From the editor...

- Shark Fins or Dolphin Leaps? A Reflection on Ethical Leadership in Catholic Health Care.
- Honoring Experience in Moral Discourse
- Requests for Inappropriate Treatment: Can A Doctor "Just Say 'No'"?

More information on how to subscribe to Health Care Ethics USA.

Review the Health Care Ethics USA Index of Past Publications.
From the editor...

There has been a substantial expansion of the Catholic Health Ethics Partnership (CHEP) that publishes the electronic journal (ejournal) *Health Care Ethics USA*. The ejournal will continue to use the year and number identifiers in continuity with the original format. As editor of the ejournal, I welcome our new health system members. The journal is designed to assist ethics committee members and other health professionals in Catholic health care. And the electronic format is adopted to facilitate easy and widespread distribution of the ejournal across different health systems. Moreover, there is a new format for the ejournal, including essays of just 1000 words (previously they were considerably longer) with a brief executive summary - the new format is designed to make it easier for busy health professionals to find time for the essays.

The original version of each issue of *Health Care Ethics USA* is archived online for CHEP members who have online access to the current and all of the previous issues at: [http://chce.slu.edu/chep.html](http://chce.slu.edu/chep.html). After connecting to "log in to the current issue", the User Name is, hceusa (lower case only), and the Password is, 2005.

This new format for *Health Care Ethics USA* contains three essays. The first essay is by Gerard Magill, PhD (editor of the ejournal), who is Executive Director & Department Chair of the Center for Health Care Ethics at Saint Louis University. His essay provides an exhortative reflection rather than a scholarly analysis; the title is, "Shark Fins or Dolphin Leaps? A Reflection on Ethical Leadership in Catholic Health Care." The second essay is co-authored by Mark Repenshek, PhD, who is the health care ethicist at Columbia St. Mary's in Milwaukee, Wisconsin and by David Belde, PhD, who is the Director of Ethics at the Center for Ethics in Healthcare at Saint Joseph's Health System in Atlanta, Georgia. Their essay discusses "Honoring Experience in Moral Discourse" in Catholic health care. The final essay is by Ann Suziedelis, PhD who is the Director of Mission Services at St. Joseph Mercy Oakland Hospital, Pontiac, Michigan. Her essay discusses "Requests for Inappropriate Treatment: Can A Doctor Just Say 'No'?"

I hope you enjoy the essays and I look forward to receiving suggestions for topics that we might address in future issues. For ejournal email, please contact: hceusa@slu.edu.

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Shark Fins or Dolphin Leaps?
A Reflection on Ethical Leadership in Catholic Health Care.
Gerard Magill, PhD

Executive Summary. The essay provides an exhortative reflection on ethical leadership by considering two ocean metaphors: the menacing circling of shark fins or the joyful progression of dolphin leaps. To ascertain which metaphor better describes our ethical leadership (with dismay or delight accordingly), there are three unusual ethical stances that can help.

Introduction: Shark Fins or Dolphin Leaps.

This essay offers a personal, exhortative reflection (rather than a scholarly analysis) on ethical leadership in Catholic health care. When addressing this topic all too often we consider the complicated details of organizational effectiveness etc. This essay stands back from such details to discuss three unusual ethical stances in the hope of providing a refreshing, albeit somewhat novel, inspiration for professional integrity.

This essay's title, "Shark Fins or Dolphin Leaps" seeks to present a simple challenge for ethical leadership in the competitive environment of health care today. Are we the sort of leaders who can be compared metaphorically with sharks. Do we grow (metaphorically) shark fins on our backs as we leave our families or communities each morning, so that by the time we arrive at work we are ready to begin aggressive encounters with patients and staff in menacing circles, feeding an insatiable appetite for power or profit, whatever the cost to hapless victims caught in the shark-like jaws of competitive business realities? [Apologies, of course, to sharks for this dreadful reputation that has been thrust upon them! We mean these creatures no harm, and wish them oceans of joy, as they swim God's beautiful creation the world over]. Or, to use another ocean metaphor, are we the sort of leaders who can be compared metaphorically with dolphins. Do we provide (metaphorically) direction and hope in our professional lives, mindful of the joyful progression of dolphin leaps, as in the ancient stories of dolphins leading lost mariners to safety?

To help clarify which metaphor better describes the ethical leadership that we provide (with dismay or delight accordingly), there are three somewhat unusual ethical stances that can help us chose between the shark and the dolphin to shape our professional profiles.

The ethical stance of welcoming others.

First, there is the ethical stance of welcoming others. Health care delivery needs to be extraordinarily sensitive to an almost endless variety of different cultures (from diverse ethnic communities to varying lifestyle options). By fostering personal sensitivity to different cultures in our workplaces, we welcome others by displaying our empathy and respect for their dignity. Catholic health care believes that we are made in the image of God: if that religious belief has practical meaning, surely it is to recognize the giftedness of different cultures and to celebrate their diversity. Respecting human dignity in the rainbow of cultural diversity is a matter of both recognition and commitment: first, recognition, by seeing individuals in their own context as people worthy of respect; second, commitment, by implementing that respect in our daily dealings with them. Interestingly, that recognition and commitment in religious settings can be compared with the virtue of faith: that is, recognition of the presence of God in the world, and commitment in God's name to the many actions that we pursue and the types of professionals that we become.

The ethical stance of pursuing success responsibly.

Second, there is the ethical stance of pursuing success responsibly. This ethical stance encourages us to combine our various proficiencies in leadership and management expertise in order to facilitate
dolphin like leaps that will provide astute direction and inspiring hope. In our professional lives we are undoubtedly committed to success, and so we all glory immensely in hope. Such hope can inspire us to aim high, to plan well, and to flourish. But for hope to be healthy it must be honest and realistic. For example, there is little sense in starting an expensive new enterprise in health care, hoping to fund it with a dream of winning the lottery. To ensure that hope is a reliable friend rather than an elusive dream, it must keep our feet firmly placed in what can be described as honest practicality: honing our personal expectations and dreams with hard-nosed realities of fairness and justice, of robust competition, of quality improvement, of performance enhancement, and of professional productivity. In religious settings, this sense of honest practicality can be compared with the virtue of hope: vigorously anticipating a better future in God's name and working tenaciously to begin its realization now, thereby honoring eternal life within our present world realities.

The ethical stance of joyful living.

Third, there is the ethical stance of joyful living. This ethical stance enables us to provide deep meaning to the ordinary tasks that we undertake in our professional lives. The point here is that we should embrace joyful living by celebrating our own personal values, religious or otherwise, in a manner that enables us to transform what we do in the workplace. The image of the famed British sherry trifle comes to mind here, where the sherry utterly transforms the flavor of the pudding - and what joy in the eating! By letting our personal values (just like the sherry in the trifle) imbue our professional life, we can profoundly transform its meaning, perhaps from mundane routine, to a celebration of joyful living. And in religious settings, this "joie de vivre" can be compared with the virtue of love: love of self, love of others, and love of God, each enhancing the other in the celebration of life and grace, imbuing our souls and those around us with the generous spirit of God.

Conclusion

As we ascertain whether our ethical leadership is metaphorically more like the menacing circling of shark fins or the joyful progression of dolphin leaps, there are three ethical stances that can assist us: the ethical stance of welcoming others, the ethical stance of pursuing success responsibly, and the ethical stance of joyful living. And if these ethical stances call to mind the great cardinal virtues of faith, hope, and love, then we can have ocean-deep confidence in them.

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This essay was presented as the invited plenary address during a forum on professional integrity at Saint Louis University on August 12, 2005.
Honoring Experience in Moral Discourse
Mark Repenshek, PhD
David Belde, PhD

Executive Summary. This essay seeks to address the role of human experience in moral discourse. The authors propose that it is precisely through incorporating a collective experience of what it means to be human in moral discourse that we come to understand the relevance of moral norms in ethical decision-making. We conclude by offering a number of recommendations for ethics committees and hospital administrators.

Ethics education - whether in our hospitals or in our communities - is a core element of our work as healthcare ethicists. In the midst of meeting this professional obligation we have witnessed a polarizing dichotomy: on-the-one-hand, a move away from a search for the right and the good in ethical decision-making toward a procedural account of conflict resolution and, on-the-other-hand, an expressed level of clarity on complex ethical issues nearing absolute certitude. Our concern is not the dichotomy per se (i.e., we do not suggest the dichotomy is a new development), but rather the degree to which the polarity so influences the tenor of our moral discourse that it seems the relevance of human experience for ethical decision-making is becoming increasingly limited.

We have witnessed this dynamic most evidently in the wake of the Terri Schiavo case in the context of invitations to speak on the moral obligations concerning the use of life-sustaining treatments. One of the problematic effects of this kind of dynamic is that it tends to undermine a significant source of moral wisdom, human experience. While there is no doubt that the combination of controversial issues (e.g., withholding or withdrawing life-sustaining treatment) and strongly held opinions (e.g., that removing life-sustaining treatments from critically ill patients is, in every instance, morally akin to murder) can and often does create the conditions for heated moral discourse, this does not suggest that such issues and opinions should silence the lived experience that has informed the moral points of view of others.

The appeal to moral norms and the Catholic moral tradition is important for moral justification because the norms grow out of an understanding of the collective experience of what it means to be human. As our norms continue to emerge from a collective human experience, the Catholic moral tradition continues to promote those norms that build up and promote the dignity of human life. In other words, "all this means that our moral theology [and our moral discourse] must pay close attention to what our experience, past and present, is telling us about what it means to be human." This understanding of honoring experience in moral dialogue has important implications for the intersection between Catholic moral teaching and current bioethical issues. First, this understanding implies that moral teaching does not separate the development of moral norms from the experience of values constitutive of human flourishing. This requires a profound sense of humility in our moral discourse and formulations of moral norms insofar as one recognizes that his or her knowledge of these values is by no means exhaustive. In other words, as one continues to seek meaning in these values, the collective experience of others may add moral nuance and complexity not yet considered in an individual's formulation of the norm.

Second, the idea of a collective experience recognizes the dignity and value of each person's involvement in the understanding of truth. This is not to suggest relative parity of each person's contribution; rather, it is to suggest that each person contributes to his or her own level of competence, respectful of differences in authority, expertise and responsibility. This understanding of a collective experience notes the mutual sharing in the teaching-learning process toward the fuller grasp of truth. Richard McCormick highlights this point noting,
Through many initiatives of Vatican II (and the theology that led to and formed it), we now are more aware than ever that one of the richest and most indispensable sources of moral knowledge is human experience and reflection. To be ignorant of it or to neglect it is to doom moral theology to irrelevance and triviality.\(^8\)

Echoed in the teachings of Vatican II, for instance:

She [the Church] must rely on those who live in the world, are versed in different institutions and specialties, and grasp their innermost significance in the eyes of both believers and unbelievers. With the help of the Holy Spirit, it is the task of the entire People of God, especially pastors and theologians, to hear, distinguish, and interpret the many voices of our age, and to judge them in light of the divine Word.\(^9\)

Third, the idea of honoring experience in moral dialogue implies an inductive method that is respectful of the concrete and the historical. This does not preclude the role of deductive reasoning in moral discourse, but it does suggest Catholic moral teaching in the arena of bioethics is reluctant to draw conclusions independently of the complexities of human experience. To draw such conclusions to the exclusion of human experience, for example in the application of the *Ethical and Religious Directives for Catholic Health Care Services*, would be contrary to the American Bishop's understanding that "the Church cannot furnish a ready answer to every moral dilemma, [but rather provides the ERDs]â€¦as normative guidance and direction."\(^10\)

Although this essay may seem to be exclusively concerned with methodological issues in moral discourse, its practical implication is extremely relevant for ethics committees attempting to fulfill one of their central tasks, namely education of itself and others. For this reason, we recommend a three-step process that can give human experience its just place in ethics education in the Catholic context.

First, ethics education is best begun with a descriptive case study that examines an ethical problem from an experiential standpoint. This accomplishes the important task of illuminating the moral points of view within a group as a whole. Invariably, diversity of moral points of view will emerge. This diversity is important for ethics education, for it lends credence to the view that human experience, which informs one's moral point of view, is a vital source of moral wisdom. Therefore, a diversity of moral viewpoints is not only healthy for ethics education, it is to be expected.

Second - and this often happens naturally without much prodding from the group facilitator - it is important that participants are given a chance to share their experience. Moreover, it is vital that this occur without the fear of moral judgment. In sharing one's experience, a collective sense of moral wisdom can emerge. Others who have seen or understood a controversial issue one way can begin to see it in another light.

Third, and this is especially important in the Catholic context, it is insightful to examine the meaning of one's lived experience in the light of Catholic tradition on the matter at hand. This is crucial because human experience is not a flight of individual or collective moral fancy. Its insights have been incorporated into Catholic moral teaching. Therefore, it is an important moral exercise to understand how and to what extent human experience informs Catholic moral teaching.

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Suggested Readings


3. Gula highlights this concern noting that we may not grasp the whole of reality through any one experience, or express it in any one formulation, see: Richard Gula, *What Are They Saying About Moral Norms?* (New York: Paulist Press, 1982).


Requests for Inappropriate Treatment: Can A Doctor "Just Say 'No'"?
Ann Suziedelis, PhD

Executive Summary. This essay examines (1) the underlying philosophical considerations when patients or decision makers request "inappropriate treatment"; (2) questions to consider in determining if the treatment sought would be ineffective, or, in the words of Weijer et al., effective toward a controversial end; and (3) practical ways to resolve such conflicts.

In the 1980s, Nancy Reagan invoked the nation to "Just say 'no'." Practicing medicine in the 21st Century would be far simpler if doctors could simply take her advice when responding to requests for inappropriate treatment. Alas, they cannot. Instead, the reason for the request must be discerned, and a discussion must take place about why the physician and the patient or decision maker disagree. Like the requests themselves, such conversations are a relatively new phenomenon.

Before the 1970s, it was accepted that doctors practiced medicine paternalistically: the doctor knew best. There were relatively few treatment choices to consider. Since then, however, the stunningly rapid development of medical technology and the ascendance of the bioethical principle of autonomy, have changed the dynamics of the patient/physician relationship in regard to treatment choice. While now clearly and appropriately stated in law and ethics that a competent patient has the right to be fully informed, and to consent to or refuse treatment, somewhere along the way some patients have assumed a right not only to accept or refuse offered treatment, but to demand from medical professionals whatever treatment they desire. They seem to consider doctors and other health care professionals as skilled contractors, paid to do as they are told.

This phenomenon is facilitated by the fact that physicians are no longer the only source of medical information. Today's patients arrive at the doctor's office or the hospital already well-versed about products they have learned about on television, through advertisements, or at the "Google School of Medicine." They arrive with strongly held preconceived notions of what they want done, before even hearing the doctor's treatment recommendations. Others just want anything and everything done to keep themselves or their loved one alive. Whatever the reasons, doctors continue to be confronted with requests for inappropriate treatment.

Practical Considerations

This raises two important questions that the doctor must reflect upon, which are the focus of this discussion: (1) Why do the patient and I disagree? and (2) How should I respond? To answer the first question, the doctor must give careful consideration to why the request seems inappropriate. Here, rather than getting bogged down in the philosophical marshland of debate about futility, it is quicker and more direct in a clinical setting to determine, as suggested by Canadian bioethicists Charles Weijer, et al, whether the proposed treatment would be (a) ineffective, or (b) effective, but toward a controversial end.¹

Ineffective Treatment

If the doctor believes the treatment would be ineffective - and here he or she can engage the empirical criteria often used in determining quantitative futility (e.g., useless in the last 100 cases,² or unable to be systematically reproduced) - then there is no legal or ethical obligation to provide the treatment. Indeed, if the doctor believes the treatment to be against the best interest of the patient, as in causing gastrointestinal distress by introducing or continuing medically assisted nutrition and hydration (and particularly so if requested by a proxy decision maker and not the patient) the physician has an ethical obligation not to deliver the treatment. What remains is only a duty to explain clearly why the treatment would be ineffective, and to continue effective care.
Effective treatments that support controversial ends are akin to those sometimes referred to as "qualitatively futile." In the physician's judgment, they will not reverse or ameliorate the patient's condition. That goal of improving the patient's condition is the value that grounds the physician's belief that the treatment is inappropriate. Controversy arises when the patient or decision maker argues from a different value. In these cases, the doctor needs to determine the nature of that value. If it is found in cultural or religious concerns, does the end that the patient or family seeks simply differ from what is familiar to the doctor and the local community, or does it actually conflict with accepted ethical values and/or norms? Do ethnic or socioeconomic conditions give rise to the differences? Does guilt or denial on the part of the patient or family cause them to demand what the doctor feels is inappropriate treatment? At this point, the physician would be wise to call on sources from the patient's family, faith, or community to assist in working through the controversy. It may be that the physician will ethically have to cede that while the end that is sought still seems inappropriate, it has sufficient validity to others to be respected.

Conclusion

If the doctor remains ambiguous about whether to refuse to provide effective treatment toward a controversial end, he or she might consider the following questions: (1) Would agreeing to this treatment conflict with my obligation to act in the best interest of my patient? and (2) Would agreeing to this treatment conflict with my primary obligation to "First, do no harm?" If the answer to those questions is "no," the patient's request should probably be honored. Answering "yes" to either indicates that ethically, the doctor should seriously consider declining. If after such consideration the doctor concludes that providing the treatment would violate his or her personal integrity, there is strong justification for refusing. The patient's autonomy does not include the power to demand action that would violate the doctor's ethical integrity. Nevertheless, the doctor may not abandon the patient, but continue care until another can be found, if that is the path sought by the patient or family. As in all cases of disagreement between health care providers and patients, successful resolution of requests for inappropriate treatment requires conscientious and honest conversation with the patient: It can be ethical to say "no," but never to just say "no."

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Suggested Readings

