoral care teams should have appropriate professional preparation. More often than not, professional preparation will require training in Clinical Pastoral Education (CPE) programs. Over the years, through promotion of the National Association of Catholic Chaplains, many men and women have been prepared for the specialized ministry to the sick and dying by participation and accreditation in CPE.

Lay Catholics may also be appointed to the pastoral care staff to serve as extraordinary ministers of communion or to offer other services associated with pastoral care, provided they are properly prepared for this ministry (Directive 10).

Commentary on Directives in Part 3

The directives in this section treat a wide variety of topics, all of them having some relationship to the patient's experience of personal worth and dignity. Thus, although it treats issues of considerable importance, this section does not have the internal coherence of some of the other sections.

Directive 23 This directive contains a reminder that respect for the human dignity of the patient or resident is the fundamental norm which must inform all services offered by Catholic healthcare. Many Catholic organizations use processes such as total quality management and continuous quality improvement to ensure quality care for patients and residents. Although these programs may improve patient care, an organization's primary motive in employing them may be at times merely economic. However, recognizing the dignity of persons and treating them with dignity, no matter what their health problem or social status, requires a deeper kind of motivation. The compassion of Christ must permeate the motivation and activities of the Catholic healthcare organization, especially its efforts to improve quality care.

Directives 24 and 25 These directives consider norms for using advance directives, whether living will or durable power of attorney. According to the federal Patient Self- Determination Act,[4] persons entering healthcare facilities in the United States are to be asked whether they have an advance directive. If they do, it is to be placed in their medical charts and must be followed by physicians if the circumstances and conditions stipulated in the directive actually occur. If the advance directives are in conflict with Catholic teaching, then the patient or a surrogate must be notified that the directive will not be followed.

Federal law recognizes that Catholic institutions also have rights of conscience in these matters. One reason for not recognizing an advance directive is that it might request that physician-assisted suicide be performed in certain circumstances. Another reason for not recognizing an advance directive is that it might request futile care. Catholic healthcare services should explain the rationale for refusing to provide interventions which are deemed "medically futile." In addition, Catholic healthcare should provide patients and families with appropriate ethical criteria to be used in determining which life-sustaining interventions are morally required and which are optional.

> Christ's compassion must permeate a Catholic healthcare organization's activities.

Directive 25 The patient or the patient's surrogate (proxy) is primarily responsible for decision making in regard to the use or forgoing of life sustaining interventions. In making such decisions, the surrogate should be guided by medical data (i.e., the attending physician's diagnosis and prognosis) and Catholic moral principles (see Part 5 of the *ERD*). As the introduction to Part 3 states: "Neither the health professional nor the patient acts independently of the other; both participate in the healing process."

If the patient is incapable of making medical decisions, then a patient surrogate or proxy is called upon to make these decisions. A person may become a surrogate in one of several different ways. First, the person may be explicitly designated as surrogate in a legal document, such as an advance directive, or verbally before witnesses. If neither of these two methods has been utilized, then the person "in a position to know best the patient's wishes—usually family members or loved ones—should participate in treatment decisions" (Directive 25).

Legal and ethical articles devote much discussion to whether the surrogate should, when making a treatment decision for an incapacitated patient, use the "substitute judgment" standard or the "best interests" standard. Substitute judgment is a preference the patient expressed in the past, which the proxy is morally bound to implement in the present. Best interest decisions consider what treatment or lack of treatment would benefit the patient here and now, based upon his or her diagnosis and prognosis. Substitute judgment decisions should not be abstracted from statements or attitudes the patient expressed in the past. Best interest decisions seem more realistic, in that they address present circumstances more effectively. They imply an assumption of great moral responsibility by the proxy.

In fact, the distinction between substitute judgment and best interest is not all that important. Try though they may, people can accurately predict neither the illnesses that will befall them nor the medical measures they would then want applied. On the other hand, a surrogate who makes a medical decision truly in the patient's best interest will always try to understand the patient's goals.

Directives 26 to 28 These directives are concerned with the issue of free and informed consent on the part of the patient or surrogate. Fulfilling the ethical mandate of such consent requires information, understanding, and freedom on the part of the decision maker. Providing the information—and ensuring that the information is understood and the decision is made freely—is primarily the ethical (and legal) responsibility of the physicians performing the medical or surgical procedure. At times, the physician should seek the assistance of persons more adept at explaining the issues in non-technical language.

When discussing informed consent, many commentators posit the autonomy of the patient as the basis on which this principle should govern medical practice. But "autonomy" is often then interpreted to imply that the patient or surrogate need not consider the needs and rights of others when making a medical decision. In our time, for example, people make autonomous decisions concerning the use of therapy, even though these autonomous wishes result in futile therapy or violate the rights of others; sometimes such decisions are supported by the courts.[5] In the Catholic tradition, the basic reason for insisting on informed consent is the dignity of the person

before God. Exercising personal dignity through decisions of conscience implies that one considers the needs of others as well as one's own needs. The need to consider others is explicitly mentioned in Directives 32, 56, and 57.

Directives 29 and 30 These directives are concerned with the moral obligation to preserve bodily and functional integrity. In accord with the Catholic moral tradition, this integrity may be sacrificed to maintain the health or life of the person when no other morally permissible means is available. Functional integrity refers to the ability of the body to function in a healthy manner. Functional integrity is not exactly the same as anatomical integrity. Sometimes anatomical integrity may be sacrificed, as, for example, when one living person donates an organ to another. But functional integrity is not sacrificed in this case, because one kidney can perform the work of two. Though the transplantation of organs from one living person to another is morally permissible in proper circumstances (Directive 30), it should not be done for economic advantage. Sacrificing functional integrity to maintain life would occur if a person agreed to the amputation of a gangrenous leg in order to avoid endangering his or her life. Whenever diseased organs are removed, injuring bodily or functional integrity is justified by reason of the overall health of the body. To put it another way, parts of the body exist for the functional well-being of the whole body. They may never be removed unless the health or life of the body is in danger. To cause dysfunction of a part of the body when the integral health of the whole body is not in question is mutilation, as we shall see in Directive 53.

Directive 31 In the medical community, efforts to obtain new knowledge are referred to as "research." In Church documents, research carried out on human beings is usually called "experimentation."[6] This document uses the word "experimentation," but it would seem to speak more accurately to the American medical community if it used the word "research." For the American medical community, experimental procedures usually refer to unproven therapies, whereas research is said to test proven therapies as well as unproven ones.

At any rate, the directive requires free and informed consent for therapeutic or nontherapeutic experimentation. "Therapy" aims at healing a person and research aims at gaining new knowledge; and a medical procedure may have both goals. Thus therapeutic research aims at healing a person, as well as gaining new knowledge. Nontherapeutic research aims only at obtaining knowledge, usually for the benefit of persons not involved in the research project. Testing new forms of allergy medicine on persons with asthma would be therapeutic research, because it seeks to treat the asthma as it evaluates the new medication. Nontherapeutic research would occur if the same medication were tested on persons without asthma to determine if it caused a skin rash.

A competent person may give permission for therapeutic or nontherapeutic research even if serious risk is involved, if the procedure is justified by the hope of a proportionate benefit. However, though a surrogate may give consent for therapeutic research with serious risk for a ward, the surrogate may not expose the ward to "significant" risk if the research is nontherapeutic. "The greater the ward's incompetency and vulnerability, the greater the reasons must be for allowing any medical experimentation, especially nontherapeutic" (Directive 31).

Directive 33 This directive says: "The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side effects can be justified only by a proportionate benefit to the patient."

The directive is misleading unless considered in conjunction with Directive 29 because it justifies therapeutic interventions to provide for the "well-being" of a person without defining the meaning of "well-being." If one considers only the "well-being of the whole person," and not the bodily integrity of the person, then it seems that any therapeutic procedures can be justified "by a proportionate benefit" to the patient. Earlier in discussing the dimensions or functions of the human person, we distinguished between the physiological, psychological, social, and spiritual. If this directive were to be used without reference to others, it could be employed to justify mutilation of the body for "the well-being of the whole person." Indeed, this was the way a similar statement—Directive 6 in the 1971 edition of the *ERD*—was interpreted by those seeking to justify contraceptive sterilization.[7] Clearly, the "well-being of the human person" should not be abstracted from the well-being of the body, and the well-being of the body may not be sacrificed unless a pathological condition threatens the health or life of the body. Thus Directive 33 implies that social and spiritual well-being should be taken into account along with bodily well-

being when determining whether to use therapy, but that bodily well-being may not be sacrificed solely for social or spiritual objectives (Directive 29).

Directive 34 This directive says that healthcare professionals are responsible for protecting their patients' privacy and for maintaining confidentiality concerning medical and personal information about them. Given the easy access to patient information in most healthcare facilities, this directive is more difficult to observe than it may at first appear.

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Directive 36 Women who have been raped are often treated in emergency rooms of Catholic hospitals. They must be offered "psychological and spiritual support" and "accurate medical information." Moreover, "a female who has been raped should be able to defend herself against a potential conception resulting from the sexual assault." Hence, "if after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction or interference with the implantation of a fertilized ovum" (Directive 36).

No currently available tests can reveal that a woman has conceived as the result of a recent rape. Hence the notion of "appropriate testing" is meaningful only if there is some indication that the woman was already pregnant when she was raped. If this indication is not present, then testing for pregnancy would be unnecessary. From a moral point of view, the problem with preventing ovulation is that the same medication which prevents ovulation, sperm capacitation, and fertilization also makes it impossible for a fertilized ovum to implant in the womb. Thus, if it were certain or highly probable that conception had already occurred, medication which makes implantation impossible could not be used. But it is clearly difficult if not impossible to determine, shortly after a rape, whether conception has occurred.

Hence it seems the only time when anti-ovulation medicine could *not* be used to treat a rape victim would be immediately after the time she was sure that she had ovulated. If the woman had not ovulated, or if she were in doubt about the time of ovulation, it seems an anovulant medication could be used. Doubts about whether the woman had ovulated near the time of a rape could be decided in favor of the woman seeking to avoid conception by suppressing ovulation. In discussing the use of an anovulant medication, it is important to note that the doubt involved in the ethical analysis is primarily about ovulation, not about conception. Thus acting to suppress ovulation does not necessarily involve an intention to destroy a conceptus. The usual medication for preventing ovulation would be a contraceptive such as Ovral. This is not a "morning after" pill, because it does not induce an abortion and is effective in preventing ovulation only one or two days after it is used. Discussions with people involved in research on reproduction indicate that, in the near future, a medication will be developed that can prevent ovulation at any stage of the cycle.

On the whole, this statement concerning the medical treatment to avoid conception allows hospitals more options than they commonly had *in the past. Many Catholic hospitals would not* even treat rape victims. While some Catholic theologians have advocated the revised *ERD*'s approach to avoiding conception, others have vehemently opposed it. Although the discussion is far from over, Directive 36 seems to increase Catholic hospitals' ability to offer compassionate care to women who are the victims of rape.

Directive 37 The last directive in this section stipulates that ethical consultation should be available in every Catholic healthcare facility, usually through an ethics committee. The ethics committee should educate and offer consultations in accord with the Catholic moral tradition. But such committees should be encouraged to realize that their first obligation is to deepen their own understanding of the Catholic moral tradition.

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SAFEGUARDING

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The *ERD*'s norms are directed at the community's common good.

Some have questioned the right of ethics committees in Catholic facilities to follow the *ERD* for all patients in the facility, suggesting that there should be a separate committee for those patients who do not agree with some of the *ERD*'s restrictions.[8] However, as we explained in our commentary on the first part of the directives[9], the norms of the *ERD* are directed toward the common good of the community and are not applicable to members of the Catholic community alone. Though the directive says that particular dioceses will have "appropriate standards for medical ethics consultation," it seems unrealistic to expect every diocese to frame such standards. □

NOTES

1. "Bishops' Pastoral Letter on Health and Health Care," *Origins*, December 3, 1981, 1,A.
2. *ERD*, Introduction to Part 2.
3. *ERD*, Introduction to Part 2.
4. "Sources of Concern about the Patient Self-Determination Act," *NEJM*, December 5, 1991, p. 1666.
5. Daniel Callahan, "Medical Futility, Medical Necessity," *Hastings Center Report*, July-August, 1991, pp. 30-35; Gina Kolata, "Withholding Care from Patients: Who Decides?" *New York Times*, April 3, 1995.
6. Congregation for the Doctrine of the Faith, *Donum Vitae*, pp. 2, 22, 87; n. 28.
7. USCC Committee on Health Affairs, Clarification on Directives 6 and 20, March 15, 1973.
8. Eric Lowey, "Institutional Morality, Authority, and Ethics Committees," *Cambridge Quarterly on Health Care Ethics*, Vol. 3, 1994, pp. 578-584.
9. Jean deBlois and Kevin D. O'Rourke, "Introduducing the Revised Directives," *Health Progress*, April 1995.

DIVERSE TEAMS

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New decisions will be made on the foundation that was created.

cials had been shown how to conduct a candid evaluation.

EVALUATION

Over several decades Guam Memorial Hospital had developed from a small tuberculosis facility operated by the military into a general, acute care community hospital employing sophisticated technology. Its managerial practice had not kept pace with the technology and the changing healthcare environment. Developing leaders meant evaluating successes and failures and modifying approaches to achieve results.

Past failures occurred when advisers did not consider the local environment: political interference, natural disasters, and the island life-style. Since the hospital was a semiautonomous agency of the government of Guam, each turnover in governmental leaders brought new goals for running the hospital as well as a change in top hospital administrators and trustees. The typhoon season interrupts normal hospital operations because its entire staff is used to ready it for major storms. The island—isolated yet autonomous, self-reliant, and resilient—has a particular culture which affects learning, change, and decision making. These factors had to be considered in setting goals and expectations for an effective management development plan.

The team met frequently to assess progress and to informally brainstorm new and creative ways of developing and training managers. One approach that worked was jointly establishing goals with key hospital officials. We introduced the concept of planning, organizing the hospital's first planning retreat for managers, governing body, and medical staff. Since then, planning retreats have begun every annual planning and budgeting cycle. The hospital managers now prepare semiannual reports of their progress for the board of trustees and the governor of Guam.

OUTCOMES

Today Guam Memorial Hospital is a different place from what it was nearly five years ago. The building itself has undergone major reconstruction to conform to the current codes. Continuing political changes have helped delay accreditation by the JCAHO. But the managers are now familiar with the standards of JCAHO and HCFA and what must be done to achieve accreditation. A hospital-wide continuous quality improvement system is in place, with over three years of documentation. Developing motivated local leaders was the key to improvements in the hospital.

Were the goals of the team accomplished? In the long run, we can answer that only by assessing the future operation of the hospital. MIHS's stated goals were to set tasks, develop management, and build systems. Our unstated goals were much broader and more ambitious. Although we saw certain changes during our years at the hospital, change will continue to occur and new decisions will be made on the foundation that was created. The hospital's managers now know how to learn and how to solve their own problems. They may still need assistance, but they should be able to recognize that need and know where to turn to find help in solving future challenges.

In joining hands with this developing hospital, MIHS transcended the interests of the system, and thus acted on one of the values of Catholic healthcare. □

Those interested in Mr. White's experience on Guam may contact him at 804-282-8708.