

Catholic Bioethicists and Moral Theologians Drifting Apart?: A Sequela of Specialization and Professionalization

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CATHOLIC THEOLOGY HAS A LONG HISTORY with health care. The allegory of Christ as the Divine Healer evidences the strong relationship between the two fields. Regarding moral theology, Augustine's writings on suicide (*City of God*, I.22) and Thomas Aquinas' discussion of amputation (ST II-II, q. 65, a. 1) and the beginnings of the principle of totality are well known, and even Tertullian wrote on maternal-fetal conflict (*On the Soul*, 25). Yet the focus of practicing Catholic bioethicists and academic moral theologians seems to have drifted apart over the past several decades. This drift has led to a disconnect between the theoretical arguments and topical concerns of moral theology and the practical, real-world concerns that bioethicists face in their daily cases, consults, and conversations with clinicians and hospital administrators.

As a consequence, the focus of moral theologians often differs from the problems that bioethicists and clinicians face on a daily basis. Subsequently, the theological discussion of issues most commonly faced by bioethicists is smaller than other areas of theological concern in bioethics. In this paper, I argue three points. First, this disconnect has been caused by a number of factors, especially the increasing specialization and professionalization of bioethicists. Second, Catholic bioethicists and moral theologians would mutually benefit from a closer relationship. Finally, both groups could take several steps towards this end without substantial effort or increase in time or resources.

To be clear, I am not claiming there is a complete or even substantial divergence between the two fields. Many of my ethics colleagues who currently work within health care organizations have degrees in moral theology. Furthermore, a number of texts on Catholic bioethics have been published by moral theologians in the past decade.¹ Thus,

¹ Nicanor Pier Giorgio Austriaco, *Biomedicine and Beatitude: An Introduction to Catholic Bioethics* (Washington DC: The Catholic University of America Press, 2011). David DeCosse and Thomas Nairn, ed., *Conscience and Catholic Health Care: From Clinical Contexts to Government Mandates* (Maryknoll, NY: Orbis Books,

there is a good amount of interaction between moral theologians and bioethicists, and many theologians are doing significant work in bioethics. Yet the relationship between theologians and bioethicists could be stronger. This opportunity for improvement is where I focus my comments.

CAUSES OF THE DRIFT

I see six factors behind the divergence between academic theologians and practicing bioethicists. First, bioethics has become a separate field of study in and of itself with its own subspecialties. Hence, it may be the case that moral theologians are not writing in bioethics as much as they used to, but it is in part because many now consider themselves to be bioethicists rather than moral theologians. The field of Catholic bioethics draws as much from theology as it does from philosophy, sociology, law, medicine, nursing, chaplaincy, business operations, health care administration, and a host of other fields. Moral theology can also be interdisciplinary and draw from other fields, but it is still theology at its core. Bioethics, on the other hand, cannot be said to be any of these at its core. It truly has become a field in its own right rather than a subspecialty or application of other fields. The *Encyclopedia of Bioethics* defines the field as “the systematic study of the moral dimensions – including moral vision, decisions, conduct, and policies – of the life sciences and health care, employing a variety of ethical methodologies in an interdisciplinary setting.”²

The field of bioethics is even developing subspecialties of its own. Some bioethicists specialize in public health ethics or pediatric ethics, while others focus on clinical ethics or research ethics.³ In fact, some subspecialties even have certificates or degrees, for example a certificate in public health ethics or pediatric ethics, or a doctorate in nursing

2017). C. Ryan McCarthy, *What to Do with the Least of Our Brothers?: Finding Moral Solutions to the Problem of Endangered Embryos* (Charlotte: St. Benedict Press, 2015). David F. Kelly, Gerard Magill, and Henk ten Have, *Contemporary Catholic Health Care Ethics*, 2nd ed. (Washington DC: Georgetown University Press, 2013).

² Thomas Warren Reich, *Encyclopedia of Bioethics, First Edition* (New York: Macmillan, 1995), xxi.

³ These are broad generalizations, but, for an example on clinical research see Ana Iltis, “Lay concepts in informed consent to biomedical research: The capacity to understand and appreciate risk,” *Bioethics* 20, no. 4 (2006): 180-190; for an example on standardization of health care ethics, see Mark Repenshek, “Attempting to Establish Standards in Ethics Consultation for Catholic Health Care: Moving Beyond a Beta Group,” *Health Care Ethics USA* 18, no. 1 (2010): 5-14; for an example on organ issues, see James DuBois, “Increasing rates of organ donation: exploring the Institute of Medicine’s boldest recommendation,” *Journal of Clinical Ethics* 20, no. 1 (2009): 13-22; and for an example on moral distress, see Mary Corley, “Nurse Moral Distress and Ethical Work Environment,” *Nursing Ethics* 12, no. 4 (2005): 381-390.

ethics.⁴ Thus, rather than bioethics being a subspecialty of moral theology, as some theologians might see it, bioethics is now a field in its own right with subspecialties of its own.

Second, and closely related to the first, there is a growing trend towards professionalization among bioethicists, especially those in health care. This leads bioethicists to turn more inward towards bioethics rather than outward towards other fields like moral theology. I believe this trend is a direct result of the fact that bioethics has become its own field. After all, if it is a separate area of study distinct from others, it is only natural that some people would specialize in it. Today, health care ethics consultation is mostly performed by physicians or hospital employees who volunteer their time to participate on an ethics committee. They often have no formal or extensive training in ethics or health care ethics.⁵ Some systems have explored various structural models that employ a combination of volunteer consultants and full-time ethicists.⁶

Yet several authors have described the benefits of a full-time ethicist.⁷ Due to concern for the quality of background and education of all consultants, full-time or volunteer, some groups have proposed certification programs for health care ethics consultation. The American Society for Bioethics and Humanities has even created its Healthcare Ethics Consultant-Certified Program.⁸ As numerous studies have shown the positive impact of ethics consultation on operational met-

⁴ Graduate Certificate in Public Health Ethics, University of Massachusetts Amherst, www.umass.edu/sphhs-online/programs/graduate-certificate-public-health-ethics. Pediatric Bioethics Certificate, Children's Mercy Center for Bioethics, www.childrensmercy.org/bioethics/certificate-program. PhD in Nursing Ethics, Duquesne University, www.duq.edu/academics/schools/nursing/graduate-programs/phd-in-nursing-ethics.

⁵ Ellen Fox, Sarah Myers, and Robert Pearlman, "Ethics Consultation in United States Hospitals: A National Survey," *American Journal of Bioethics* 7, no. 2 (2007): 17.

⁶ Matthew Kenney, "A System Approach to Proactive Ethics Integration," *National Catholic Bioethics Quarterly* 18, no. 1 (2018): 93-112. Courtenay Bruce, Jocelyn Lapointe, Peter Koch, Katarina Lee, and Savitri Fedson, "Building a Vibrant Clinical Ethics Consultation Service," *National Catholic Bioethics Quarterly* 18, no. 1 (2018): 29-38.

⁷ Kate Payne, "Reflections on the Role of Ethicists in the Catholic Health Ministry," *Health Care Ethics USA* 18, no. 2 (2010): 25-27. Birgitta Sujdak Mackiewicz, "Essential Goals of Ethics Committees and the Role of Professional Ethicists," *National Catholic Bioethics Quarterly* 18, no. 1 (2018): 49-57.

⁸ American Society for Bioethics and Humanities, "Healthcare Ethics Consultant-Certified Program," asbh.org/certification/hcec-certification. American Society for Bioethics and Humanities, "Benefits of Certification for Leadership in Healthcare Ethics Consulting," asbh.org/certification/hec-c-benefits-to-leadership.

rics, it seems possible that the number of full-time positions for ethicists will grow.⁹ Today, more full-time positions are available in health care ethics than ever before.

To fill these positions, educational programs tailored to bioethics, health care ethics, and clinical ethics have sprung up. At least three Catholic universities offer a PhD in bioethics (sometimes titled health care ethics), two offer a practical doctorate (doctorate in bioethics or health care ethics), and numerous universities offer master's degrees.¹⁰ Moreover, both Catholic and non-Catholic universities and health centers offer fellowships in clinical ethics. These programs certainly entail an academic component, but they are substantially geared toward the practical aspects of health care ethics consultation. As part of their training, ethics fellows participate in clinical rounds with care teams, observe clinical ethics consults with faculty members, and eventually take call and perform consults independently. They learn how to interact with clinicians, patients, and family members to provide real-time advice in a manner that is meaningful and helpful to those involved. Just as clinicians must learn to avoid medical jargon when speaking with patients, ethics fellows learn to avoid theological, philosophical, and moral jargon.

In my view, this tendency toward professionalization and use of full-time clinical ethicists has made those professional ethicists more likely to read, write, and publish in bioethics. The more they specialize in bioethics and subspecialties of bioethics, the more invested they are in that narrow subspecialty. Consequently, they are less likely to read or publish in moral theology journals, for instance, such as the one in which this article appears. Conversely, moral theologians often subspecialize in specific areas of application or on specific questions within moral theology. Thus, for both groups, learning enough about the other field to speak competently becomes a barrier to entering it. The path of least resistance is to write in the area they know best, and that is often what occurs.

Third, bioethicists are increasingly focusing on subspecialized areas rather than more fundamental questions of method or frameworks,

⁹ Selena Au, Philippe Couillard, Amanda Roze des Ordon, Kirsten Fiest, Dianne Lorenzetti, and Nathalie Jette, "Outcomes of Ethics Consultations in Adult ICUs: A Systematic Review and Meta-Analysis," *Critical Care Medicine* 46, no. 5 (2018): 799-808.

¹⁰ For examples, see these among others: Albert Gnaegi Center for Health Care Ethics, Saint Louis University, bioethics.slu.edu; Center for Healthcare Ethics, Duquesne University, www.duq.edu/academics/schools/liberal-arts/about-us/centers/center-for-healthcare-ethics; Neiswanger Institute for Bioethics & Healthcare Leadership, Loyola University Chicago, hsd.luc.edu/bioethics; Center for Health Policy and Ethics, Creighton University, www.creighton.edu/chpe; Catholic Clinical Ethics Master's Program and Certificate Program, Catholic University of America and Georgetown University, clinicaethics.georgetown.edu.

which creates obstacles for theologians to enter debates given the extra time and research needed to become familiar with a topic's details. Historically, prominent bioethicists and theologians often wrote on any and all topics. Many of the seminal works like those of William May, Kevin O'Rourke, Jean deBlois, and Benedict Ashley, Orville Griese, and others addressed a wide variety of topics from organ donation and feeding tubes to informed consent and ectopic pregnancy.¹¹ Secular bioethicists were similar, as evidenced by the writings of Tom Beauchamp and Jim Childress, Albert Jonsen, Mark Siegler, and William Winslade, and Robert Veatch.¹² They certainly wrote in more detail on specific topics, but they were, in a sense, bioethics generalists.

However, as the field has matured, the number of topics and specific issues that draw our attention has grown exponentially. Very few bioethicists are able to be generalists nowadays, in part because the need for bioethics work nowadays increasingly requires bioethics specialists. This seems to be the natural evolution of any new field of academic inquiry: the first few generations lay the foundation(s) and subsequent generations build on that foundation by filling in the gaps on narrower issues. The scholars mentioned above wrote much on methodology, frameworks, and approaches to bioethics. These debates are not settled (nor do I think they ever will be), but the bioethics conversation as a whole seems to have moved away from methodology and more towards application. The field appears to be transitioning from foundation-building to gap-filling. This is true both for Catholic bioethicists and secular bioethics.

The sheer volume of issues demanding scholarly attention requires more discussion of application; yet, perhaps, this transition is also occurring because the questions of methodology are less prominent. If the broader approaches and frameworks are well-sketched in the literature, they may not warrant as much discussion as their application. Regardless, the increased focus on specialization and application makes it all the harder for moral theologians to break into the fray. The more specialized a discussion is, the more technical knowledge one needs to enter it. The fact that this technical knowledge is often in a field far outside theology, such as medicine or biology, probably does not help attract moral theologians either. The reverse is also true. The

¹¹ William May, *Catholic Bioethics and the Gift of Human Life, Third Edition*. (Huntington: Our Sunday Visitor, 2013); Orville M. Griese, *Catholic Identity in Health Care: Principles and Practice* (Braintree: The Pope John Center, 1987); Benedict Ashley, Jean deBlois, and Kevin O'Rourke, *Health Care Ethics: A Catholic Theological Analysis, Fifth Edition* (Washington DC: Georgetown University Press, 2006).

¹² Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 2012); Albert Jonsen, Mark Siegler, and William Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* (New York: McGraw-Hill, 2015); Robert Veatch, *The Basics of Bioethics* (New York: Routledge, 2016).

more time that bioethicists must spend on a specialized topic, the less time they have to devote to broader questions of moral theology or even to specialized topics within moral theology itself besides bioethics.

Fourth, the skillsets required of moral theologians in academia and those of ethicists in health care are quite different. This difference makes it difficult for anyone to excel at both, thus posing a barrier to someone in either field making a substantial impact on the other. The fast-paced nature of modern health care makes it very difficult for an ethicist working at a hospital or health system to devote significant time to scholarly work, and it also makes it difficult for theologians to be aware of emerging issues in real time. Some ethicists do not have publication or academic work as part of their job description, giving them no dedicated time to publish. Publishing may even be actively discouraged in some roles. Others simply lack interest in publishing, finding the practical problems and projects in their job more intellectually satisfying than publication. Yet even if there is some slight allowance for scholarly writing, the focus on productivity and operationalizing ethics can monopolize an ethicist's time.

The speed at which conversations take place also is unlike anything encountered in academia. Academics often take months or years to parse out every permutation and detail involved in a concept before publishing or presenting on it, which is quite appropriate given the expectations of their role and the nature of their inquiry. This requires a unique skillset including patience and analytical skills that those in health care ethics may not have. In contrast, those in health care do not have the luxury of time, especially in the clinical setting. One is expected to have conversations on any topic and think through many levels of nuance with little if any time to prepare a definitive response, sometimes less than thirty minutes. In this timeframe, one must sift through extraneous information (and there is much of it), identify the relevant moral factors (it is not uncommon for a single consult to have three or four major issues), weigh various options (and usually generate new ones the care team, patient, and family have not considered), and make a recommendation. This also requires a unique skillset including quick-thinking and the ability to triage priorities that those in academia may not have.

This skillset is more similar to the pastoral skills employed by those who put moral theology into practice like parish priests or confessors than to the skills used by those in academia who teach, read, write, and present. In my opinion, the former skillset was not required or expected of ethicists before the focus on professionalization in bioethics, but now it is starting to be expected. This change in skillset expectations increases the drift between theologians and ethicists. These skillsets are so different that it is hard to acquire one once you have the

other, and it is a rare person who is equally skilled in both. Even for those who have both, it is hard to have the time to do both.

Fifth, some in academia have an aversion to applied fields as they find them unscholarly or not rigorous enough to be worthy of serious attention. Several authors have pointed out this tendency, especially among analytical philosophers, to look down on applied ethics.¹³ I admit that I felt this way while studying philosophy as an undergraduate before I really encountered bioethics. However, I have learned through experience the necessity of nuanced, technical, theological discussion for health care ministry today. To have such a discussion with clinical colleagues who are unversed and untrained in moral theology is a daunting challenge. It requires conveying the technical concepts the field of moral theology has developed over the centuries without using any of the terms, concepts, words, or language that accompany these concepts.

Sixth, it is possible many moral theologians are unaware of the need for more bioethicists in Catholic health care, the need for younger ethicists (or those from related fields wishing to start a second career) to fill positions, and the attractive salaries these positions carry. Catholic health systems and hospitals have great difficulty finding qualified ethicists to fill jobs. Anecdotally, my current position at CHRISTUS Health was vacant for almost two years, and my previous position was vacant for more than two years after I left. Thankfully, the Catholic Health Association has collected data that illustrates this problem through three surveys of ethicists working in Catholic health care.¹⁴ Table 1 shows the age breakdown of the forty-seven ethicists who responded to the 2015 survey.¹⁵ This is consistent with the 2009 survey that found 68.9 percent of ethicists were fifty or older.

¹³ Tom L. Beauchamp, "On Eliminating the Distinction between Applied Ethics and Ethical Theory," *The Monist* 67, no. 4 (1984): 514-531; Lou Marinoff, *Philosophical Practice* (New York: Elsevier, 2001), 185-186; Martha Holstein and Phyllis B. Mitzen, *Ethics in Community Based Elder Care* (New York: Springer Publishing Company, 2001), 23, n. 6.

¹⁴ Thomas Nairn, "Ethicists in a Quickly Changing Environment," *Health Progress* 96, no. 4 (2015): 72-74; Ron Hamel, "Ethicists in Catholic Health Care: Taking Another Look," *Health Care Ethics USA* 23, no. 1 (2015): 34-44; Ron Hamel, "A Critical Juncture," *Health Progress* 90, no 2. (2009): 12-22. The third survey occurred in early 2018 and has not yet been published.

¹⁵ Hamel, "Ethicists in Catholic Health Care: Taking Another Look," 35.

Table 1

Age	Percentage
20-29	4.5%
30-39	18.2%
40-49	13.6%
50-59	25%
60-69	36.4%
> 70	2.3%

Given this age, it is unsurprising that 70.6% of the 2015 respondents said they plan to retire in the next 15 years, or by 2029 (the survey occurred in late 2014). Moreover, there is a disproportionately smaller percentage of ethicists in the lower age range, especially 20-29 years old. Thus, many will be retiring in the coming years, and there are not enough qualified younger ethicists to fill those positions.

Regarding salary, the 2015 survey breaks down responses into increments of \$25,000 (Table 2).¹⁶

Table 2

Salary Range	Percent of Respondents
\$50,001 to \$75,000	8.8%
\$75,001 to \$100,000	20.6%
\$100,001 to \$125,000	14.7%
\$125,001 to \$150,000	8.8%
\$150,001 to \$175,000	8.8%
\$175,001 to \$200,000	8.8%
\$200,001 to \$225,000	11.8%
\$225,001 to \$250,000	5.9%
\$250,001 to \$275,000	2.9%
\$300,001 to \$325,000	2.9%
\$425,001 to \$450,000	2.9%
\$450,000 and above	2.9%

The salaries are also stratified by the scope of ethicist’s role. Unsurprisingly, those who work at an acute care facility fall between \$75,000 and \$175,000, those in a regional position range from \$50,000 to \$325,000, and those at the system level fall between \$100,000 and \$450,000 and above. These numbers are slightly higher than the 2009 survey. It is reasonable to conclude that more moral theologians would be interested in working in Catholic health care as ethicists if they

¹⁶ Hamel, “Ethicists in Catholic Health Care: Taking Another Look,” 37.

were familiar with this data on demographics and salaries. This seems especially true since most moral theologians already have the educational background of many ethicists. In the 2015 survey, 63.6 percent held a PhD in philosophy, moral theology, or a related field.

BENEFITS OF INTERACTION

These six reasons have led moral theologians and bioethicists in Catholic health care to drift apart over the past few decades (and it is certainly possible that there are other reasons I have not mentioned here). There are at least three benefits for increased interaction between moral theologians and Catholic ethicists. First, ethicists would benefit from more work by moral theologians on practical topics they frequently encounter. If the two groups do not interact then they do not communicate. If they do not communicate, then they cannot listen to each other. If they do not listen, they cannot encounter ideas relevant to their work. This leads to a lack of familiarity among theologians with the moral issues that Catholic health care actually faces, which in turn leads to a lack of scholarly interest. Moral theologians sometimes write on topics that have substantive theological implications but are rarely encountered by health care ethicists. Human embryonic stem cell research is a good example of this. Dozens of conference presentations, articles, and even entire books have been devoted to this topic. Certainly, it is a fascinating moral issue, serious and worthy of discussion, but one I rarely encounter. In over one thousand ethics consults I have performed so far in my career, I have had only four or five that were related to stem cell research. Even then, the consults centered more on the question of morally justified cooperation than on stem cell research specifically.

Yet ethicists in Catholic health care regularly encounter other topics which warrant deeper theological discussion, such as medically inappropriate treatment (or its misnomer medical futility). This topic touches on Church teaching on proportionate and disproportionate means but is also related to moral distress, burnout of clinicians, respect for human dignity and just distribution of resources. Other issues include shared decision making, informed assent for minors, the limits of the obligation to provide charity care, just distribution of resources in a disaster or decision making capacity. By applying their unique skillset to these topics, moral theologians could make a lasting impact on the provision of health care.

Second, stronger engagement in bioethics from theologians could have an influence not just on Catholic bioethics but secular bioethics as well. The smaller proportion of theologians prominently engaging in secular bioethics has led secular ethicists to overlook the contributions theologians have made to these debates. This oversight is both historical and contemporary, as seen in a recent issue of the *American*

Journal of Bioethics, a prominent secular bioethics journal. In the target article, the authors casually claim that the pioneers of bioethics “were almost to a person ethics or humanism professors.”¹⁷ Granted, the authors’ list of pioneers includes three Catholic and two non-Catholic theologians, yet the first “pioneer” ironically began his career in 1971, which is the same year the second edition of the *Ethical and Religious Directives for Catholic Health Care Facilities* was published by the National Conference of Catholic Bishops. While this was officially the second edition, it was, arguably, the fourth edition.¹⁸ Catholic moral theologians and ethicists in the United States had been working in bioethics (or medical ethics) for decades before the first pioneers on this list, yet none are mentioned by the authors.

Similarly, a response to this article in the same issue is titled, “Where Have All the Theologians Gone and Should We Lament Their Passing?”¹⁹ The authors note that some theologians still work in bioethics but mostly in academia and that the majority of those doing health care ethics consults nowadays do not have any formal training in theology. They lament this change and argue the field of bioethics is weakened by this lack of diversity. While this claim is similar to my own here, that there has been a decrease in the percentage of theologians among those who work in bioethics (especially clinical ethics), it neglects the ethicists and ethics consultants in the 654 Catholic hospitals throughout the United States.²⁰ It is worth noting that this oversight of the historical and contemporary contribution of theologians is relatively new. In his book *The Birth of Bioethics*, published in 1998, Albert Jonsen devotes an entire chapter to the contributions of theologians to bioethics in the 1960s and 1970s.²¹ Jonsen also notes the significant work in medical ethics done by moral theologians over the past few centuries, especially in the late nineteenth and early twentieth centuries.²² It is discomfoting to know they see bioethics as a secular field dominated by secular thinkers and even more discomfoting to know that they are likely correct. Catholic bioethics and moral theology has much to offer secular bioethics due to the origin and content

¹⁷ Bruce White, Wayne Shelton, and Cassandra Rivais, “Were the ‘Pioneer’ Clinical Ethics Consultants ‘Outsiders’? For Them, Was ‘Critical Distance’ That Critical?” *American Journal of Bioethics*, 18, no. 6 (2018): 34-44.

¹⁸ Kevin O’Rourke, Thomas Kopfensteiner, and Ron Hamel, “A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services,” *Health Progress* 82, no. 6 (2001): 18-21.

¹⁹ Cynthia Geppert and Toby Schonfeld, “Where Have All the Theologians Gone and Should We Lament Their Passing?” *American Journal of Bioethics* 18, no. 6 (2018): 60-62.

²⁰ Catholic Health Association, “Facts and Statistics,” www.chausa.org/about/about/facts-statistics.

²¹ Albert Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998).

²² Jonsen. *The Birth of Bioethics*, 35-37.

of its thought. An increase in the presence of moral theologians writing in secular bioethics or working in health care ethics could get more exposure for their ideas.

Third, a closer relationship between Catholic bioethicists and moral theologians would connect academic investigation with daily lived experience and practical ethicists with elements of the broader theological tradition. New practical approaches could arise from theoretical discussions, and new insights into theological concepts could stem from solutions to practical problems. Several recent works have such implications. To the first, Martin Rhonheimer's book on maternal-fetal conflict re-examines the reasons underlying why killing is wrong and what distinguishes the justified, indirect causing of death and the intentional, purposeful taking of human life.²³ His insights provide a new way of responding to cases of ectopic pregnancy and, by extrapolation, any situation in which a pregnancy threatens the life of a woman.

Regarding new insights into theory, in analyzing Physician Orders for Life Sustaining Treatment (POLST) forms, Peter Cataldo and Elliott Bedford make some important contributions to the broader theoretical discussion of proportionate and disproportionate means. They state that, when determining whether a particular treatment is proportionate or disproportionate:

Catholic moral teaching and tradition have never limited the determination of what is ethically proportionate treatment to the immediate, present-moment circumstances. The evaluation of circumstances is inclusive of both circumstances in the present moment and circumstances that may reasonably be foreseen in the future.²⁴

This point is an important distinction in the discussion regarding POLST forms and, to my knowledge, is not addressed in magisterial teaching or the Catholic moral tradition.

Other authors make another important theoretical point regarding the application of the principle of double effect to maternal-fetal vital conflict. Much of the discussion regarding double effect and abortion over the past century has focused on the good effect as the cure of a pathological condition of the pregnant woman. The authors point out the principle of double effect itself does not require a pathology be cured, merely that a good effect be achieved. They posit that "intervening to eliminate the threat to a person's life, even if it does not

²³ Martin Rhonheimer. *Vital Conflicts in Medical Ethics: A Virtue Approach to Craniotomy and Tubal Pregnancies* (Washington, DC: Catholic University of America Press, 2009).

²⁴ Peter Cataldo and Elliott Bedford, "Prospective Medical-Moral Decision Making," *National Catholic Bioethics Quarterly* 15, no. 1 (2015): 60.

eliminate a persistent underlying pathological condition, can be sufficient to satisfy the moral criteria” involved.²⁵ These are but two examples, and there are many others. Whether one agrees with the practical application used in these articles or not, the theoretical points these authors make are relevant to the broader moral tradition. Despite the move from generalist bioethics to specialized topics described above, bioethics literature can offer new insights into the foundational concepts of moral theology. By following that literature closely, moral theologians could also add to the theory and development of bioethics and moral theology in ways bioethicists cannot.

PROPOSING A RAPPROCHEMENT

While much could be done to strengthen the relationship between ethicists in Catholic health care and moral theologians, four possible steps stand out. First, moral theologians in the academy writing in medical ethics could seek out a local hospital, volunteer to be on their ethics committee, or even serve as a liaison or dialogue partner for their ethicist if they have one. If there is no Catholic hospital nearby, theologians could seek out non-Catholic hospitals. Every hospital accredited by The Joint Commission (TJC) must have a mechanism to address ethical issues that arise in patient care. Since TJC accredits 88% of accredited hospitals in the United States, it would not be difficult to find a local hospital interested in a moral theologian’s expertise.²⁶

Second, moral theologians and Catholic bioethicists could be more visible in each other’s fields of study. For moral theologians, this includes publishing in Catholic bioethics journals like *Christian Bioethics*, *Health Care Ethics USA*, *Health Progress*, *The Linacre Quarterly*, *National Catholic Bioethics Quarterly*, or even secular bioethics journals like *American Journal of Bioethics*, *Cambridge Quarterly of Healthcare Ethics*, the *Hastings Center Report*, *Healthcare Ethics Committee (HEC) Forum*, or *Journal of Clinical Ethics*, to name a few. Similarly, they should consider attending bioethics conferences like the Catholic Medical Association, American Society of Bioethics and Humanities, the International Conference on Clinical Ethics Consultation, or the Pediatric Bioethics Conference at Seattle Children’s, to name a few. The *American Journal of Bioethics* maintains and updates a list of secular bioethics events.²⁷

²⁵ Ascension Health Colloquium, “Medical Interventions in Cases of Maternal-Fetal Vital Conflicts: A Consensus Statement,” *National Catholic Bioethics Quarterly* 14, no. 3 (2014): 487.

²⁶ The Joint Commission, “Facts About Hospital Accreditation,” www.jointcommission.org/facts_about_hospital_accreditation.

²⁷ bioethics.net, “Bioethics Events,” www.bioethics.net/events.

On the other hand, ethicists in Catholic health care could follow theology journals just as they follow those in bioethics, medicine, nursing, and business. They stand to gain insight from their moral theology colleagues. Their discussions are bound to open new avenues of thought and investigation that they would not discover on their own. If they do not read moral theology, they cannot benefit from the expertise of moral theologians. Similarly, attending theology conferences like the Catholic Theological Society of America would allow ethicists to engage with theologians first hand. Submitting talks to conferences like this would get the concerns of Catholic bioethicists even more direct exposure to academics.

Third, ethicists in Catholic health care could contribute more to the literature as a whole. Many ethicists in Catholic health care do not publish regularly, so even one publication a year in a bioethics or theology journal would be a significant advancement. I suggest a standard of at least one article, essay, or letter to the editor per year. Ethicists could also include scholarly publication as part of their job description. For those ethicists who write multiple articles per year, consider submitting one per year to a journal that is more strictly theology than bioethics. Opening discussions in these venues on topics of concern to ethicists in Catholic health care would go a long way to benefitting from the reflective insight of moral theologians. While it is important to focus on these practical issues, it is just as important to consider them in a reflective manner removed from time constraints and potential conflicts of interest, which is traditionally the role of moral theologians.

Fourth, ethicists could consider occasionally teaching at a local Catholic university, perhaps even obtaining an adjunct position, even if it is for only one class a year. This could be in the theology department, but even philosophy or health sciences would be beneficial. If it is impractical to add this to the time commitments of modern health care, offer to be a guest lecturer for a class once a semester. It provides positive exposure for the health system and could prompt students to consider a career in Catholic health care as a bioethicist, mission leader, chaplain, or even a clinician. Alternatively, universities and health systems could work together to create non-traditional positions. For example, they could design two full-time positions in which each person spends half their time at each institution, or a teaching assistantship funded by both institutions that functions as an intern or fellow at the health system. This is likely the most difficult of these steps, but expanding any of these options would go far in bringing moral theologians and ethicists in Catholic health care closer together.

OBLIGATION TO WORK TOGETHER

While it may be true that moral theology and Catholic bioethics have drifted apart, they have not completely diverged. This drifting

seems to be a natural consequence of the professionalization of bioethics as its own field, the specialization of ethicists in different areas of bioethics, the different skillsets required by academia and the health care, an aversion among some academics to applied theology, and a lack of knowledge among moral theologians about basic demographics of Catholic ethicists. Bringing Catholic bioethicists and theologians closer together would enrich both fields (and maybe secular bioethics as well). For bioethicists, this would provide access to more analytical deep thought on the practical troubles they face daily. For moral theologians, this would be one more way they can further develop a living theology attentive to the needs of the flock and to answer Pope Francis's call to "be shepherds, with the 'odour of the sheep', make it real, as shepherds among your flock, fishers of men."²⁸ As representatives of the largest united provider of health care in the world, moral theologians and Catholic bioethicists have an obligation to work collaboratively to smell like sheep together. **M**

²⁸ Pope Francis, "Chrism Mass Homily," March 28, 2013, w2.vatican.va/content/francesco/en/homilies/2013/documents/papa-francesco_20130328_messa-crismale.html.