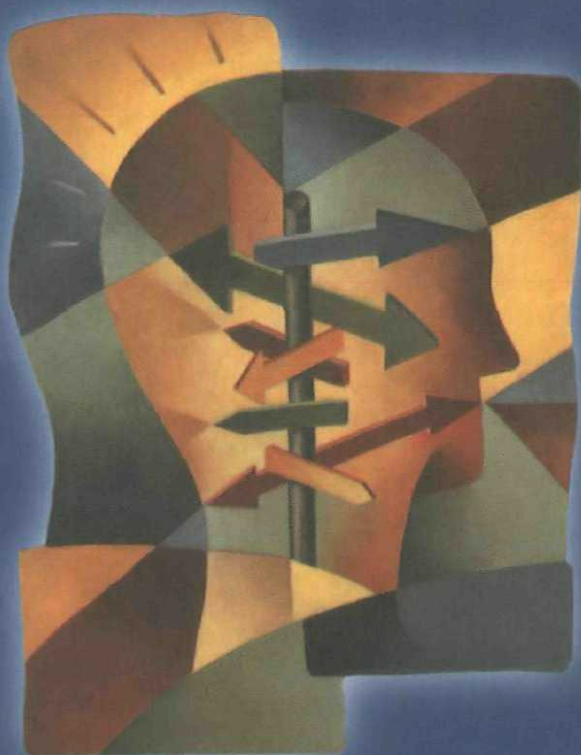


SPECIAL SECTION

# ETHICS *and* CATHOLIC HEALTH CARE



**ETHICS PERMEATES EVERY ASPECT** of health care. On the business side, decisions regarding mergers and sales, employee and community relations, and resource allocation and use—to name only a few of the issues—are all laden with serious ethical considerations. And when it comes to patients, the number of examples demonstrating the role ethics plays in care decisions is endless, many of them falling into categories of beginning- and end-of-life concerns, questions of fair and just access, and professional-patient relationships. For Catholic-based institutions, ethical considerations are further developed by a moral tradition that finds its vigor in the healing ministry of Jesus.

This *Health Progress* special section offers a sampling of what is going on today in the world of Catholic health care ethics. Whether expressing an approach for the health ministry's engagement of genomic advances, discussing institutional stewardship of scarce resources, or demonstrating the evolving role of ethics committees, each article will undoubtedly offer new insights to ministry leaders and caregivers. The central piece in this section, a question-and-answer session with ethicists and executives, reveals what is on the minds of some of those most concerned with ethics.

The timing of the special section is no accident. Following a successful ethics conference hosted jointly by CHA and Loyola University Chicago Stritch School of Medicine (see Ed Giganti's column, p. 10), the articles presented here, along with the knowledge they offer, may inspire readers to seek even more insight by attending the 89th Catholic Health Assembly, June 6-9, in Chicago. Titled "Ethics: Faith in Action for Service," this year's assembly promises to provide colleagues in the community of care an opportunity to learn, share, reflect, and be renewed.

See you there. —Scott McConnaha



# WHO CARES ABOUT ETHICS?

**E**thical considerations in health care are as varied as the many facets of health care itself. And as science and medicine evolve, ethics follows directly behind, making sure the right questions get asked. Some of the assorted, evolving foci of health care ethics can be seen in the next few pages. The five ethicists and executives involved represent a wide range of Catholic health care organizations. Their combined assessment of ethics—its role now and in the near future—makes one thing clear: Ethics is today an inseparable part of health care.

## ETHICISTS

*What one or two ethical issues have you or your organization spent the most time on over the past 12 months? Please explain.*

**Carol Bayley, PhD**, vice president, ethics/social justice education, Catholic Healthcare West (CHW), San Francisco: CHW has spent a good deal of the last 12 months improving our financial stability in order to be able to carry on with our mission of caring for people regardless of their ability to pay. We've acted as advocates for an adequate piece of the budget pie, in terms of hospital reimbursement, so that we can continue to serve people. We have overhauled our sys-

*Five Ethicists  
and Five  
Executives  
Discuss the  
Importance  
of Ethical  
Guidance in  
Catholic  
Health Care  
Today*

BY SCOTT A.  
McCONNAHA

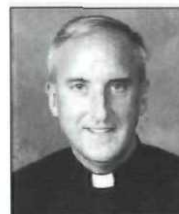


Bayley

tem of calculating and reporting community benefit and better tailored our charity care policies to current needs. In short, we've better situated ourselves to catch those who fall through the gaping holes in our national medical system.

The ethical issue here is the national medical system itself. It is designed to produce injustice—and it does that very well.

**Fr. Peter A. Clark, SJ, PhD**, assistant professor, Department of Theology, St. Joseph's University, and bioethicist, Mercy Health System, both in Philadelphia: One of the main ethical issues that have confronted the Mercy



Clark

Health System recently is the issue of futile treatment for patients who have no next of kin or durable power of attorney for health care. In the last few years, we have been confronted with more and more elderly and homeless patients who have no family or durable

power of attorney for health care and have medical conditions that require mechanical ventilation, artificial nutrition and hydration by percutaneous endoscopic gastrostomy, intravenous antibiotics, various cardiac medications, and other similar treatments. In many cases, these treatments are considered nonbeneficial by the medical staff and even medically futile. However, since there is no proxy decision maker, these patients are kept alive for weeks and even months when palliative care would be far more beneficial for them. Physicians will not withdraw treatment without some form of consent from a decision maker, for fear of litigation. The process of obtaining a legal guardian-



*Mr. McConaha is a communications specialist for the Catholic Health Association, St. Louis. The interviews from which the following remarks are taken were conducted in January and February 2004.*



ship in the city of Philadelphia is often a long and tedious process. As a result, in order to do what is best for the patient, and to be cognizant of our responsibility to be good stewards of scarce medical resources, our ethics committees are serving as proxies for these patients. This has afforded these patients the dignity and respect they deserve as human persons and serves as a check and balance on the medical staff. To date, this procedure has been very beneficial for all concerned.

**John A. (Jack) Gallagher, PhD, corporate director, ethics, Catholic Healthcare Partners, Cincinnati:** There are two issues that have assumed a significant amount of attention over the past year. The first is perhaps somewhat theo-



Gallagher

retical, but with very practical applications. In virtually all the presentations I have given recently—presentations that have addressed a wide range of clinical, organizational, and business issues—I have tried to stress the fact that ethics is about pursuing the good, about how the common good of a community might be maintained or enhanced. Too frequently, people assume that ethics is about the identification and classification of moral evil. Moral evil cannot be grappled with until one knows what the good is that is lacking. The payoff comes when it dawns on executives and clinicians that ethical reflection or discernment is not finished when one has reached moral certitude that one is not doing evil.

The second issue is work with an ongoing task force charged, in part, with preparing a philosophy statement on salary and compensation. The task force is looking to define how far above the poverty line the compensation of all our associates should be. The statement will also suggest to the corporate board that it is responsible for ensuring that equitable reasons exist for the gap between the lowest paid and highest paid in the organization.

**Jennifer (Jenny) Heyl, PhD, director, ethics, St. John's Mercy Health Care, St. Louis:** It is no surprise that beginning-of-life issues and end-of-life issues are those requiring the most time and attention from ethics. As a Catholic medical center with over 7,000 deliveries per year, a level III neonatal intensive care unit (NICU), and a group

**"Beginning-of-life issues and end-of-life issues are those requiring the most time and attention from ethics."**

—Jenny Heyl

of maternal fetal medicine specialists, St. John's Mercy treats a large number of women with high-risk pregnancies and babies requiring NICU intervention. Many of the high-risk mothers have serious co-morbidities. The ethical issues surrounding the attendant medical situations of these patients require a great deal of continued discussion with patients, families, physicians, and members of the health care team.



Heyl

These discussions include education on the *Ethical and Religious Directives for Catholic Health Care Services* and their application.

To adequately address end-of-life needs requires the coordination of many people from a myriad of disciplines. To that end, in the past year we have developed a palliative care program to be implemented this spring. Just one aspect of end-of-life care is illustrative of the time and energy required. Because our chaplains assist patients with advance directives, we often have an indication of what the patient's wishes are. However, this is not enough; in many ways the advance directive is an *invitation* to a continuing dialogue with the patient and family. In a large and complex medical organization this discussion is often interrupted. The need for continuity of care and effective communication with the patient and family members remains the greatest challenge in discerning how to best uphold the patient's wishes and minister to the needs of the family.

**Fr. John F. Tuohey, PhD, holder, Endowed Chair for Applied Health Care Ethics, Providence St. Vincent Medical Center, and director, Providence Center for Health Care Ethics, Portland, OR:** One key



Tuohey

issue we have struggled to address has to do with informed consent by parents of extremely preterm infants. Such decisions, for infants born between 22 and 25 weeks, are fraught not only with confusing and sometimes conflicting data and strong parental emotions, but also with what can be strong professional bias. Our concern has been that care plans are often shaped strongly by this professional bias. Our ethical questions were: Should we have a standard consent protocol that



ensures that parents are "consented" in as an objective manner as possible? and, if so, what form should this protocol take? After many meetings and intense debates, we now have a standard consent protocol to ensure that parents are being consented in an objective way. We plan to publish results of a patient satisfaction survey of this protocol in the near future.

**What do you see as one or two key ethical issues for which Catholic health care needs to become better prepared? Please explain your selections.**

**Bayley:** First, we need to see that even though we, as hospital organizations, are deeply embedded in a health care system that does not work very well, our tradition offers us rich conceptual tools (such as the common good, subsidiarity, participation by and respect for individual persons) for the reform of that system. One ethical challenge is how to incorporate these tools into the formation of leadership and management. We also have to figure out ways to encourage our leaders to call for reform of a system in which they have a stake. If we see ourselves simply as hospital organizations with a special flavor or unique history, we won't be brave enough to do it.

The second issue we need to prepare for is the transition from the infectious disease model of health care, in which hospitals are very important, to a genetic model of health care that stresses testing, probabilities, and prevention, in which hospitals are much less important.

**Fr. Clark:** The two key ethical issues in which Catholic health care needs to be better prepared are palliative care and pain management. One of the primary purposes of medicine in caring for the dying is to relieve pain and suffering. Patients, especially in Catholic hospitals, have an ethical right to have their pain and suffering, especially at the end of life, adequately assessed and managed as part of the basic dignity and respect that is accorded every human person. Often, physicians are not being truthful and realistic with their patients in regard to their terminal conditions. Hospice is being overlooked as a viable option; nonbeneficial treatments such as chemotherapy, radiation, and surgeries are being proposed and encouraged without patient comprehension of the effects; quality of life is being ignored; and

valuable assets such as pastoral care, social work, and ethics committees are underutilized.

If we, as Catholic hospitals, are going to respect the dignity of every patient, then we have to institute palliative care teams and pain management teams and better educate our medical staffs on end-of-life issues. Unless we take the needs of dying patients seriously and institute the needed reforms, more and more patients may actively seek the option of physician-assisted suicide. We can do better; we must do better.

**Gallagher:** There are any number of specific issues that could be identified, but for me the core and underlying issue pertains to how we define ourselves in relationship to the expectations of the communities we serve and those of contemporary American medicine. In an era of health care scarcity, do we need to acquire all the state-of-the-art equipment, costly pharmaceuticals, and boutique services? There is no answer to this question that will "fit" every Catholic health care facility. But how this question is resolved over time—that is, both the process and the outcome—will provide the self-identity, the character of Catholic health care in the future.

**Heyl:** The announcement in early February of the creation of a human embryo by cloning and the subsequent extraction of embryonic stem cells by a team of South Korean researchers will no doubt reignite the "therapeutic" versus "reproductive" cloning debate and the pending legislation on these issues. Most salient to Catholic health care will be the related issue of the use of embryonic stem cells. Even though Catholic facilities do not participate in research using embryonic stem cells—of either preexisting embryonic stem cell lines or embryos cloned to the blastocyst stage and then destroyed to harvest their embryonic stem cells—they must be prepared to address the moral permissibility of using therapies that may result from this research. More immediately, we must address our role at this time; in what ways can we effectively advocate the development of adult stem cell therapies (from sources such as bone marrow, peripheral blood, umbilical cord blood) that bypass the moral prohibitions of the destruction of embryos but also require more resources in time and money to develop?

**Fr. Tuohey:** It seems to me that—although this may be more of an issue here in Oregon than

"We need to  
prepare for the  
transition from  
the infectious  
disease model  
of care to a  
genetic  
model."

—Carol Bayley



elsewhere—Catholic health care is going to have to come to terms with the reality of rationing the care it provides amongst the poor. Certainly Catholic health care has a large charity commitment. We are finding, however, that as more people lose coverage, we are being challenged to question whether all the poor should be treated the same way, or if we should prioritize that care—and, if so, according to what criteria.

For example, we have a large population of Medicaid patients who are about to lose coverage due to state budget cuts. Do these people now fall into our charity care program, or does our preexisting therapeutic relationship impose on us an obligation to them that is prior to other vulnerable patients? In concrete terms, whereas charity emergency care may have us giving patients a limited supply of medications at discharge, do we ensure that those with whom we have a preexisting relationship have a continued drug benefit?

No one likes the idea of rationing care among the poor, but I do think we have to at least entertain the question: Is it just for Catholic health care to care differently for different groups of the poor and vulnerable by, as one criterion might be, honoring the different types of relationships we have with the poor?

**Why does ethics matter in the day-to-day running of a health care organization?**

**Bayley:** Ethics matters in the day-to-day running of health care because people depend on us at the most vulnerable times in their lives. *Caveat emptor* doesn't work in health care—people need to be able to trust that our values, which form the framework on which we make difficult decisions, are more than feel-good marketing fluff that we frame and post by the elevator. Patients, communities, and employees need to be confident that our values guide our individual behavior and organizational action. This is important for any company—that values guide decisions—but it is particularly crucial for organizations that seek to be the presence of God in people's lives.

**Fr. Clark:** Unfortunately, ethics and medicine are often seen as at odds with one another. In many instances it is the bioethicist who challenges the physician, and even the administration, to see other options. Is there an ethical responsibility to

**"Ethics,  
medicine, and  
administration  
need not be  
adversaries."**

—Fr. Peter Clark

be more explicit about the medical treatments available to the patient? Is it a matter of justice not to close the maternity unit in an inner-city hospital that has the reputation of giving excellent care to the poor among us? Do we need to be honest with the patient when we as an institution have made a medical mistake, even though it has not harmed the patient?

However, ethics, medicine, and administration need not be in an adversarial position. If they can work together for the best interest of the patient, it will only strengthen patient care and make the Catholic health system stronger and a leader in health care today. We have seen that the team approach works, whether it is a pain management team, the corporate team, or a team of surgeons. But for the team approach to work, ethics must be considered a valuable part of the team. When we can combine the talents and abilities of medicine, administration, and ethics, the result can only enhance the organization as a whole and allow us to serve those in need, "animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church."

**Gallagher:** Now you're asking the ethicist why there should be future employment in Catholic health care. We make very strong claims about ourselves. Albeit we formulate it in different ways, we speak about continuing the healing ministry of Jesus and the church. The values we embrace, a commitment to the poor, the enhancement of human dignity and the common good—these are bold claims easily challenged. Whatever we have accomplished to this point in the history of American Catholic health care, it is always at risk and open to the possibility of decline. Sponsors, board members, administrators, and staff share the responsibility of ensuring the success of the mission as an expression of the organization's value commitments. Ethics is the discipline within an organization that helps everyone keep his or her eye on the ball and to focus on the good that might be accomplished. Recall Peter Drucker's comment that the success of not-for-profit organizations is more difficult to measure than for profit ones. In the latter, success is easily measured in terms of return on investment and profit; the success of the former can be assessed only in terms of the fulfillment of its mission.

**Heyl:** Most human activities include a significant moral component; but I believe it can be argued



that the delivery of health care is, in itself, a moral endeavor. Given that understanding, ethics is integral to the day-to-day operations of any health care organization. In health care delivery we encounter individuals at their most vulnerable or in their greatest need; the imbalance in the relationship that results requires all the more from us. This is true for those who provide direct patient care as well as for those who work "behind the scenes." An approach of doing the right thing for the right reason should permeate the organization. As Catholic health care organizations, we have added motivation. Because of who we say we are (a Catholic ministry) and what we are called to do (carry on the healing ministry of Jesus), we should make sure that we direct our actions accordingly. This calls us to recognize and understand our identity and then demonstrate integrity by having the courage to live out who we say we are.

**Fr. Tuohey:** Whoever would have believed that clinical care could become so complicated? One could start by asking who should be a patient's decision-maker when the patient ends up, by default under state law, with the very person whom the patient has just removed as an agent by destroying her advance directive form? Then there is the patient for whom oral nourishment seems to be nothing more than tube feeding with a spoon. And there is always the patient whose verbal wishes were very clear when he or she was conscious, but whose appointed agent has other plans. Care decisions in the clinical setting can be very complicated. One reason for the importance of ethics is that it provides us with an objective way to organize complicated cases so that we ask the right questions, rightly consider the various and at times competing interests, and discern the most defensible care plan with an inner confidence that is not shaken even if everything turns out very badly.

## EXECUTIVES

*Which one or two ethical issues have you or your organization spent the most time on over the past 12 months? Please explain.*

**Chris Carney**, president and CEO, Bon Secours Health System, Marriottsville, MD: Two main areas in ethics have occupied us over the past year. The first area is structural, the second applied. We have spent much time and care

in engaging leaders and board members in organizational ethics education and discussion. Bon Secours is committed to executive ownership of



Carney

organizational ethics and a robust organizational ethics program. We believe that organizational ethics is the place in which our mission and values meet strategic and day-to-day decision making. Our leaders now have some tools to help them integrate the ministerial and business dimensions of their work.

One very practical application of organizational ethics has been in reviewing the composition of our ministry in the communities we serve. Over the past year, we have engaged in a careful review of each of our ministries, including community need, quality of care, and operational effectiveness. A holistic approach, using organizational ethics principles, was applied. This important project is aimed at creating and refining services in a way that improves our ministry and contributes to long-term organizational success with special focus on stewardship and capital allocation.

**John Finan, Jr.**, president and CEO, Franciscan Missionaries of Our Lady Health System, Baton Rouge, LA: We have focused our efforts on development of an integrated model of organizational ethics, in addition to



Finan

attention to specific issues. We recognize the ethical dimensions of every function and process within our sponsored organizations, and our team has completed a conceptual model to provide guidance in addressing ethics throughout our system. It is based upon an

integrated approach, defining organizational ethics as who we are and how we ought to act, encompassing dimensions of medical, business, and social ethics. It does this in consideration of the varied roles we have in the communities we serve—provider, employer, purchaser, citizen, and others. Additionally, a revised code of conduct, entitled *Principles of Organizational Ethics*, combines our moral commitments with legal and regulatory requirements. We have also continued our efforts to improve governance through specific goals based upon "best practices," updated our study of just treatment of employees, standard-

"Whoever  
would have  
believed that  
clinical care  
could  
become so  
complicated?"

—Fr. John Tuohey



## SPECIAL SECTION

ized our internal audit function to support performance improvement, and taken other specific steps to ensure alignment of our priorities, actions, and behaviors with our values.

**Rich Statuto, president and CEO, St. Joseph Health System (SJHS), Orange, CA:** St. Joseph Health System just completed the fourth



Statuto

year of a seven-year implementation plan to strengthen the quality of ethical decision making in clinical practice. Last year, we expanded and deepened preparation of the clinicians who serve on the Clinical Ethics Response Teams. We also established executive-supported conflict resolution groups in each hospital to provide administrative support for timely and ethically appropriate clinical decisions.

Our Human Resources Department continued our 10-year commitment to make SJHS advance to the kind of workplace envisioned in Catholic social teaching. Our efforts on the Nursing Center of Excellence were especially intense and rewarding.

**Lola (Lu) Westhoff, executive director, Nazareth Living Center, St. Louis:** One issue our organization spends a great deal of time on is residents' choice regarding their ability to eat



Westhoff

solid food or drink liquids. This frequently arises after the resident has had a spell of illness, is hospitalized, and returns to our campus with a feeding tube. The resident does not want the feeding tube and continues to have difficulty swallowing—or is not able to swallow—and is thus a high risk for aspiration, but wants to eat and drink.

The second issue is the increasing number of people who need access to a Medicaid-certified bed or financial assistance when a certified bed is not available. Our state has not increased our per diem for Medicaid skilled nursing care for more than five years. This results in our private pay population having an increased burden for subsidizing our Medicaid residents. The issue is our ability to continue to care for those in need of financial assistance at the same time that the Medicaid shortfall to cover the cost of care continues to increase.

**Sr. Laura Wolf, OSF, JD, president, Franciscan Sisters of Christian Charity HealthCare Ministry, Manitowoc, WI:** We had a situation at one of our markets that involved interpretation



Wolf

of the *Ethical and Religious Directives* in specific clinical situations. We spent significant time in consultation with physicians, administration, the diocese, and the local church on the policies in place and how to interpret the policies with the specific fact situation.

It was a delicate situation and one that was very time consuming. In the end all worked out well, but not without much delicate work.

**"An issue we spend a good deal of time on is residents' choice regarding their ability to eat solid food or drink liquids."**

*—Lu Westhoff*

***What do you see as one or two key ethical issues for which Catholic health care needs to become better prepared? Please explain your selections.***

**Carney:** Two ethical issues are front and center for Catholic health care: first, stewardship and allocation of resources, and, second, advocacy for access to care. Maintaining a community-responsive ministry means managing resources in a very disciplined way. We do not have the luxury of spending one dollar unwisely. Health care leaders need to evaluate the use of limited financial capital carefully in addressing both community need and ministry viability. This balance is not an easy one, and may require us to ask new and creative questions. Is it possible, for instance, to organize a system which is genuinely and intentionally interdependent? A system, that is, in which regional success is subordinated to the whole, and where each community contributes, as its gifts allow, to the life and health of the other?

The second challenge is to advocate, in a focused and unified way, national health care reform. The challenge for the Catholic health ministry is to assume a truly prophetic stance in view of the status quo. We need to partner not only with one another but also with socially responsible businesses and civic leaders for reform that is genuine and deep. The concept of solidarity comes to mind. We need to work together for the good of one another. Historically, we have been good at charity care, at providing services to those who cannot pay. We must also become



good at "justice care," at looking out for the deeper needs of those we serve, and of society.

**Finan:** Universal, dignified access to health care is obviously a critical issue. Despite our nation's incredible resources, we still have over 20 percent of our population without health insurance coverage. A recently published report called *The Value of Investment in Health Care*\* demonstrates the remarkable gains that our delivery system has accomplished: declines in disability rates, death rates, and days in hospital, while life expectancy has improved. However, reviews of utilization, cost, and quality data demonstrate additional opportunities to improve the efficiency of resources consumed. The lack of adequate health insurance for all results in disparities in care which are inconsistent with our values. Although the issues of access to insurance differ from those involving access to care, every individual should have access to basic coverage. Catholic health care has a long and creditable history of advocacy for the underserved. We must continue our tradition through CHA leadership in education and reform.

Selection, development, and retention of talented people who share our values constitute another important ethical issue. The Gospels call us to act as Jesus would, and it is through our behaviors that we demonstrate our moral agency. Choices continue to be more challenging and complex and to bear greater risks and rewards. We want to ensure that expectations are clear, structures and resources are supportive, and accountability for outcomes is present. CHA has always been, and can continue to be, a valuable resource in identifying and understanding approaches to formation and development of individuals who will lead the ministry in the future.

**Statuto:** Our executives and clinical leaders need improved support to help physicians abide by informed patient consent and surrogate decisions about forgoing life-sustaining treatment. Education about the *Ethical and Religious Directives* is necessary but not adequate. In fact, to simply educate and hope for improved outcomes is a futile strategy. The ethics of American rescue medicine still considers death

"Catholic  
healthcare can  
make a  
significant  
contribution to  
societal ethics  
through  
increased  
involvement in  
fundamental  
health care  
reform."

—Rich Statuto

as a failure of professional duty, a moral position denounced by the Vatican. We need to build systems into our quality structures that are conducive to supporting dying as the final stage of personal growth.

Catholic health care can make a significant contribution to societal ethics through its increased involvement in fundamental health care reform. Because our society has such underdeveloped language and other tools for the handling of societal ethics, Catholic social teachings and individual and corporate champions can contribute to the resolution of this grave social injustice. A bonus to us will be the fact that our theology itself can only grow and mature in its confrontation with such an enormous challenge.

**Westhoff:** As people continue to live longer with chronic conditions, and as their personal financial resources decline and the cost of their care grows, their need for subsidy in long-term care continues to increase as well. The issue for Catholic health care is balancing how we serve those in need, providing them with a purposeful and full life, and also maintain our financial viability so that we can continue to carry on Jesus' healing mission.

The second issue is medical treatment decisions. The tension comes from having to decide whether to treat or not treat the condition or spell of illness of an elderly, vulnerable resident. Frequently, adult children may have different expectations than their parent and feel they can make the decision without including the parent, although the parent is capable of making such a decision or at least has the capacity to participate in the decision. The issue frequently is that the resident does not want the treatment, but the children do.

**Sr. Laura:** I believe the issue of genomics and its application in daily clinical practice is going to be a key issue for the ministry in the near term. As the choices in medical practice get more numerous, the ethical issues will become more difficult. Whether it is cloning for stem cell research or selecting the sex of an unborn child, the issues will be difficult and demanding. We will need a good understanding of the science in order to understand the distinctions in data that arise, or the ramifications of positive or negative statements on issues. I think that the interface between the medical research community and the institutional church needs to be closer than it is today.

The second issue that will face us is providing

\*Medtap, *The Value of Investment in Health Care*, Bethesda, MD, no date, is available at [www.medtap.com/products/policy.cfm](http://www.medtap.com/products/policy.cfm).



health coverage for the uninsured. As the ranks of this group grow, the gulf between the haves and have-nots widens. I believe this disparity of access to needed health services challenges our whole moral system.

## **Why does ethics matter in the day-to-day running of a health care organization?**

**Carney:** Health care is not just another business. Our responsibilities are to serve the basic needs of people and to support the life and health of communities. The special nature of this commitment calls us to ethical reflection and decision making. This is especially true at a time in which health care is distressingly viewed as a commodity.

We have inherited an important legacy of care. It is not enough simply to make sure that our institutions continue. We must make sure that they continue with integrity. Looking to the sisters of our founding congregations, to their example of grassroots initiative and perseverance, is an important part of how we make sure the work goes on.

But ethics must also be forward-looking. Leading a health care organization today means balancing many, often competing, priorities. To do this well, we must be deliberate and values-driven. We must put structures into place that ensure formal ethics reflection by our leaders and integrate mission and values discussion in a practical way into all forms of decision making. Frank conversation, open communication, and disciplined action are all part of the ethics agenda. And although I think we are probably on the right path, I also know we have a long way to go.

**Finan:** Ethics aids our understanding of the moral order and directs our actions to be morally good; it also creates an obligation to do good and avoid evil or harm. Our first duty is to the benefit of the patient and our communities, while serving as good stewards of our resources. One of our system's senior executives reminds us that management is about doing things right and leadership is about doing the right things. It seems that the ethics of an organization that takes values and behaviors seriously is about both—doing the right things right. Our system's mission statement calls us to be a "healing and spiritual presence for each other and for the communities we serve." Service comes in all of those moments of truth—in each and every interaction

throughout each and every day. In those moments, we seek to experience the presence of Christ through the presence of our ethics.

**Statuto:** Ethics matters because dignity is the dearest name and deepest dimension of every issue we handle, every budget we develop, every strategic plan we hatch. Ethics presses us to dig down and find this dignity-substance that can easily hide beneath all the other names we give it.

**Westhoff:** Ethics matters in day-to-day operations because it makes us stop and think about the reasons for doing things and also about the potential outcomes. When we make decisions based on ethics, we take the time to reflect on our mission, values, and tradition. For our residents, ethics forces us to look at the situation from varying perspectives and provides us with the opportunity to be creative in how to meet the wishes of the individual and assist the family to accept the resident's decision. It also demonstrates to our staff that we care as an organization to listen to their concerns and help them to accept residents' choices.

From the organizational perspective ethics provides us with the framework for discerning how our business decisions can continue the healing mission of Jesus and support us in living our values. We are faced with increasing competition, with an increasing need for technology (though with limited financial resources for acquiring it), and with increasing opportunities to partner or network with others so as to enhance care and services, all of which will enable us to manage in a more complex business environment.

**Sr. Laura:** Christian ethics provides the basic structure of what we do in patient care and why. Each and every day, our colleagues demonstrate respect for the person, the value of life, and the importance of compassion in each and every contact with those we serve. In short, our ethics form the answer to the question: Why does Catholic health care exist? Our business ethics are equally important in our day-to-day activities, because they provide the consistent structure for decisions regarding the use of the resources, both human and financial, that are the tools used to carry out the mission. How we apportion those resources and how we steward them in service to others is essential to providing the healing touch of Jesus Christ in this modern world. Without our ethical system we would be like leaves in the wind. □

**"Health care  
is not just  
another  
business."**

—Chris Carney