

## REFLECTIONS ON THE ETHICIST'S ROLE

Four experts in Catholic health care ethics talk about their roles.

## Standing at the Crossroads

When I started my doctoral studies in theological ethics many years ago, a faculty advisor asked me how I would use my degree. I told him that I would like to serve in Catholic health care as what was then called a medical ethicist. After a moment of silence, an arched eyebrow and a lopsided smirk, he condescendingly replied, "Then you want to engage in *practical* theology?" Even as a graduate student I knew it was best to keep my retort to myself.

Time has shown that the discipline now more often called bioethics is at the nexus of Catholic theory and praxis, at the crossroads of health care and theology. And the ethicist stands precisely at that same juncture where the healthy meet the sick, the rich meet the poor, theology converses with medicine, compassionate care dialogues with public policy, and fear and doubt struggle with difficult decisions. Far from being the ugly step-sister of theology, bioethics is precisely where Pope John Paul II in *Redemptoris Missio* said faith should be — at the areopagus, a tribunal or gathering place, where the faith of the Gospel engages with culture and science.

The role of the ethicist has changed considerably during my years in Catholic health care. At first, clinicians asked ethicists to assist in resolving difficult and complex medical cases presented by the ever-expanding technological advances in modern medicine. This was ordinarily done through case reviews with members of ethics committees or ethical consult groups in hospitals, although some ethicists functioned as white-coated consultants, reviewing patient charts and logging recommendations therein. This ethical focus was immediate, individual and practical. Such decisions were fodder for ethical study, analysis and ultimately, for ethics education throughout the organization.

It was not long, however, before clinicians, administrators and ethicists realized that clinical decisions are never separate from organizational and business decisions. During this period, in the early 1990s, even the Joint Commission on

Accreditation of Healthcare Organization gradually shifted its ethical focus from "patient rights" to "organizational integrity," thus fostering a modification in the role of the ethicist and the committees he or she served. Organizational ethics committees, subcommittees or ad-hoc groups gathered to address a complexity of issues raised by the rapidly changing health care market, mergers and acquisitions, marketing, human resources and myriads of other challenges. The ethical focus for this type of discourse was more systemic, analytical and procedural. A common mistake was the misperception that somehow one could separate clinical and business ethical decision-making, not understanding that one invariably impacts the other.

As hospitals merged into systems, and systems joined forces with one another, linking hands across states, dioceses and even countries, Catholic health colleague Jack Glaser, S.T.D., who is the author of *Three Realms of Ethics*, gave voice to what many other ethicists were beginning to feel. He maintained that one cannot "do" Catholic ethics without taking into consideration its three realms — the individual or personal, the institutional or organizational, and ultimately, the societal realm. Catholic facilities, long the "safety net" hospitals in their communities, realized that individual cases affect the institutions, the communities and the societies in which we serve.

The societal role of the Catholic ethicist is still nascent. As this nation finally addresses health care reform, ethicists will engage not only with health care clinicians and administrative leaders, but also with civic and public policy leaders to articulate and advocate for the principles upon which such reform must be based.

From this admittedly brief review of one ethicist's experience, it is evident that health care ethics has changed considerably during the past quarter-century. And, one can state with certainty that changes will continue apace in the foreseeable future.

Some of my colleagues opine that Catholic health care is now moving into its third or even



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fourth generation of ethicists. The first generation were priest-theologians (Fathers Benedict Ashley, Edwin Healey, Gerald Kelly, Richard McCormick, Charles McFadden, Thomas O'Connell and Kevin O'Rourke, among others) usually working in academia and consulting and assisting Catholic health care. The second cohort — priests, religious and lay philosophers and theologians — work directly in facilities and systems today. The next generation, which is starting to make its mark, brings new energy, competence and commitment to the field.

Whenever a beginning theologian or philosopher asks me about becoming a bioethicist within Catholic health care, I suggest that he or she should study, evaluate and measure certain hallmarks first, to discern whether he or she is suited to Catholic health care. After all, the field of bioethics is exploding; jobs for an academically prepared ethicist are available in government agencies, drug companies, banks and businesses, colleges and universities, ethics centers and independent think tanks.

### NECESSARY PREREQUISITES

Some prerequisites are necessary for an individual hoping to enter the ministry of Catholic bioethics. First, the individual needs to be grounded in the church's moral teaching. Whether one is a philosopher or theologian, the bioethicist in a Catholic institution needs a respect for and facility with the language and history of the church's centuries-old bioethics tradition. Otherwise, how could one understand, teach and interpret the *Ethical and Religious Directives for Catholic Health Care Services*? How could one converse with church leaders, scientists, clinicians and business persons?

I am not speaking about an apologetic approach that simply parrots papal pronouncements. Such an approach would do a disservice to the church's long and rich tradition, and would ultimately prove too shallow to address today's medical/moral complexities. Furthermore, even an in-depth knowledge of moral manuals of the 19th and 20th centuries — absent a facility with the church's social teaching — would do little to adequately address Glaser's three realms of ethics or to lead an executive team through a robust corporate decision-making process.

A person desiring to enter the field of bioethics must be a lifelong learner, one who, to quote a

science colleague, is "addicted to the printed word." Scientific advances change almost daily, and ethicists need to keep abreast of recent literature in major medical journals, business journals, secular ethics literature and Catholic theological journals. This individual needs to be someone who can respond to a query with "I don't know, but I know how to find out." Learning will take place in medical units, at patients' bedsides, in board and consulting rooms and in libraries. The ethicist must also be a team player in order to achieve success.

Obviously, the individual should have expertise in ethical theory, analysis and teaching. Additionally, he or she will need to engage in ongoing ethical discourse, recognizing that everyone who is charged with the care of a patient — physician, nurse, nursing assistant, technician, dietitian, housekeeper and primarily patient and family members — shares a moral investment in the facility's commitment to be what the *Ethical and Religious Directives for Catholic Health Care Services* term a "community of care." Thus, although the ethicist will invariably spend more time with attending physicians or charge nurses, he or she must recognize that each caretaker has moral convictions that may need to be aired and must always be respected.

Finally, although this is not a comprehensive list of competencies, beginning ethicists within a Catholic facility need to be humble. We are not talking about Uriah Heep obsequiousness. Humility, in its Latin understanding, is being rooted or grounded in the earth. Administrators must expect someone who is prepared, competent and self-confident; a pedantic ethicist will be a failure.

Ultimately, standing at the crossroads of humanity, the ethicist will be edified at the earnestness and deliberation with which patients, their families and their caretakers address the difficult decisions they often face. He or she must put ego aside to listen — listen to patients, families, caretakers, listen to the church's teaching and listen to the demands of organizations and society.

Ethicists stand at a privileged intersection, where, with a sense of awe and amazement, one must say, in the words of the Second Eucharistic Prayer, "We thank you for counting us worthy to stand in your presence and serve you." ■