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From the Director...

The festive season is upon us again. On behalf of all at the Center for Health Care Ethics I wish our readers a very peaceful and joyful Christmas.

We have now finished the Fall semester at the Center, so end of term essays are occupying the time of students and faculty alike. After another successful term we are looking forward to a restful and peaceful Christmas vacation. Then, in January, we will have a new member of faculty: Ana Illis, PhD, who recently graduated from Rice University, will join the tenure-track faculty at the Center. We extend a warm welcome to Ana and wish her every success as she settles at Saint Louis University.

As usual, this issue of *Health Care Ethics USA* has three essays. The first essay on organizational ethics is by myself, "Quality Improvement in Patient Safety: An Opportunity for Mission Leadership in Health Care." The essay suggests that mission leadership has an important opportunity to connect the individual autonomy among health personnel with professional teamwork to address the underlying causes of medical error. The second essay on foundational ethics, "God's Dominion and the Wrongness of Killing" is by Jill Burkemper, PhD, who is a member of the departmental faculty at the Center. Jill explains that attributing the prohibition of killing to the concept of God's dominion does not mean religious assumptions are necessary to support legal prohibitions of physician-assisted suicide. The third essay on organizational ethics, "Should Hospitals be Patriotic?" is by Griffin Trotter, MD, PhD, who is a member of the departmental faculty at the Center. Griffin argues that, despite potential pitfalls, patriotism can be valuable, especially when there is a mandate for terrorism preparedness. I hope you enjoy the essays and I look forward to receiving suggestions for topics that we might address in future issues.

Professor Gerard Magill, PhD
Executive Director & Department Chair
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This essay is the second part of an analysis of increasing concerns with medical error and patient safety that have elicited a great deal of attention over recent years. The goal of this essay is to suggest an opportunity for mission leadership that connects the sense of personal vulnerability and responsibility among individual health personnel with a commitment to professional teamwork in the quest for quality improvement in patient safety.

Principles

A common mission characteristic of Catholic health care is respect for the reciprocity between individual autonomy and the common good. This essay considers how this sort of reciprocity between health professionals, as (1) individuals focusing upon patient care and (2) team players seeking the common good of improving underlying systems of care, can ameliorate the pervasive problem of medical error. The opportunity to enhance this sort of reciprocity presents an important challenge for mission leadership in health care today.

The Institute of Medicine (IOM) has issued three major reports on medical error that have established patient safety as a national priority in the delivery of US health care. And these reports highlight the role of systems failures, rather than individual carelessness, as the main cause of medical errors. In light of these reports, mission leadership in health care has an important opportunity to assist health professionals to better connect their individual vulnerability and responsibility with professional teamwork that improves underlying systems in the delivery of care.

The first IOM report, *To Err is Human*, highlighted the serious reality of medical error in health care today and emphasized the need to focus upon systems as the main cause of medical error. The second IOM report, *Crossing the Quality Chasm*, focused upon the lack of coordination in health care that prevents the provision of so many medical interventions already recognized and established as benefiting patients. The third IOM report, *Leadership by Example*, considers the opportunity for urgent improvement in the nation's health care safety and quality of care. The new report studies quality enhancement processes for about one third of Americans in six different government programs: Medicare (40 million), Medicaid (42.3 million), the State Children's Health Insurance Program (4.6 million), the Department of Defense (8.4 million), the Veterans Health Administration program (4 million), and the Indian Health Services program (1.4 million). The report invites the Government in its federal programs to establish better quality standards in clinical data reporting requirements and in purchasing standards to reward and foster higher levels of quality. Moreover, the report encourages the development of 21st century health care delivery models and the expansion of applied health services research to support quality enhancement.

The fundamental tenet of these three IOM reports is the urgent need for improvement as we encounter the nation's health care safety and quality of care. These reports emphasize that delivery systems rather than individual professionals are the primary cause of problems about patient safety. Hence, there is an obvious need to better integrate the autonomy of individual health personnel with their commitment to professional teamwork in the shared quest of improving systems and quality in the delivery of care.

Discussion

Recently, the *New England Journal of Medicine* initiated a helpful series of essays to discuss patient safety from multiple perspectives. The series includes essays on medical errors that can arise from fatigue among clinicians, infection control, dealing with adverse events, and the role of information technology, etc. The authors recognize two important steps that have led to the current focus upon
medical error and patient safety: first, that the theory of latent errors in the work of James Reason helped clarify the need to focus less upon mistakes by individuals and more upon deficiencies in systems etc. as providing the conditions for individual error; and second, that the publicity elicited from high profile medical errors in the 1990s in the United States added fuel to the fire.

A recent essay in this series in the *New England Journal of Medicine* emphasizes how views of physicians and the public differ on medical error, especially when dealing with reporting errors. In the survey, 831 physicians and 1207 members of the public responded, and 35% of the physicians and 42% of the public reported errors in either their own care or a family member’s care. Yet, 86% of the physicians consider that medical errors in hospitals should remain confidential, while, not surprisingly, 62% of the public claim information on such errors should be released. The underlying and understandable concern among physicians to retain confidentiality is both to enhance openness among colleagues and to minimize the threat of public humiliation and lawsuits if errors are released. In fact, the IOM reports suggest that only remediating the underlying systems (such as improving quality standards in clinical data reporting requirements, as mentioned previously) will effectively accomplish these goals of enhancing professional openness and diminishing professional shame for medical errors. A recent editorial in the *New York Times* excoriated physicians in this report for their "retrograde attitudes" – the editorial argued emphatically that, "Reform can succeed only if the medical profession gets behind changes that expert groups and plain common sense suggest could significantly reduce harm caused by medical errors."

Basically, the chasm between where health professionals are just now and where they need to be requires a bridge to connect the current emphasis upon individual autonomy and a new focus upon the common good. Another essay in the series on patient safety in the *New England Journal of Medicine*, makes a similar point: "As a profession, we are busy, averse to conflict, and oriented toward individual autonomy more than toward organizational effectiveness." The conclusion of this essay is that a balanced approach to medical error requires a focus upon teamwork collaboration for quality improvement of patient care. And it is this teamwork collaboration that needs to be fostered as a function of mission leadership in US health care today.

**Conclusion**

In this environment of medical error where so much trust has been lost between patients and health professionals, mission leadership has an important role to play in fostering the cause of patient safety. Akin to the reciprocity between individual autonomy and the common good that characterizes the mission of Catholic health care, mission leadership can help to bridge autonomy among health personnel with professional teamwork to improve systems in the delivery of health care. On the one hand, mission leadership can help individuals to understand a legitimate sense of vulnerability and responsibility that reflects their own finitude and limitations as health professionals. On the other hand, mission leadership can foster a commitment to professional teamwork that diligently addresses the underlying system causes of medical error in the pursuit of organizational effectiveness. And cumulatively, such mission leadership will enhance patient safety by constructively connecting the old focus upon professional autonomy with a new, teamwork emphasis upon the common good seeking continuous quality improvement to enhance patient safety and care.

Professor Gerard Magill, PhD, Executive Director & Department Chair, Center for Health Care Ethics

1. See, Gerard Magill, "Medical Error and Patient Safety," in the previous issue of *Health Care Ethics USA*.
2. Institute of Medicine, Committee on Quality of Health Care in America, *To Err is Human: Building a Safer Health System* (Washington, D.C: National Academy Press, 2000); Institute of Medicine, Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A
Questions For Discussion

1. What contribution can mission leadership make to bridging individual autonomy among health personnel and professional teamwork to address the underlying causes of medical error?

2. What are the underlying causes of medical error in the Institute of Medicine Reports on quality care and patient safety?

Suggested Readings

Institute of Medicine, Committee on Quality of Health Care in America, To Err is Human: Building a Safer Health System (Washington, D.C: National Academy Press, 2000).

Institute of Medicine, Committee on Quality of Health Care in America, Crossing the Quality Chasm: A New Health System for the 21st Century (Washington, D.C: National Academy Press, 2001).


"God’s Dominion" and the Wrongness of Killing

In November 2001 U.S. Attorney General John Ashcroft attempted by means of a federal statute, the Controlled Substances Act, to give federal drug agents the right to take action against doctors in Oregon (or any state) who assist terminally ill patients to commit suicide by means of drugs covered under the act. Such physicians would lose their licenses to prescribe federally controlled drugs. In April 2002 a federal judge in Portland, Oregon blocked this attempt, though the issue is not yet settled as the Justice Department filed its appeal at the end of September 2002 with the 9th circuit.

Attorney General Ashcroft, following the Drug Enforcement Administration, argues that assisting in suicide by means of controlled substances should be punished under the Controlled Substances Act because suicide is not a “legitimate medical purpose.” This raises the question of what makes something a legitimate purpose of medicine. No one will contest that it is legitimate for medicine to promote goods such as health and alleviation from pain—goods fairly essential to human flourishing. But why should medicine not also help persons to terminate their lives in a painless way when they, in accordance with what they believe is important, wish to do so?

A quick answer is that it is simply wrong to intend the death of innocent human beings. There is an absolute moral prohibition against it, such that it is wrong even when done in secret and even when the consequences appear at first glance welcome. This prohibition against killing, strongly embraced by Catholic health care, is often assumed in discussions that draw moral distinctions between cases of killing and cases of letting die and in discussions that employ the principle of double effect. For example, the act of providing palliative medicine that may hasten the death of a patient can be justified in certain cases essentially because there is no intent to bring about the patient’s death. Many, however, are not convinced that there is an absolute moral prohibition against intending the death of innocent persons (including the death of oneself), especially if persons make an autonomous decision to die. Thus, seeing no adequate reason to oppose physician-assisted suicide (PAS), proponents of PAS accuse opponents of failing to be adequately concerned about the self-determination of patients or the suffering they are made to endure. As some proponents of PAS put it, failing to provide the option of PAS to certain patients subjects them to "a prolonged or delayed death that only adds a period of extended pointless suffering while denying an individual control over his or her final days."¹ They propose that many opponents of PAS are at bottom vitalists, committed to the idea that the value of life trumps all other considerations, and that thus we ought to do everything possible to preserve human life. Such a position has been labeled "vitalism."

The Ethical and Religious Directives for Catholic Health Care Services, while opposing PAS and euthanasia, clearly reject vitalism. The directives state, "The duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome."² Proponents of PAS, however, may well wonder: If it is justifiable for patients to decide to refuse life-saving treatment in light of the great burdens they may have to endure, why should it not also be justifiable for patients to directly terminate their lives. What precisely is wrong with intending death?

**Principles**

Some argue that intending the death of persons is wrong because, since it intends the end of a person’s existence, it denies the dignity of a person (i.e., the intrinsic worth a person has in virtue of being a person).³ This argument weakens considerably once we consider hope in life after death. Why should assistance in suicide necessarily be an attack on the worth of a human person if the soul lives after death, and, as Christians believe, is eventually reunited with the person’s resurrected body?

Even without invoking the concept of life after death, it is hard to see how helping to hasten death necessarily goes against the worth of human persons. Persons who euthanize their pets by no means
imply that their pets have no worth. Rather it is precisely because they recognize the worth of their pets that they help them escape suffering through euthanasia. The motivation is similar with regard to euthanizing persons (beings with a much more significant worth than that of non-human animals). It is with respect to the great worth of persons, and what they deserve in virtue of that worth, that euthanasia and PAS are seen by many as a legitimate manner of ending a life, and are often referred to as "death with dignity." (Though "dignity" in this context does not directly refer to the intrinsic worth of persons, it connotes conditions that are appropriate to the dignity of persons.)

Immanuel Kant provides another dignity-based argument against intending the death of human persons. The argument is that because moral agency is a key font of human dignity, termination of one’s own or another’s life is morally prohibited because such termination eradicates all opportunities to exercise moral agency. Kant makes a good point in calling to our attention that even in great hardship persons continue to have the marvelous capacity to exercise moral agency. In spite of severe physical handicaps persons have been able to offer morally excellent responses. Nevertheless, this argument against terminating human life has a weakness in that we can imagine cases of patients whose rational capacities are so handicapped that it is meaningless to refer to opportunities to exercise their capacity to respond to their circumstances morally well. Kant himself recognizes this weakness in his argument against suicide. He discusses the case of a person bitten by a mad dog, soon to lose opportunities to act rationally, and suggests that in such cases suicide would be justifiable.

A stronger reason for holding that there is an absolute prohibition against killing innocent human life is the assumption that to intend the death of innocent human beings lies beyond human dominion. (The assumption is often expressed by the phrase "the sanctity of life," implying that one commits a sacrilege in certain manners of treating life.) On this assumption, regardless of however beneficial it could be to help persons escape the burdensome conditions of their lives, we simply have no right to bring about the death of innocent persons. The principle at stake is what could be called "the dominion principle." The idea is that respect for God’s dominion, or acceptance of our creaturely status, entails that we allow certain events to occur naturally. To directly cause these events goes beyond our rights as creatures.

Discussion

It is no wonder that the dominion principle is largely hidden from secular debate, for it requires a religious perspective to determine which events are those with which creatures are forbidden to meddle. Not only does it require belief in God, but very particular religious assumptions about the illegitimacy of interfering with certain natural processes. Without these assumptions, certain religious arguments against euthanasia and suicide fail to make evident that these acts are wrong, such as the argument that these acts are wrong because our lives are a God-given gift of which we are to be good stewards. Persons could assume that good stewardship implies acting responsibly to ensure that death occurs before one succumbs to certain debilitating conditions. Why should one not use one’s resources responsibly to discern and bring about the right timing and right manner of one’s death—to ensure, as some say, that one does not spoil the book of one’s life by a bad ending?

Thus, it is not simply that life is a gift that elucidates the wrongness of euthanasia and suicide. The wrongness of these acts rests upon the additional idea that we have no right to do away with this gift—the idea that we are not meant to take responsibility for our deaths, for this responsibility is reserved to God. The Catechism of the Catholic Church makes this claim in stating, "We are obliged to accept life gratefully and preserve it for [God’s] honor and the salvation of souls . . . [Life] is not ours to dispose of." Scripture also makes this claim in the command, "You shall not kill." Is then the prohibition against killing innocent human life simply to be understood as a God-given prohibition? According to one ethical approach, Divine Command ethics, actions forbidden by God, such as "You shall not kill," are morally wrong simply because God forbids them. The Roman Catholic approach, in contrast, tries to show how the commands of God help to foster our well-being and are reasonable (though perhaps finding them reasonable requires "reason enlightened by Divine Revelation and by faith"). While attention to human nature and well-being is not sufficient to make evident certain moral prohibitions, we can yet find ways that respecting these prohibitions harmonize with our well-being. Addressing the special dominion that God has over human life, John Paul II writes, "Man is not the master of life, nor is he the master of death. In life and in death, he has to entrust himself completely to the ‘good pleasure of the Most High’, to his loving plan." The "loving plan" of
God—a plan (it is assumed) that would not allow for us to linger on meaninglessly—makes awaiting a natural death (even when many factors make this waiting seem inadequate to human dignity) a good for us.

Conclusion

In claiming that the concept of God’s dominion is significant in supporting an absolute moral prohibition against killing innocent human beings, I am not claiming that we need to appeal to religious assumptions in order sufficiently to support a *legal* prohibition against PAS. As one ethicist well argues, legalizing PAS promotes the idea that some lives are not worth living, and the negative effect that promoting this idea can have on citizens (significantly harming their freedom), is a sufficient reason not to make PAS an option endorsed by the state.

This being the case, it nonetheless remains worthwhile to explore the foundations of an absolute moral prohibition against intending the death of innocent persons. The four widely accepted principles of bioethics—beneficence, nonmaleficence, autonomy and justice—clearly are not sufficient (taken in their purely secular meanings) to make evident that these acts are wrong. Claims about God’s dominion appear to be necessary, and religious thinkers ought to strive to show the reasonableness of such claims if they are to help persons grasp the wrongness of euthanasia and suicide.

Questions For Discussion

1. How helpful is the notion of dignity in arguing against physician-assisted suicide and euthanasia?
2. Are religious notions necessary to argue
   a. for a legal prohibition against physician-assisted suicide and euthanasia?
   b. for an absolute moral prohibition against physician-assisted suicide and euthanasia?
3. Besides prohibitions against physician-assisted suicide and euthanasia, are there other absolute moral prohibitions in health care that rest upon ideas about God’s dominion?
Should Hospitals be Patriotic?

When Henry Clay died in 1852, America fell gloomy mourning one of its greatest orators and statesmen. In Springfield, Illinois, Abraham Lincoln delivered the eulogy and quoted the following from one of Clay’s political opponents.

Who can realize that freedom’s champion -- the champion of the civilized world, and of all tongues and kindreds of people, has indeed fallen!… His career has been national -- his fame has filled the earth -- his memory will endure to ‘the last syllable of recorded time.’

Alas, Americans are not known for their long memories. It is a mere one hundred and fifty years after Clay’s death and syllables are zooming across the globe at record speed. But hardly anyone remembers Henry Clay. According to a recent survey of America’s top universities, Americans don’t remember James Madison either (less than 23% can identify him as the “father of the Constitution”) and most recall almost nothing about the careers of Abraham Lincoln and George Washington. As memories fade, so do collective ideals, patriotism, and the sense of our country as a genuine community.

But our memories were activated on September 11, 2001. And so far they remain in service. In this essay, I discuss the links between memory, community, and patriotism, and inquire about patriotic duties of hospitals arising in the War on Terrorism. Despite pitfalls and limitations, I hold that hospitals ought to be patriotic.

Principles

America’s great idealist philosopher Josiah Royce describes community in the following terms:

Now when many contemporary and distinct individual selves so interpret, each his own personal life, that each says of an individual past or of a determinate future event or deed: "That belongs to my life"; "That occurred, or will occur, to me," then these many selves may be defined as hereby constituting… a community. They may be said to constitute a community with reference to that particular past or future event…

Because of our collective emotional and intellectual involvement with the 9/11 tragedies, Royce would say that the United States has once again become a "community of memory." Whether we hail from New York, Saint Louis, or Walla Walla, each of us has been affected by these events. They belong to our lives.

One result is that patriotism is again a part of our national landscape. Patriotism is a characteristic of persons and communities who regard their nation as a moral community worthy of service and sacrifice. Patriots honor and cultivate national memories, and they are loyal to national ideals. This is not to say that the patriot will be un-critical, or that she will not strive at times to revise, re-interpret or resuscitate the collective morality. To the contrary, constructive criticism is a duty of patriots and the only way to keep national ideals vital. Patriotism devoid of the critical spirit is a form of what Royce called "degenerate loyalty," where the ideal is taken as a static dogma championed by a moral elite.

Patriotism is often regarded with suspicion because of fear that it will devolve to one of its degenerate forms -- jingoism. Like any degenerate loyalty, jingoism results from an uncritical, chauvinistic assertion of the primary community (the polis in this case), over and against other communities and their interests. Degenerate loyalties derive from an inability to see humanity as sharing a common, or at least overlapping, moral destiny.

Discussion
Assuming that hospital mission statements can be taken at face value, the typical American hospital can be regarded as a kind of moral community, defined by its members’ commitments to determinate future events such as the amelioration of patients’ suffering and the prevention of untimely deaths. As such, patriotism is a possible predicate of hospitals. Insofar as hospitals exhibit loyalty to the polis, they are patriotic. But should they be?

In the aftermath of the 9/11 attacks, hospitals are being asked to shoulder an increasing burden in preparations for terrorism. Hospitals have been co-opted by public health authorities in the construction of advanced bioterrorism surveillance systems. Hospitals have also been directed by local, state and federal authorities to enhance their readiness for decontaminating chemical, biological and nuclear casualties, and for providing emergency triage, stabilization and definitive care in disaster contexts.

There are many reasons for cooperating with these (largely un-funded) government mandates. They are linked, for instance, to JCAHO certification, which is linked in turn to Medicare reimbursement. Disaster preparation can also be a good marketing ploy (and conspicuous disaster failure a public relations black eye). But, putting these motives aside, is it a patriotic duty of hospitals to prepare for terrorist attacks? Should hospitals cultivate patriotism in their own ranks by aligning their mission with the memory of 9/11 and with other memories that define the United States as a kind of community? Or is disaster preparedness an entirely generic, non-political response to the mandate for healing?

There are several reasons for favoring the latter interpretation. First and foremost is the concern that patriotic rhetoric could degenerate into jingoism, or a kind of pro-American elitism. This would detract from the unqualified nature of hospitals’ response to human suffering and place non-Americans (or Americans with the wrong ethnic backgrounds) at risk. Second, a sense of patriotism or civic duty could dilute the independent self-image of hospitals and healers, and could diminish their focus on medicine’s primary task: healing actions. Third, a sense of patriotism could overwhelm the critical impulse and hence stifle the constructive, dialectical interplay between hospitals and political bodies. Hospitals, at their best, are not government agents. They serve patients.

No patriotic response could succeed without attention to these possible pitfalls. Nevertheless, it should be possible to cultivate patriotism while avoiding them. If government is truly "of the people, for the people," as Lincoln maintained, then dualism between serving patients and serving the polis is false. Indeed, clinicians serve the polis primarily by serving patients. Sometimes patient advocacy will elicit disagreements about public policy. Such disagreements are an expression of patriotism, not its opposite. Nor does patriotism require ethnic distinctions or selectivity in the response to human suffering. To the contrary, a great virtue of patriotism in healthcare is that it could be a strong humanitarian motive.

Conclusion

Patriotism is valuable because: (1) it mobilizes our moral energies by inspiring loyalty, (2) it fortifies the connection between healthcare providers and the communities they serve, and (3) in its non-degenerate forms it contributes to the cultivation of a larger, all-inclusive community of humanity. Hospitals should respond patriotically to the mandate for terrorism preparedness. Presumably this response would involve efforts to honor the victims and the rescuers who labored and died on September 11th, to cultivate a community of memory, and to cooperate energetically in designing and implementing consequence management strategies. Healthy patriotism does not beget simple acquiescence to government orders. Hospitals are justified, for instance, in calling government to task for its meager financial support of hospital disaster preparedness measures. So regarded, a patriotic hospital with patriotic clinicians is an asset not only for the country, but for the freedom and health of all people.

Griffin Trotter, MD, PhD

Questions for Discussion

1. We have discussed the role of patriotism in hospitals' disaster preparedness response. Does the patriotism of hospitals also pertain in other contexts, such as charity care, healthcare reform and coordination of services with competitors? If so, how?
2. Is there a role for civil disobedience in the repertoire of the patriotic hospital? What are the precipitants that would justify acts of civil disobedience? How should hospitals react when employees engage in civil disobedience?