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CATHOLIC HEALTH CARE ETHICS CONSULTATION: A COMMUNITY OF CARE

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Introduction

Health care ethics consultation within any Catholic health service, be it a large system, a hospital or long-term care facility or any of the myriad services offered outside these institutions, should be done within a community of care[1] (1, section 9). The ethicist cannot function like the Lone Ranger, zipping into a medical unit or board room, prepared to rattle off the philosophical or theological principles necessary to solve the problem at hand. Rather, an ethicist within a Catholic facility functions as part of the community, drawing the community together to reflect upon the rich ethical tradition of the Church, in order to apply it to the pressing and ever-changing complexities that comprise contemporary health care. I have functioned as a health care ethicist within two Catholic systems, and now serve with The Catholic Health Association of the United States (CHA).

CHA is neither an institution nor a system. As an association, it represents the combined strength of its members, more than 2,000 Catholic health care sponsors, systems, facilities and related organizations. It unites members to advance selected strategic issues that are best addressed collectively rather than as individual organizations. It strengthens the Church's healing ministry by advocating for a just health care system, convening leaders to share ideas and foster collaboration, and uniting the ministry voice on critical issues.[2]

As Vice President, Mission Services at CHA, and as a Catholic moral theologian and ethicist, I have been privileged to offer educational and consultative services to Catholic facilities throughout the country. These organizations vary from large tertiary and quaternary care facilities to community hospitals in inner cities or remote, rural areas. They comprise long-term care, hospice, homecare and clinics for the poor. Topics for consultation range from the usual "clinical suspects" like end-of-life

decisions and peri- and neo-natal issues, to organizational concerns regarding human resources, finance and budgeting, and contracting, among many others.

Educational and Work Background

When I entered religious life in the early 1960s I could not dream that one day I would serve as a health care ethicist. For one thing, "health care ethicist" was not then a distinct career. Furthermore, Catholic women, during that pre-Vatican II era were not permitted to apply for or attain a terminal degree in theology. So, the path to my current ministry was circuitous at best. In the course of my professional life I have taught at every level from grade three through graduate school. During the tumultuous seventies I served as vocation and formation director for my congregation. For the past sixteen years, I have ministered within Catholic health care as a moral theologian and ethicist.

The Sisters of Mercy, of which I am a proud member, are a congregation of religious women leaders within the Church serving in a wide variety of ministries. We are teachers, social workers, physicians, nurses, attorneys, advocates, theologians, philosophers, psychologists and even ethicists. From the time I entered religious life, my colleagues and I were immersed in an academic milieu that embraced Pope Pius XII's call to women religious to be as professionally prepared as others in their fields.[3] My undergraduate degree is in Humanities. I graduated with 159 credits, giving me enough courses for a second major in elementary education and educational certification for 99 years in the state of Pennsylvania. The humanities focus incorporated literature, history, philosophy, psychology, Latin and French. There was no such thing as a "capstone" course at that time. However, good professors and mentors assisted the integrative process, challenging me to expand my intellectual horizons.

As a religious, I have never considered myself "only" a teacher or professor. The spiritual and corporal works of mercy, foundational commitments for my congregation, drew me into hospitals, homes and even prisons to extend pastoral ministry to those in need. From 1968-1970, I was privileged to teach and minister in a small parish in the Pennsylvania anthracite coal region. While the people and the parish were mournfully short on financial and cultural resources, the pastor, Monsignor J. Francis Haley, brought a tremendous abundance to my life. He served as a friend, mentor and goad to deepen my spiritual life while, at the same time, expand my professional hopes and dreams. He shared with me every theological journal he received, eliciting from me not only ratification and response but

challenges and arguments as well.

In the post-Vatican II years of fervor, I began a Masters degree in Religious Studies at St. Charles Seminary in Philadelphia. Many of my professors had been doctoral students in Rome during the 1960s and had attended the Second Vatican Council as observers. Their enthusiasm brought fullness and nuance to my study of the documents of Vatican II. Most influential for me were the Constitution on the Church (*Lumen Gentium*), the Decree on Renewal of Religious Life (*Perfectae Caritatis*), and the Pastoral Constitution on the Church in the Modern World (*Gaudium et Spes*). Other realities drew me to a more focused study of moral theology. My ministerial work teaching teens during the school year and working with both Southern and urban poor during the summers, coupled with the study of the Church's social tradition, formed in me a commitment to work toward a more systemic influence upon my world. The war in Vietnam and the subsequent peace movement had a profound impact upon my bourgeoning moral consciousness. The fact that two of my brothers served in the United States Marine Corps (one in Vietnam), and a third brother registered as a conscientious objector made for some invigorating family conversations. I recognized firsthand that facile answers were insufficient for truly perplexing questions.

During my Masters' studies, I eagerly awaited each edition of the journal *Theological Studies*, particularly Richard McCormick's annual "Notes in Moral Theology"(2).[4] The United States Supreme Court's 1973 Roe v. Wade decision to legalize abortion galvanized my attention to medical decision-making and morality. The emotional furor it evoked heightened my understanding of the religious and moral pluralism within American culture and challenged me to articulate Catholic teaching in a way that could be both true to the abundance of our tradition and at the same time germane to my students. I continued to read Catholic moral theologians like Bernard Haring, John Dedek, Charles Curran, Benedict Ashley and Kevin O'Rourke as well as the newly published periodical, *The Hastings Center Report* (3; 4; 5; 6; 7). My interest caused me to ferret out more vintage Catholic medical ethicists like Gerald Kelley, Edwin Healey and Charles McFadden (8; 9; 10).

By the time I began full-time doctoral studies in moral theology at Marquette University in Milwaukee, I had a wide range of teaching, formation and pastoral experience behind me. Although I majored in theological ethics at Marquette, the curriculum compelled me to ground my studies in historical theology, particularly the foundations of the Catholic social teaching of the nineteenth and twentieth centuries. This concentration proved invaluable during my years as a system ethicist. By the mid-eighties, clinical ethics had moved beyond the argumentation surrounding the use of

ventilators and the Quinlan case to the still-challenged issue of tube feeding. I chose to dedicate my dissertation to the nexus between tube feeding decisions and Catholic teaching on life, suffering and death (11).

Not insignificant to my practice of ethics is the fact that in the ten years from the time I began doctoral studies my family experienced the deaths of two of my brothers (both in their thirties) and of my eleven-year-old nephew. I learned painfully that medical treatment decisions deeply affect not only the person who is sick, but his or her loved ones, caregivers and friends.

Institutional Commitments

Catholic health care institutions and providers have a long and rich tradition upon which to draw for inspiration and guidance in moral challenges and quandaries. We have sought to "minister in the spirit of Christ and in accord with the teachings of the church" (12). This history traces back at least to the 16th century when theologians began to address issues of medical treatment decisions (12). Today, Catholic health care providers have the rich guidance of the Church in the United States Conference of Catholic Bishops' (USCCB) *Ethical and Religious Directives for Catholic Health Care Services*.[5]

The Directives articulate key themes repeated throughout church teaching and grounded in the fact that we comprise a believing community. Among these are: the social responsibility health care services assume, the spiritual and pastoral responsibility integral to this ministry, and the (traditional) professional-patient relationship. It does not shy from addressing more neuralgic issues regarding care for persons at both the beginning and end of life. Recognizing the extraordinary change and complexity of today's American health care scene, the document also addresses the challenges Catholic sponsors and leaders may face when forming partnerships outside of the "traditional" Catholic models.

The bishops proffer normative principles to guide and inform the Church's healing ministry. Chief among these, they maintain, is the fact that Catholic health care must be rooted in "a commitment to promote and defend human dignity" (1, section 8). Primary among one's obligations to insure human dignity is the basic responsibility to respect the sacredness of every human life, from conception until death. But the call to foster human dignity likewise extends to the right to the means for the proper development of life and adequate health care for all persons.

Second, recognizing the biblical call to justice, and realizing the intimate connection between poverty and inadequate health care (most scandalously experienced in the midst of the breadth and technological sophistication of

US health care), the bishops urge Catholic facilities to commit to care for the poor in concrete action at all levels of health care. Not content with mere, albeit necessary, "band-aids" for the poor, they issue a clarion call to work for systemic justice for the poor, uninsured and underinsured.

Third, reiterating the message of the USCCB's 1986 pastoral, *Economic Justice for All*, the Directives call Catholic health services to build toward the common good, which it states occurs "when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals." If one contributes to the common good, then one must exercise responsible stewardship of health care resources, their fourth principle. Building upon the first normative principle, human dignity, the bishops realize that humans are created to be in relationship and that healing occurs best when people experience the good of communities of compassion. They thus speak in terms of equity of care and the good health of communities, calling health care leaders to dialogue with persons at all levels of society "in accordance with the principle of subsidiarity" (1, section 9).

Lastly, while recognizing that in the United States Catholic health care has always functioned within a pluralistic society, it must remain true to the moral teachings of the Church (13). Within the document, this charge is enfleshed by reminding facilities of their relationship with the local bishop. Directive # 37 urges that there be "appropriate standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop's pastoral responsibility."

Earlier editions of the Directives[6] addressed specific clinical concerns of physicians and nurses. The first iteration, shared with the health ministry in the 1920s, attempted to provide accessible guidance for both Catholics and non-Catholics serving in Catholic health care. The then Catholic Hospital Association (now The Catholic Health Association) published these editions in order to encourage Catholic hospitals throughout the country to act in a way that would be true to their faith tradition. The Directives, by their very nature, cannot capture the fullness of the Catholic tradition; however, they carefully set forth a framework upon which those working within Catholic health care can base their decisions.

By grounding the ethicist within a community of believers, the bishops' directives, and particularly the normative principles, serve as an antidote to the individualism that haunts American culture and presses our health care system to the breaking point. Principles of the common good and stewardship continually remind one that no moral decision, no matter how private, can be evaluated only in light of the single, autonomous moral agent

(14; 15).[7]

Ideal Role of Personal Commitments

How does an individual ethicist, who usually relates to more than one facility or service, begin to educate colleagues about the moral responsibilities they assume when working in Catholic health care? There are probably as many answers to that question as there are ethicists within Catholic health care. For this ethicist, the foundation of my ministry is grounded in the belief that I function within a true community of care and compassion. I do not see my role as either the Lone Ranger in a white hat (albeit working with Tonto), nor as a physician "wanna-be," arriving at the medical unit in a white coat to make decisions or even worse, to give "permission" for certain actions. Instead, I see my role as a listener and educator, who is pastorally sensitive to the reality that each organizational and clinical case presents.

Before explaining these approaches, let me first propose a metaphor for ethics consultation, one that I have used many times with residents and interns in teaching hospitals. The metaphor is that of a prism. When one is faced with either a clinical or organizational case study, certain steps can assist in the process of moral analysis.[8] One must gather the facts about this patient or case, assessing the relevant medical data, the patient's diagnosis, prognosis, and treatment options. One must also see the patient in a broader, wholistic sense, learning (as much as is possible in what may be a brief encounter) relevant information about his or her family, religious beliefs, culture, history, etc. One must listen to the patient, to his or her family, and to the various professionals entrusted with his care (which may include physicians, nurses, social workers, therapists, nutritionists, pastoral care personnel and others). One also listens to the voice of philosophical and theological principles to guide the decision. Each time one listens to a voice it is as if one turns the prism, seeking for light to shine through to give guidance. It is only when one has carefully turned the prism, allowing light to reflect through each of its facets, that one may be able to see most clearly the light to direct one's path.

A Narrative Approach

The ethical principles that one can utilize to address cases are not rocket science and are readily available in books, libraries and websites. For Catholic facilities ethical principles rest upon the dignity of the patient as an individual and as a member of a human community. One method of insuring

respect for another is by using a narrative approach to consultation. This method approaches each patient as an individual, realizing that he or she comes to the hospital, office or clinic with a particular sacred history that often has a profound effect upon his or her health and well-being. Patients often exercise their decision-making capacity, elicit information for informed consent, and share truths or withhold confidences depending upon these stories.

A narrative methodology should not surprise Christians. Jesus taught in parables, told stories to illustrate greater truths, and was able to elicit information from (at first) unwilling confidantes like the women at the well (John 4:4-29). Caregivers need to evoke, solicit and listen to patient's stories. One must listen always for the story beneath the story to reveal what is truly happening. A narrative approach demands that one be prepared to ask skillful and well-directed questions. Often the narrative must extend beyond the patient to the family's experience, or to the experience of the caregivers themselves.

A case study might be illustrative. Margaret[9] was a 94 year old nursing home resident who came to the ER for the third time in as many months with symptoms of congestive heart failure. She also suffered from high blood pressure, adult diabetes and senile dementia. A pulmonologist had treated her during her last hospitalization and suspected that she had pulmonary fibrosis. Margaret had filled out two separate advance directives (one for each state in which her children lived, believing that it might be possible she would become ill while visiting one of them). In the directives she had firmly stated that she wanted "no extraordinary means to prolong her life" including CPR, ventilator support or tube feeding. Margaret had three devoted, adult children – a son who was a physician, and a son and daughter, who were both attorneys. The daughter, who lived closest to Margaret's long term care facility, arrived at the ER demanding that "everything be done for my mother." She castigated the attending physician that theirs was a Catholic family and that the physician must preserve life at all costs. She further informed anyone who would listen that she and her brothers were prepared to "spend whatever it takes to obtain the best medical care possible" to restore their mother to health.

The attending physician, in consultation with a pulmonologist and cardiologist, maintained that designating Margaret a full code would bring her harm rather than benefit. Furthermore, they believed that it did not honor her bodily integrity or her human dignity. They argued that she had filled out two forms to assert her wishes and they were determined to respect her wishes. Margaret's daughter tried to trump the conversation with the comment, "I know every judge in this county and I will sue you and take

your license!"

It was into this hostile environment that the ethics consultation team arrived. (I was the ethicist, accompanied by a physician member of the ethics committee, the director of pastoral care, a social worker and the nurse manager on Margaret's unit.) The ethical principles at stake were clear. Primary among these was non-maleficence. Performing CPR on a weakened 94-year-old female would probably break her ribs, cause her greater discomfort and possibly hasten death. Margaret was now senile and unconscious due to medications, and there was the issue of her advance directives. If the patient is the primary locus of medical decision-making, how were we to address these very concrete evidences of her wishes? Furthermore, there was the care-givers' belief that the use of life-sustaining technology "must be judged in the light of the Christian meaning of life, suffering and death" (1, section 30). Margaret's daughter, on the other hand, was fiercely religious and insisted that the hospital must "do everything" to keep her mother alive.

Our first task was to get past the anger to learn about Margaret. Upon first meeting with the daughter and her rather taciturn brother, we extended our sympathy regarding their mother's repeated illnesses. We said, "We have only known Margaret through the emergency room and intensive care unit. We never knew her when she was well. Tell us about your mother. Tell us who she is, what gives her joy, what does she believe in, what has she achieved in life?" In the midst of not a few tears, they painted a picture of a well-informed, determined, energetic and loving woman. The pastoral care director then asked, "Tell us about the last time your family experienced a death." The daughter looked rather puzzled, so I suggested, "Your Mom is 94, and we assumed that your father has died." With a pained expression the daughter replied, "My father left us when I was 12 and my brothers were 6 and 8; she is the only parent we have ever known." Catching her breath she concluded, "I can't imagine life without her." Everyone in the room paused in silence and eventually the pastoral care director commented, "You are deeply dedicated to your Mom as she was to you. You obviously want what is best for her and so do we." The physician then carefully explained why the attending did not want to perform CPR on Margaret. In an honest sharing of information, and through attentive listening, the group finally came to the consensus that the hospital continue to treat Margaret's symptoms, making her "comfortable" without initiating "heroic" measures to prolong her life. Margaret lived for 4 more days. She died comfortably and surrounded by those who loved her.

A narrative approach cannot and does not solve every case dispute. What it does do is put the patient first, recognizing that the medical analysis has

meaning only in light of this particular person at this point in time. It also situates the individual within a context. The death of any individual, while vital to the patient and family, is only one chapter in the narrative of an entire lifetime. Decisions about dying must be seen in light of the human person, wholly and integrally considered. A narrative approach involves family and care-takers in a joint process of listening, questioning, and clarifying. Ethical principles are woven into the conversation to assist and direct the community that gathers to assess the case.

A narrative approach might be well suited to the clinical reality, but how can such an approach be adapted to complex and thorny organizational ethics issues? Take for example, the all-too familiar experience of hospitals and systems, constrained by inadequate reimbursement for services, who are forced to downsize? How does an organization arrive at such a decision? Who is involved in the process? How is it seen as part of the chronicle of this particular system? Is it possible to look at this process respectfully, seamlessly? As senior management gathers to grapple with such issues, the ethics consultant should be at the table asking clarifying questions. How does the downsizing fit into the story of this organization? How can we assure that the voices of those least-paid and least influential in the organization are heard (at least implicitly) and considered in this decision? A narrative approach to downsizing recognizes that every good story has a beginning, middle and end. The story is approached reverently, carefully listening for clues, warnings and conclusions. Economically-driven decisions have vast human implications. A narrative approach prepares the organization for the effect a downsizing will have not only on the "affected" employees but also on their colleagues who are lucky enough to "remain" in their jobs. It realizes that the story does not end on the day the pink slips are distributed but continues to ripple through the organization for weeks and months to come (16; 17).

An Educational Approach

Some ethicists are unable or choose not to gather a group for ethical analysis. Although I have spent the past sixteen years as an ethicist, I consider myself first and foremost a teacher. I believe that ethical decisions are best reached not from an ivory tower, but at the bedside, in the board room, on the unit. Therefore, the time it takes to involve a host of individuals in an ethics case consult is part of the ethics educative process. The more physicians, nurses, technicians and others are involved in this process, the better they understand the complexities of medical decision-making, and the more prepared they are to do what I call "preventive" ethics before dilemmas

become crises. Often it is the person closest to the bedside who can reflect with clarity and poignancy what a particular treatment costs a patient.

Because Catholic health care purports to be a compassionate community of service to the sick, employees at all levels within the organization share in the moral commitment to render respectful, ethical care to each patient. If it takes a village to raise a child, today it takes a town to care for the sick, especially those who are acutely ill. The ethicist must remember that everyone involved in the care of a patient has a stake in his or her care. Therefore, educational opportunities should be open to clinicians and ancillary staff alike.

Another case might best illustrate this point. Staff on a particular unit had cared for John for over three months. An elderly man in his early 80s, John had suffered from a stroke and was immediately placed on a ventilator. Mary, his wife of fifty-plus years begged the doctor to maintain him on life support until she was able to come to a "real" decision about his care. Although the attending physician communicated well with Mary and John's five children, they vacillated between hope for his recovery and despair that his treatment was causing him more discomfort. Finally, Mary realized that the repeated suctioning, medications and even the ventilator itself were not helping John to recover. She requested that the hospital cease all "extraordinary" treatment, but added the caveat that she would like to wait until Saturday when her youngest son could travel from the military base where he served. When the family had gathered, the pastoral care director joined them in prayer, and John later died peacefully in their arms.

The following Monday morning, the unit clerk asked the nurse manager where John was. The manager explained that he had died on Saturday, to which the clerk retorted, "You mean we killed him." Catholic facilities do not endorse or permit euthanasia nor assisted suicide, so the clerk's words were a red flag for the nurse manager. She deftly arranged a case review for all who worked on the unit to be held that day at the swing shift, so as many persons as possible could attend. When I walked into the room (with two other members of the ethics committee), I was heartened to see the ward clerk, housekeeper, nutritional service personnel, certified nurse assistants, along with nurses and therapists. Without divulging confidential information about John's family or case, we were able to review the decision-making process and ethical principles involved so that everyone understood clearly that John's family had requested the removal of "disproportionate means of preserving life" (1, section 31, Directive 57). Such a process takes time, but it respects and educates those committed to the care of patients.

Ethics education may take a broad range of forms within an organization. Certainly the formal opportunities for education found at medical staff

meetings, department meetings, instructional sessions for house staff or nurses, are all opportunities to raise consciousness about the ethical challenges health care givers face each day. The Catholic Health Association, keenly aware of the need for such education has recently published a toolkit for its members to instruct them regarding *The Ethical and Religious Directives*. The toolkit consists of a video, selected articles, bibliography, prayers and case studies to enable all those working within Catholic health care to better understand the Directives (19).

In my opinion, it is almost impossible to over-emphasize the importance of ethics education within health care institutions and systems. Because of the large turnover of personnel, one cannot assume that the physician, nurse, technician or executive whom one encounters necessarily understands the ethical import of a particular decision or action. This is not to say that persons are unethical, but rather, that in the hurried pace of today's health care, they often do not have the luxury of time to reflect and articulate their deeply held commitments or beliefs. While one should avoid being a pedant, a well-framed question, eliciting an explanation of meaning, motivation and principles, can heighten the ethical awareness of individuals and deepen the ethical integrity of the organizations in which they serve.

Discussion

I have chosen to emphasize two aspects of ethics consultation as I have lived them. The narrative approach to case consultation is certainly not the only approach, nor is it always the best one. A skilled ethicist can quickly assess when to apply this approach. It is also not the same as a mediation process, although the necessary skill sets overlap and the eventual case outcome may be similar (20).

The American Society for Bioethics and Humanities sets forth a lengthy list of "Core Competencies for Health Care Ethics Consultation (21). Even for someone who has worked in this area for a long time and in several venues, the list can seem daunting. I wholeheartedly support the effort to set clear, professional standards for anyone engaging in this vital health care work. In reading the comprehensive list of competencies, I take heart again that within Catholic health care we commit ourselves to care for the patient as a community. Similarly, in the educative process, I have learned again and again the sage line from *The King and I* that, "when you become a teacher, by your pupils you'll be taught." The ethicist comes to any consultation not as THE expert, but as one expert among many. Ethics is by its very nature an interdisciplinary science, forcing one to dialogue with and continually learn from physicians, nurses, attorneys, business experts, compliance officers and

a host of other experts.

For an ethicist functioning within a Catholic institution, it is vital that he or she be well-versed in the Church's moral tradition. This does not just mean that the ethicist can declaim the relevant citations or directives from the Catholic bishops, but that he or she has a firm grasp of the historical context in which the current moral teaching has developed. The Catholic Christian moral tradition is a living reality. There are not ready answers to every conundrum arising within the clinical or organizational reality. At any given time in history, a "particular formation is only more or less adequate."[10] The United States Catholic Conference of Bishops acknowledges that there are some medical ethical questions that "require further reflection" (1, section 30). Therefore, one who undertakes the privileged task of serving as ethicist within a Catholic system must continually engage in research, education and renewal. The homework never ends.

While an ethicist may render a personal opinion about a specific case, the Catholic health care service commits itself to act in accord with the Church. This fidelity is neither obsequious nor blind obedience. Because the Catholic tradition is a living one, health care administrators, physicians, scientists and others pledge themselves to be in respectful but candid dialogue with theologians, philosophers and bishops in order to respond with credibility, alacrity and moral authority to the innumerable situations that occur in providing health care services.

In the past ten years the number of ethicists at Catholic health care systems and hospitals has mushroomed. Forces like the Joint Committee on Accreditation of Health Care Organizations (JCAHO), by insisting that facilities have a "mechanism" to resolve ethical conflicts, have contributed to this growth, as have federal Corporate Compliance programs and federal offices like the Office for Protection from Research Risks and Office for Human Research Protection. The increasing complexity of medical technology likewise raises ethical challenges for patients, families and clinicians. Systems scrambled to hire qualified women and men to help steer through the turbulent seas of technology, managed care, diminished staffing and fiscal restraint. Most of these individuals began their work as clinical ethicists, assisting in emergency rooms and intensive care units. However, due to the complexity of health care systems, they soon began to address the less acute but no less challenging dilemmas in executive suites and boardrooms.

While there is a growing cadre of committed persons academically primed for this challenging career, academic preparedness alone is not sufficient. In ethics, it is not simply what one knows, but who one IS that insures

credibility, efficacy and endurance in the field. The ethicist must be knowledgeable, but if he or she is not also virtuous, they will do little to advance the ministry of the systems they purport to serve.

Today's health care ethicist stands at a bustling crossroad of humanity. It is a place where the healthy meet the sick, the educated teach those who are untutored, life gives way to death, science faces mystery, and doubt and despair seek faith and understanding. The discipline requires a strong academic and doctrinal foundation. But in my experience, ethicists are also involved in a ministry that is first and foremost relational. Not ivory tower philosophers or theologians, they have no choice but to work with people with a variety of needs. Daily they encounter people in crisis, persons who are extremely vulnerable, persons from a variety of cultural, ethnic and religious backgrounds. The ethicist is neither a medical insider nor an outsider, but often serves as a facilitator and negotiator, a listener and a guide.

To stand at this particular bustling intersection, to serve in this particular manner, is an unbounded privilege. I stand, like Moses in the wilderness, realizing that I must remove the sandals from my feet for the place upon which I am standing is holy ground (Exodus 3:8).

NOTES

[1] Directive # 1 states that Catholic health care is a "community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church."

[2] For further information see the CHA website, "About CHA," at: www.chausa.org .

[3] The Sister Formation Conference began in April, 1954 during the National Catholic Education Association's annual meeting in Chicago. Sister Mary Emil Penet, IHM, along with other members of a special NCEA committee, traveled throughout the United States to research the professional preparation of young religious for Church ministries. Their study found many inadequacies and galvanized religious superiors to radically alter and improve their religious formation programs.

[4] McCormick continued to write these *Notes* until 1984. McCormick's *Health and Medicine in the Catholic Tradition*, (New York: Crossroad, 1984) stepped back from the specifics of *Notes on Moral Theology*, to analyze Catholic medical ethics within a broader, ecumenical context. McCormick continued to be the foremost contributor to the field until his death in February, 2000.

[5] Other countries offer similar guidance. The Catholic Health Association of Canada has published its *Health Care Ethics Guide*, available on line at www.chac.ca. The contents of this resource parallel many of the same themes and issues as the United States Bishops. Similarly, Catholic Health Australia published its *Code of Ethical Standards for Catholic Health and Aged Care Services* in 2001.

[6] The historical development of the *Directives* is succinctly described in O'Rourke, Kopfensteiner and Hamel.

[7] The Catholic Health Association has raised the consciousness of its members in this regard through publishing its 1991, *Social Accountability Budget* and its 2001 *Community Benefit Program* as well as numerous articles in its periodical, *Health Progress*.

[8] There are many such models. See: The Catholic Health Association of Canada (www.chac.ca) on Ethical Reflection and Decision-Making.

[9] Not the patient's real name. This case, while true, represents a composite.

[10] Catholic Health Association of Canada. Website "Ethical Reflection and Decision-making."

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