

AN ABSTRACT OF THE THESIS OF

Laura L. Hosford for the degree of Master of Arts in Applied Ethics presented June 12, 2017.

Title: Allocation in Health Care: Antecedent Conditions & Catholic Insights

Abstract approved: _____

Professor Courtney Campbell

This research was aimed at providing the foundation for changing standards of care in a critical care setting using Catholic concepts of respect for human dignity, subsidiarity, common good, and solidarity as a matter of social justice. I first unpacked the nature of ICU care and the inevitability of the rationing of scarce medical resources. I presented data to support the theory that end-of-life care varies by region and that there is something unique in end-of-life care in the state of Oregon. I used the work of Margaret Mohrmann to detail the presence of social determinants in allocation decisions. To gain further insight into the literature regarding allocation of health care resources I examined the parable of The Good Samaritan as unpacked by Allen Verhey and “Who Shall Live When Not All Can Live” by James Childress. I also relied heavily upon the anthology *Allocating Scarce Medical Resources: Roman Catholic Perspectives* edited by H. Tristram Engelhardt Jr. and Mark J. Cherry to reflect upon the issues of a purely secular debate of allocation of medical resources. I introduced the concept of moral luck as revealed through the work of Richard Miller and Thomas Nagel as an antecedent condition to allocation decisions. Finally I conclude with the work of John Coleman, Megan Clark and Pope Francis to re-imagine solidarity in contrast to the individualism that supports the ideology of the current healthcare system and state my case for regional change in end-of-life standards of care.

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Allocation in Health Care:
Antecedent Conditions & Catholic Insights

by

Laura L. Hosford

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I understand that this thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Laura L. Hosford, Author

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As long as there is poverty in the world I can never be rich, even if I have a billion dollars. As long as diseases are rampant and millions of people in this world cannot expect to live more than twenty-eight or thirty years, I can never be totally healthy even if I just got a good checkup at Mayo clinic. I can never be what I ought to be until you are what you ought to be. This is the way our world is made. No individual nation can stand out boasting of being independent. We are interdependent. (Martin Luther King Jr. qtd Clark, 101).

Introduction

As a clinical ethicist, I am tasked with the job of ensuring that the medical care provided in the hospital system I work from is carried out in a manner consistent with our institutional core values (Respect, Stewardship, Collaboration, and Social Justice), as well as broader Catholic social teachings. I receive “ethics orders,” which are part of the electronic record system of the hospital I work for. Each morning, I receive a list of ethics orders entered into the system by all those who have access to the electronic medical system. In addition, I receive verbal ethics referrals during daily rounds in the ICU. Rounds in the ICU are an interdisciplinary group that consists of: intensivists (physicians who specialize in critical care in an intensive care unit), physical therapists, speech therapist, respiratory therapist, social workers, spiritual care chaplains, pharmacists and myself, the clinical ethicist. If any ethical issues arise, I as the clinical ethicist am there to provide guidance. For example, to provide assistance with decision making for a person who is unrepresented (meaning they have no family or friends to make decisions for them when they are unable) and the care team is trying to determine if they should pursue aggressive care or comfort care considering the persons condition. In general, the group walks from patient to patient, briefly laying out the prognosis and goals for each patient. The goal of ICU rounding is for

the care team to be in communication about the patient and their goals of care, not just in a medical manner, but attending to the whole person consistent with the principles of the institution.

Working as a clinical ethicist in a Catholic-affiliated hospital, I see patterns in the type of orders that are referred to me. Of interest to me are not just the patterns of cases referred to me, but how cases are categorized. With frequency, two types of cases are referred to me: claims of social justice and claims of futile care. I will use the following two cases to bring out the differences in the two types of claims:

Case A: Social Justice Claim

A thirty-something IV drug user is in the hospital for endocarditis. Endocarditis is an inflammation of the heart caused by bacteria. For this patient, endocarditis was a result of IV drug use that had damaged the heart valve. The patient required a heart valve replacement that would be the second same surgery in two years. The attending physician as a matter of social justice referred this case to me through the electronic health care system. The physician claimed that it was not a good use of finite resources to operate for a second time on the patient.

Case B: Futile Care Claim

This patient was in their late seventies and in multi-organ failure in the ICU. This patient had been chronically ill for many years with multiple admissions to the ICU over the last few years. The patient was receiving maximum life support that included mechanical ventilation, artificial nutrition, dialysis, and maximum medication to support blood pressure. The patient was unconscious and had been for several weeks. The physician

stated that the patient was not likely to regain consciousness. This case was referred to me as a matter of futile care. I acknowledge that the term futile care is problematic and for the purposes of this paper, by futile care, I mean as those interventions that might affect the patient but have little to no discernable benefit.

I categorized both of these cases as issues of social justice. The care team felt confident in making a social justice claim regarding the IV drug user. However, they were less comfortable speaking in terms of social justice regarding the case of futile care. In my understanding, using the scarce resources of the ICU in the presence of a claim of futile care is a matter of social justice. I was curious about the ideology that supported a claim of social justice in Case A, but did not support a social justice claim in Case B. There was an aspect of praise and blame at work in the two cases that I found interesting. In the situation of Case A, the IV drug user, there was an element of blame for his condition that seemed to make the social justice claim easier to make. In the situation of Case B, the patient was receiving futile care and there was the absence of blame, but also the presence of praise. Praise is often given for “fighting against the surrender to death” and in persevering in conditions of terrible burden.

I understood both cases to be matters of microallocation that are “bedside decision[s] about whether an individual patient will or will not receive a scarce medical resource” (Scheunemann & White, 1626). Because I see these same types of cases over and over I also considered what these case types meant in respect to macroallocation, which “occur at the societal level and includes decision[s] about how to allocate funds across a range of public goods” (Scheunemann & White, 1626). I could not separate in my mind the claim of futile care at the end-of-life in Case B and the context of Case A, which I see as

reflecting systemic inequalities, such as inadequate community addiction services. For me these two cases are intimately related.

Knowing that macroallocation decisions impact microallocation decisions, I considered regional differences in standards of care at the end-of-life. In addition, I explored the unique culture of the state of Oregon being on the forefront of healthcare change as it pertains to medical ethics and rationing of health care. I examine the work of Allen Verhey and James Childress as they unpack the issue of rationing and allocation in healthcare. I introduce the work of Margaret Mohrmann as a means for challenging both Allen Verhey and James Childress in their reliance upon the ability to make determinations of medical acceptability absent social determinants.

I explore how Catholic social teachings might inform complex health care situations and the potential limitations of a purely secular debate. My instinct is that stronger considerations need to be given to standards of care at the end-of-life with critical thought given to situations of futile care. I intend to introduce the concept of moral luck as it pertains to antecedent conditions that precede decisions of medical acceptability and allocation of scarce medical resources. I also critique a biologically reductive account of the human condition that I see as contributing to contemporary medical ethics, which is driven by what I call the a-Samaritan (a –Latin prefix which means ‘without, not’). I chose the term, a-Samaritan to stand in opposition to qualities of the Samaritan, exhibited in the parable of *The Good Samaritan* that I will unpack in chapter five. The a-Samaritan is concerned with the primacy of autonomy and individual rights. The a-Samaritan is not focused on a robust conception of solidarity. The a-Samaritan tends not to acknowledge dependence upon others, but instead, empathizes less with vulnerability and more with

heroic narratives of perseverance and overcoming obstacles. For the a-Samaritan notions of individual entitlement have priority over concepts of the common good.

I ultimately advocate for a regional shift in the standard of care at the end-of-life that would allow for reallocation of funds in the spirit of Catholic solidarity and in pursuit of the common good. Consistent with the principles of Catholic social teaching, I advocate initially for a change in the standard of care within the institution I work for with the hope that this would expand to regional change and beyond. While the concepts of Catholic social teaching are contested even within the Catholic Church, I have chosen conceptions of respect for human dignity, subsidiarity, common good, and solidarity that I understand to be best suited to health care in Oregon. For example, I developed my conception of respect for human dignity, subsidiarity, and common good from papal encyclicals for their consistency. Papal encyclicals are consistent in that they often reference or are continuations of work in previous encyclicals. While I drew from papal encyclicals for the Catholic concept of solidarity, I also rely heavily upon the work of Meghan Clark. I am primarily drawn to her interpretation of solidarity as it contains to participatory obligations and a form of solidarity that does not require a flattening of differences or homogenizing. An acceptance of diversity is best suited for Oregon with its unique mix of “unchurched” and Libertarian conservative populations. I also use the work of John Coleman in “American Catholicism, Catholic Charities U.S.A., and Welfare Reform”, to unpack respect for human dignity, subsidiarity, common good, and solidarity as his essay regarding Catholic social teaching is specific to the United States and therefore most applicable to my examination of the health care system in the United States. I recognize that there are differing interpretations of Catholic social teaching. Consistent with the

teachings of the Second Vatican Council of developing an individual Catholic conscience and meeting moral obligations, I have chosen the preceding texts listed as sources for examining allocation in health care.

I conclude that exponentially increasing the amount of money spent at the end-of-life reveals a bias maintained by specific narratives in contemporary culture. In addition, the decision not to allocate greater funds to programs meant to address systemic inequalities such as addictions services, mental health services, disability services, and complex social issues such as homelessness also reveal a significant bias and dominant narrative. For these reasons, I believe antecedent conditions such as “upstream” considerations to include the concept of moral luck ought to be a part of health care allocation discussions. The “upstream” conditions I am speaking about are best represented by what is referred to as The Parable of Prevention. This parable has many iterations, one of which I have adapted from ordained priest Ronald Rolheiser’s version.

Once upon a time there was a town that was built just beyond the bend of a large river. One day some of the townsfolk were working along side the river and noticed three bodies floating in the river. The townsfolk were anguished and puzzled. They pulled the bodies from the river, tenderly cleaned them and buried them. From that day on, every day a number of bodies came floating down the river, and every day, the good people of the town would pull them from the river and bury them. This went on for years; each day brought its quota of bodies, and the townsfolk came to expect a number of bodies. However, during all the years and despite all the anguish and death, nobody thought to go up the river, beyond the bend that hid from their sight what was above, and find out why, daily those bodies came floating down the river.

I am interested in the upstream considerations in healthcare or as the parable states what is beyond the bend. I frequently find myself as a clinical ethicist in the position as gatekeeper to finite health care resources and feel at times much as the townsfolk in the

parable must have felt with bodies continually coming down the river and accumulating at their feet.

Section 1: Allocation and Rationing

1.1 The Nature of ICU Care

To anyone with firsthand experience, whether on the giving or receiving end of critical care, it is clear that detachment from the experts and gear assembled in the ICU means all but certain death for the terminally ill, whom such units are designed to save. For this reason, the fact of having more patients than available space in such units becomes a moral issue. Whom do we save and whom do we let go? And on what grounds? As long as these units remain at the cutting edge of the healing sciences, there will always be a disproportion of equipment to patients (James W. Heisig, S.V.D, 299).

Being located on the “cutting edge of healing science” places ICUs at the intersection of social justice claims; claims made by a particular individual, regarding access to ICU care that are in tension with what that individual claim means for the broader community served by specific ICUs. In The Ethics and Reality of Rationing in Medicine, Scheunemann and White detail rationing in health care:

ICU care is expensive and not always successful. In the United States, upward of 0.66% of the gross domestic product is spent on critical care services, and care for those who die in ICUs total tens of billions of dollars every year. How rationing occurs is important, because it not only affects individual lives, but also expresses what values are most important to society. We live in a world in which need is boundless, but resources are not – and medicine is not immune to the consequences of this reality (Scheunemann and White,1630).

As Scheunemann and White point out, “how rationing occurs is important, because it....expresses what values are most important to society.” The values being expressed in consuming resources as if they are limitless seems inconsistent with most ethics both

secular and religious. The issue of ICUs is that they are operated as if there are infinite resources for end-of-life care. I don't think society or physicians are prepared to confront the fact that ICU care is a scarce resource or the implications from such an admission.

"...the more the question of morality focuses on the appropriate or inappropriate use of available facilities, the stronger grows the conviction that, in the best of all possible worlds, everyone would have equal access to such treatment. The contradiction is easier to accept than the possibility that the ICU could be grounded on a creed unworthy of belief. The ICU is a metaphor of this wider myth. If the ICU is indeed a metaphor whose significance depends on a broader set of beliefs in the background, a different background implies a shift of meaning in the foreground as well." (James W. Heisig, S.V.D, 299)

I am interested in the "wider myths" that support the manner in which ICU care is administered, and public expectation about what ICU care should be. The wider myths that I am referring to will be explored in the work of Allen Verhey. The values expressed by futile care in an ICU setting demonstrates the primacy of individual desires and a lack of solidarity that necessarily means some level of disregard for others. When confronted with the values expressed by our health care system explicitly stated, it is doubtful that many people would attempt to justify such values. Despite what the health care system reveals about societal values, the system persists.

1.2 The Issue of Futile Care

In 2013, the *Journal of the American Medical Association* published a report called "The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care." The results were as follows:

During a three-month period, there were 6,916 assessments by 36 critical care specialists of 1,136 patients. Of these patients, 904 (80%) were never perceived to be receiving futile treatment, 98 (8.6%) were perceived as receiving probable futile treatment, 123 (11%) were perceived as receiving futile treatment, and 11 (1%)

were perceived as receiving futile treatment, only on the day they transitioned to palliative care. The patients with futile treatment assessments received 464 days of treatment perceived to be futile in critical care (range, 1-58 days), accounting for 6.7% of all assessed patient days in the 5 ICUs studied. (Huynh et. al., 1987)

ICUs are expensive to operate, are a limited resource, and at times may be providing futile care at a tremendous cost. For me, this meant that any referral of futile care is also a social justice claim. This prompted me to examine the situation in light of the core institutional value of respect, stewardship, collaboration, and social justice, and consider the following:

- Is providing futile care in an ICU upholding respect for the inherent human dignity of persons?
- Is futile care in the ICU living the value of good stewardship of limited resources?

What obligation, if any, do we have as a society and an institution, to shift resources away from expensive and potentially futile care in the ICU to address other areas of scarce medical resources? Was the impulse to rescue a person present in Case B and not in Case A?

1.3 The impulse to rescue

“There is no denying the moral dilemma for those who stand at arm’s length from the very best equipment medical science has to offer and having to decide where to apply it and where to withhold application” (James W. Heisig, S.V.D, 307).

The practical and moral limits to care in an ICU setting are discussed by Scheunemann & White, who detail the tension between the human impulse to provide aid

immediately when confronted with someone in need and the inability to respond with that level of resources to each person in need. This tension is unpacked through the examination of what Albert Jonsen called “the rule of rescue” which is “a powerful psychological impulse to attempt to save those facing death, no matter how expensive or how small the chance of benefit...the moral response to the imminence of death demands that we rescue the doomed” (Scheunemann, 1628). This impulse or drive to offer aid can override other concerns/obligations, such as those to the broader community. To demonstrate this impulse in action, Scheunemann & White tell the story of an Oregon boy named Coby Howard, whose bone marrow transplant coverage was denied. The public responded to the Coby Howard case with outrage due to the impulse to rescue an “identifiable person.” In the case of Coby Howard, the allocation process and the rationing that resulted from those allocation decisions were no longer an abstract idea, but had a face and a name. Scheunemann and White make the claim that if rationing in an ICU setting were to occur (which I believe it is already), and the public were aware, the response would likely be much the same as the public response to the case of Coby Howard (1629). According to Scheunemann & White “some [physicians] deny that rationing occurs and contend that their professional obligations require them not to participate in rationing. In a recent survey, only 60% [of intensivists] vouched that they provide every patient all beneficial therapies without regard to cost” (1625). Cases such as Coby Howard’s rightfully create public outrage; however that outrage is often misdirected. We have created, and are participating in a system in which decisions have to be made, where the outcome could be that children are denied potentially life-saving treatments. Interest fixates upon individual

cases as they are brought to public attention, instead of recognizing them for what they are; glimpses into a failing and potentially unjust healthcare system.

Without diminishing the tremendous dedication, planning, and skill at work in the American healthcare system, I want to acknowledge the precarious situation of critical care in our current health care system. Demand for ICU resources is tremendous: “U.S intensive care units typically run at greater than 90% occupancy and have little surge capacity”. (White et. al., 132) ICU care is not sustainable in the manner in which it is currently being operated. In Case A, the IV drug user, the impulse to rescue an identifiable person didn’t seem to be triggered. The person in the category of futile care in Case B did seem to be triggering the impulse to rescue, which led me to consider what ideological mechanisms were at work for the two different responses. Recognizing that there seemed to be a different ideology at work in the two cases, I wondered if there was also regional differences in the approach to end-of-life care?

Section 2: Regional Differences

Lisa A. Giovanni examines regional differences in end-of-life standards of care in the article, “End-of-Life Care in the United States: Current Reality and Future Promise – A Policy Review”, where she states: “Medicare patients with advanced cancer who died between the years of 2003-2007, had significant variation in end-of-life care from region to region. Roughly 29% of patients died in a hospital, and that number reached as high as 46.7% in the borough of Manhattan in New York, to as low as 17.8% in Cincinnati, Ohio and 7% in Mason City, Iowa” (128). Giovanni looked at the percentage of people who died at home

and then examined the information that provided about regional utilization of hospice service. At-home deaths typically utilize hospice service and are informative because “today, hospice focuses on, caring, not curing, and in most cases:[sic] care is provided in a patient’s home” (128). By percentage in the United States, most people will die in a hospital setting, despite the fact that dying in a hospital setting is not consistent with the public’s expressed wishes regarding the circumstances of their death: “the Gallup polling organization...has found that nine out of ten Americans say they would want to die at home if faced with the end stages of a terminal illness” (Knickerbocker, np). If people do have a preference to die at home and not in a hospital, and there are regional differences by state in the percentage of at-home vs. hospital deaths, what is unique about the locations that have higher levels of at-home death?

From the Death with Dignity Act to the Medicaid priority list, Oregon has been at a leading edge of change in medical care. In “Why Oregon is at the forefront of change on end-of-life care”, Brad Knickerbocker details some of the unique aspects of health care in Oregon. The Medicaid priority list is a ranking of treatments and procedures that will be covered for those enrolled in Medicaid in the state of Oregon, based on the fluctuating state budget. Knickerbocker points out that Oregon is an interesting mix of an “unchurched” population (“residents less likely to be members of or regularly attend churches, synagogues, or mosques”) combined with a “leave-me-alone libertarianism” (np). In addition, Oregon is also an outlier in regards to end-of-life care:

Among the fifty states, home death rates are highest in Oregon, and hospital death rates are lowest. Oregonians are also more likely to have “living wills” – documents in which they ask not to be kept alive by artificial means if recovery seems improbable – and medical directives on file, and they’re more likely to decline

medical treatments (including feeding and hydration tubes) that prolong life (Knickerbocker, np).

Wang et. al in “Geographic Variation of Hospice Use Patterns at the End of Life” looked at the state level variations in end-of-life care. Oregon was again an outlier in end-of-life care:

The implications of our findings are several. First, our results underscore the importance of assessing, not only the proportion of decedents who use hospice, but also the patterns of hospice use, recognizing the substantial magnitude of state-level variation in the United States. Of note, Oregon was in the highest quartile of hospice use, as well as in the lowest quartile of potentially concerning pattern of hospice use...it is possible that the Oregon Death with Dignity Act has resulted in (or at least reflects) more open conversation and careful evaluation of end-of-life options, more appropriate palliative care training of physicians, and more efforts to reduce barriers in access to hospice care and has thus increased hospice referrals and reduced potentially concerning patterns of hospice use in the state. (Wang, et. al. 778)

For Wang et. al, appropriate use of hospice care were factors such as proper utilization of services, no financial incentives, and looking at caregiver and family depression. The work of Wang and Knickerbocker seems to demonstrate that there may be something unique about the approach to end-of-life care in Oregon. As Wang et al. suggests, perhaps Oregon is having some of the difficult conversations surrounding end-of-life decisions. From my own experience, I can attest to the robust conversations I have had regarding documents, such as advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms. Conversations about end-of-life planning are initiated with all patients who discharge from the ICU. In addition, Mission Services employees are trained to help patients initiate conversations about end-of-life care with loved ones and to correctly fill out advance directives.

In an effort to try and understand the unique landscape of health care in Oregon, I read the work of Merger Watch called “Growth of Catholic Hospitals and Health Systems:

2016 Update of the Miscarriage of Medicine Report”. Merger Watch is concerned with the potential negative impacts of Catholic healthcare on women’s rights. Merger Watch produced a document about the growth of Catholic hospitals and Catholic health systems that included information about the percentages of Catholic hospitals by state.

As of 2016, 14.5 percent of all acute care hospitals in the United States are Catholic-owned or affiliated. Over the fifteen-year period- 2001 to 2016, the number of acute care hospitals that are Catholic-owned or affiliated grew by 22 percent, while the overall number of acute care hospitals dropped by 6 percent. One in every six acute care hospital beds is in a facility that is Catholic-owned or affiliated....in Oregon between 30-39 percent of the acute care beds are in facilities that are Catholic-owned or affiliated. (Uttley, Khaikin, 1).

Merger Watch produced an essay that includes maps and numbers citing what they see as the dangers to expansion of Catholic healthcare. This map, produced by Merger Watch, shows data by state within the United States demonstrating the percentage of hospitals that are Catholic-owned or Catholic-affiliated. In addition, using the Dartmouth Atlas of Healthcare website’s interactive tools, I created tables to display numerical information related to end-of-life care by state. I specifically looked at inpatient days per decedent, by interval before death, and level of care intensity in the same year (2014). Below is data from the Dartmouth Atlas of Healthcare website’s interactive tool that compares the inpatient days per decedent, by interval before death, and level of care intensity (ICU) by state, along with the information provided by Merger Watch that gives the percentages of acute care beds in Catholic-owned or affiliated hospitals by state.

Some states have especially high percentages of Catholic hospital beds

In some states, our analysis found, significant percentages of all short-term acute-care beds are in hospitals operating under Catholic restrictions. For example, in five states (shown below in red) — Alaska, Wisconsin, Iowa, Washington and South Dakota — more than 40 percent of the acute care beds are in hospitals with Catholic restrictions. See below.

Percentage of Acute Care Beds in Catholic Owned or Affiliated Hospitals Analysis by State

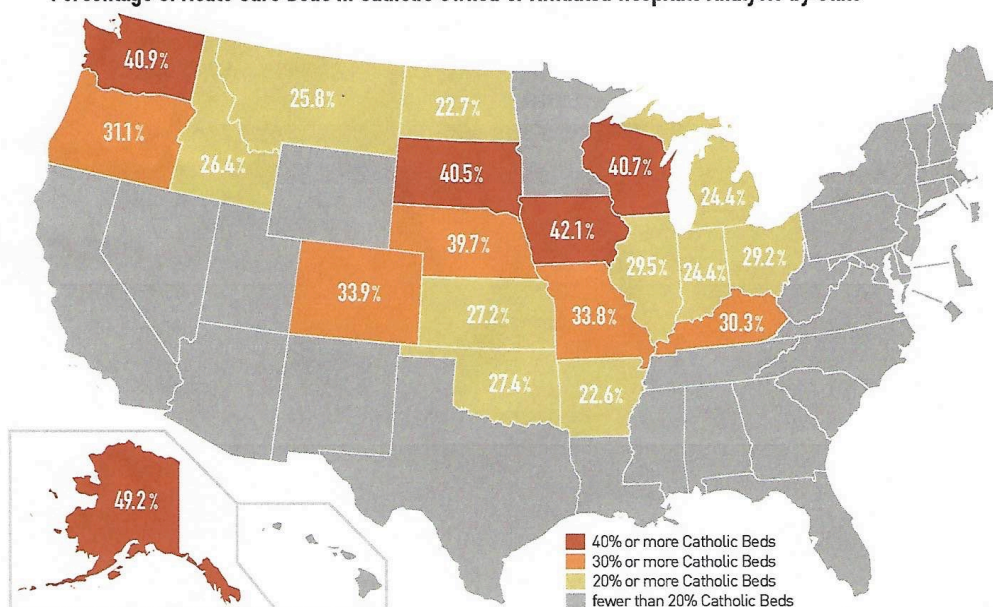


Figure 2.1, Merger Watch Map

Region	Inpatient Days per Decedent, by Interval Before Death and Level of Care Intensity. (Interval Before Death: Last Six Months of Life; Level of Care Intensity: Total ICU; Year: 2014; Region Levels: State)
Colorado	2.3
Iowa	1.8
Nebraska	2.7
Oregon	1.6
South Dakota	2.0
Washington	2.4
Wisconsin	1.7
National Average	3.5
90th Percentile	4.4
50th Percentile	3.0
10th Percentile	1.6

Table 2.1, Dartmouth Atlas Interactive tool table (Map 1)

Region	Inpatient Days per Decedent, by Interval Before Death and Level of Care Intensity. (Interval Before Death: Last Six Months of Life; Level of Care Intensity: Total ICU; Year: 2014; Region Levels: State)
Arizona	4.2
California	4.9
Florida	5.1
Nevada	4.4
Pennsylvania	3.9
Texas	3.8
West Virginia	3.9
National Average	3.5
90th Percentile	4.4
50th Percentile	3.0
10th Percentile	1.6

Table 2.2, Dartmouth Atlas Interactive tool table (Map 2)

State	Days: inpatient days per decedent, by interval before death	Percentage of Catholic Healthcare	State	Days: inpatient days per decedent, by interval before death	Percentage of Catholic Healthcare
Arizona	4.2	Fewer than 20 %	Colorado	2.3	33.9 %
California	4.9	Fewer than 20 %	Iowa	1.8	42.1 %
Florida	5.1	Fewer than 20 %	Nebraska	2.7	39.7 %
Nevada	4.4	Fewer than 20 %	Oregon	1.6	31.1 %
Pennsylvania	3.9	Fewer than 20 %	South Dakota	2.0	40.5 %
Texas	3.8	Fewer than 20 %	Washington	2.4	40.9 %
West Virginia	3.9	Fewer than 20 %	Wisconsin	1.7	40.7 %

Table 2.3, Compilation of Merger Watch & Dartmouth (2014)

The states with the largest percentages of Catholic healthcare hospitals (as demonstrated in the Merger Watch map) also have some of the lowest rates of hospitalizations in days prior to death. All the states I looked at were below the national average (3.5%) and the state of Oregon was in the tenth percentile. I do not mean to overstate the value of this data. I merely present it to further the call for critical examination regarding what may be unique about the approach to end-of-life care in a Catholic hospital or Catholic affiliated hospital, and more specifically, in Catholic health care in Oregon.

Oregon hospitals have the highest number of at-home-death vs. in hospital death rates, with the highest number of individuals completing 'living will' documents as demonstrated by the Dartmouth map. There is some evidence to support the fact that there is a unique culture in Oregon and that, once again, Oregon could be on the forefront of dramatic healthcare change. Because Oregon historically has been a region on the forefront of change in health care, I think it is reasonable to assume it could once again be the location in a shift in standard-of-care and considerations of allocation of resources.

I am not advocating for a particular set of criteria for allocation, but rather advocating for more considerations of antecedent conditions in macro-level allocation. One of the antecedent conditions that precede allocation decisions is bias.

Stage 3: Social Determinants and Margaret Mohrmann

Mohrmann is a professor of feminist, Christian, and bioethics at the University of Virginia. In her essay "The Resistance to Randomness", Margaret Mohrmann provides one example of the values at work in the medical field, specifically when she details the manner in which social determinants and bias have already quietly invaded resource allocation: "It would be a mistake simply to dismiss the troubled deliberations of conscientious professionals, acting in good faith, as exercises in unwarranted discrimination. On the other hand, judgments of social utility, perhaps inevitably, do seep into the fissures left by the ambiguity or mutivalence [sic] of "responsibility"" (339). As an example of one way that social

determinants have invaded the decision-making process in medicine, Mohrmann examines the behaviors that determine the likelihood a person would be excluded from qualifying for an organ donation. Weight is one medical determinant for inclusion and exclusion for organ recipients. Such a position has some justification in that there is empirical evidence to support the claim that obese people have poorer outcomes “post organ donation.” Unacknowledged in this examination, as Mohrmann points out, is that socioeconomic status is a contributing factor in weight. Poorer people without regular access to healthcare are more likely to be obese. Mohrmann speaks of the “casual chain” of healthcare conditions, which are inextricably linked with social determinants. If these social determinants cannot be extracted from medical conditions (which, in the opinion of Mohrmann: “they cannot”), then it is morally overriding that we must account for them in some manner (340). Mohrmann lists the barriers to optimal placement upon the transplant list, such as “weight, money for travel, support system, etc. one can read the seepage of social worth criteria into the first stage” (341-2). While obesity is a medical determination, it is not a concept that can be extracted from other factors, factors directly tied to American value system and necessarily social justice issues.

Like most of the general public, most health professionals hold and display significant bias against obese persons; much as they do in regard to patients who routinely smoke marijuana. It is not too big a stretch to think that these judgments of social worth shape judgments of medical “acceptability,” straying far from the ideal of equal regard (Mohrmann, 340).

Mohrmann’s discussion of weight is one example of a stigmatized condition.

However, there are many conditions and disease processes that have historically been stigmatized; such as alcoholism, drug use, mental illness, and homelessness.

While organ donation and ICU care are not analogous, the work of Mohrmann is important for demonstrating the bias in medicine that influences both macroallocation and microallocation. This bias takes us back to my initial two cases and the potential biases at work in macroallocation of medical resources. Specifically, is exponentially increasing the amount of money spent at the end-of-life revealing a bias maintained by specific narratives in contemporary culture? Is the decision not to allocate greater funds to programs meant to address systemic inequalities such as addictions services, mental health services, disability services, and complex social issues such as homelessness also revealing a significant bias and dominant narrative?

Macroallocation decisions, such as “how federal or state money is spent,” is a reflection of the American value system. The Kaiser foundation provides a report on how health care money is spent in a particular year.

Total federal spending on health care eats up nearly 18 percent of the nation’s output, about double what most industrialized nations spend on health care. In 2011, Medicare spending reached close to \$554 billion, which amounted to 21 percent of the total spent on U.S. health care in that year. Of that \$554 billion, Medicare spent 28 percent (or about \$170 billion) on patients’ last six months of life (khn.org).

I am not questioning whether money should be spent providing care to people at the end of their life. I am questioning if critical thought is being given to the amount of money spent at the end of life commensurate to the “goodness” it may or may not be producing. When I say “goodness,” I am referring to contributing to the condition of human flourishing, including but not limited to, restoration of health and meaningful relationships. I understand ICU care to be at the intersection of cost and goodness.

At first glance, America is making great strides toward a medical and cultural shift in its approach to end-of-life care. More and more providers are recognizing the benefits of hospice. More people are dying at home. Lastly, many health care organizations are institutionalizing the discussion between providers and patients, which would help patients formalize their wishes for end-of-life care through an advance directive. But pull up the curtain on these statistics, and the drama that unfolds tells a very different story. End-of-life care continues to be characterized by aggressive medical intervention and runaway costs (Adamopoulos, 6/3 qtd. Kaiser)

What I am proposing is a more robust commitment to the “medical and cultural shift in the approach to end-of-life care.” Mohrmann’s work is an integral component to this thesis for two reasons: (1) Mohrmann demonstrates that some medical conditions or diseases are stigmatized and (2) that social determinants influence medical determinations. Mohrmann’s example of obesity as an exclusionary factor for organ donation is an example of microallocation. I propose that, at the level of macroallocation, bias may also be at work. I do not think that it is accidental that so much federal and state money is spent at the end-of-life in the United States. I think this is a reflection of dominant world view that speaks to a general denial of human finitude.

Meghan J. Clark is an Assistant professor of Theology and Religious studies at St. John’s University wrote a lecture titled “The Possibilities & Limits of “Field Hospital”: Mercy and Justice in Catholic Social Teaching”. In this lecture, she stated the following: “We were more scandalized by Hurricane Katrina, ‘the event’ than the systemic social inequality that it uncovered.” Upon reading Clark’s comment, I recalled the case of Coby Howard and Jonsen’s concept of the impulse to rescue. Oregonians were scandalized when Coby Howard was denied a bone marrow transplant, yet daily they are silent in the face of healthcare inequity.

People would rather be scandalized by the thought of denying an identifiable person access to ICU care instead of being scandalized by the condition of our healthcare system more broadly. With what is considered by many to be a failing health care system, I next consider how one might act justly in an unjust system.

Section 4: Acting Justly in an Unjust World

4.1 Allen Verhey: The Parable of The Good Samaritan

“Independently of whom the wires and tubes happen to be attached to at any given moment, the whole kit is permanently attached to a wider network of ideas” (James W. Heisig, S.V.D, 297).

Allen Verhey's in *Reading The Bible in the Strange World of Medicine*, the biblical parable of The Good Samaritan, is used to critique issues in contemporary health care. The parable of *The Good Samaritan* tells the story of a man traveling from Jerusalem to Jericho who is beaten, robbed, and left alongside the road. Both a priest and a Levite pass the injured traveler without offering aid. Finally, a Samaritan sees the injured traveler and offers him aid. The Samaritan bandages the traveler's wounds and takes him to an inn. At the inn, the Samaritan pays the innkeeper to look after the injured traveler until the Samaritan can return. Jesus tells the story of *The Good Samaritan*, in order to help reinforce the idea of the neighbor, in reference to the commandment- to “love thy neighbor”. The historical context of the parable is that Jewish people had a contentious relationship with the Samaritans. For this reason, telling a story where the Samaritan exemplifies what it means to care for one's community, as a neighbor, is a startling choice.

In chapter ten of “The Good Samaritan and Scarce Medical Resources”, Verhey examines the parable of the Good Samaritan in light of the contemporary medical environment:

The Samaritan did not face the issue health care is forced to face today, the issue of scarcity. The limitless compassion of the Samaritan makes his story seem more odd than exemplary: unlimited care does not seem to be a real option. Suddenly, he seems a tragic figure, forced to make unwelcome choices. Goods collide and cannot all be chosen, while evils gather and cannot all be avoided (361).

As Verhey points out, concepts like compassion look very different in the contemporary medical setting. The impulse to compassionately offer every form of aid to each person in need -under current conditions, doesn't just look tragic or futile, but perhaps with the strain the current health care system is under, it is not morally defensible. While the Samaritan did not have constraints upon his compassion that the contemporary medical environment has, the message in this parable goes beyond the compassion exhibited by the Samaritan:

Tragic choices are always a consequence of our finitude, of the fact that we are not gods, that our mortality is infeasible, and that our resources, while considerable, are still finite. The point of this is obvious: medicine and medical technology do not and cannot provide an escape either from our mortality or from the finitude of our resources. Medicine does not and cannot eliminate tragedy of the Sophoclean sort. This is obvious, I say, but we have not been disposed to acknowledge the obvious. Perhaps our enthusiasm for medicine and medical technology, as a response to the sad story, has blinded us to its limits. Perhaps, because medicine reminds us so vividly of tragedy, we have used it ironically and self-deceptively to hide and deny tragedy and the limits imposed by our mortality and by the finitude of our resources (365).

In this passage, Verhey highlights two narratives that contribute to our contemporary healthcare crisis: denial of human finitude and limited resources.

What has emerged in the space created by these denials is a system of healthcare that we currently have. Societal institutions are reflections of our collective values, and as Verhey points out, “perhaps our enthusiasm for medicine and medical technology as a response to the sad story has blinded us to its limits.” Imagine the following thought experiment: I am a being from another planet without any knowledge of humanity. The contemporary healthcare system is explained to me. The human healthcare system uses militaristic language to speak about the battle against certain diseases, conditions, and even death. The healthcare system is one where not all humans have equal access to all health care, some conditions or diseases are stigmatized, and where resources and intervention exponentially increase and intensify as death approaches. Least charitably, I might assume that such a healthcare system is hierarchical and that some lives are worth more than others. More charitably, I would assume that humanity lives under the condition of limitless healthcare resources. I would also rightfully assume there was some evidence to substantiate the tremendous amount of resources spent attempting to avoid death. I would assume there was at least one case where death was defeated, for what else could provide justification for such a healthcare system? But there is no case, not one in human history, where death is defeated. And humanity does not live under the conditions of limitless healthcare resources. What one person uses is not available to another. The inherent worth of each human being is almost universally accepted in both secular and religious dialogue. Yet the healthcare system to an interplanetary observer would seem a tangle of internally inconsistent and confusing values. This thought experiment reveals the tension between how

society speaks about values: the inherent worth of each person and language of equal rights for all, versus an absolute right to autonomy and entitlement to healthcare resources without limitation. One set of values is spoken, while another set is lived out. Perhaps the health care system is living out Verhey's concern that "because medicine reminds us so vividly of tragedy, we have used it ironically and self-deceptively in order to hide and deny tragedy and the limits imposed by our mortality and the finitude of our resources."

Medicine has a narrative of individualism, progress, and technology, which is historically situated and consistent within the broader narrative of American frontier mythology. Verhey details the ways in which these two narratives are inextricably linked and reflective of normative values.

[The] American and medical story of the frontier.... frequently told in accounts of medical research and technology, is that we continuously encounter new frontiers and that on those frontiers we must constantly and bravely overcome new obstacles and secure new horizons. It's an optimistic story and it forms an optimistic character. It forms a character ready to press on and reticent to pull back. On the frontier, and just beyond, there is knowledge and wealth and freedom and a good life. The story of the frontier celebrates the rugged individualist, alone against nature and the odds, and it celebrates the technical innovations that extend human mastery over nature – and help one to beat the odds. The story of the frontier does not train those who tell it to be content with limits, and when that discontent with limits spills over onto the limits of human mortality and finite resources, then medical expectations become boundless. Moreover, the frontier knows justice, of course, but is a tightfisted justice that looks out for number one (Verhey, 373-374).

The way we think of ourselves informs the way we think of medicine and the expectations we place upon the medical machinery/institutions and the people who work within the framework of constraints and obligations we, the community, have created. Verhey correctly makes the connection between dominant narratives, such

as the frontier individual ideology and the systems that arise from the communities based upon those normative ideas. Verhey engages the concept of neighbor and the obligations that arise from changing the way in which we think of ourselves as situated always in a community. Verhey points out the limitations of contemporary concepts of social formation:

....we form a society of strangers, a social contract of individuals who use the notion of justice, like a weapon to protect themselves from those who are different from them. They may practice tolerance, but it will be the sort of stingy and tightfisted tolerance that will let the stranger be as long as the stranger stays out of my way and makes no claim on my resources" (379).

The idea of a weapon seems totally inconsistent with any form of justice. Verhey's examination of a social contract focusing on individual rights creates powerful imagery of justice as a defense system. A system designed to keep others out, protect the individual, and tolerate those that don't infringe upon borders. Justice has been reduced to, at best, mere tolerance and, at worst a defense system. Verhey accesses a richer meaning from the traditional understanding of the Samaritan, by embracing the vulnerability of the human condition through identifying with the wounded traveler, as well as making a commitment to care for those in one's community (376). Verhey points out that typically people identify with the heroic aspects of the Samaritan, of rugged individualism, which is consistent with dominant American frontier narratives. However, solidarity requires that people identify with the vulnerable condition of the injured traveler.

Solidarity requires that we identify with the vulnerable human condition and create a community that includes the most vulnerable which requires that we gaze upon the medical world, and more specifically scarce medical resources, not through the eyes of the heroic Samaritan but the vulnerable injured traveler (376-377).

The vulnerable injured traveler has something to say if society is willing to listen. Verhey's unpacking of the parable of The Good Samaritan is important because it reveals the ideology that is a challenge to compassion under the conditions of scarcity. In addition, Verhey's work demonstrates how some of the problems in the contemporary health care system may be an attempt to respond to "the limits imposed by our mortality and by the finitude of our resources" (365). Consequently, to address the issue of mortality and finite resources would be not to "ironically and self-deceptively hide and deny tragedy and the limits imposed by our mortality and by the finitude of our resources," but to embrace an allocation system that accepts these conditions and can justly respond to the question: "Who Shall Live When Not All Can Live?"

4.2 James Childress: Who Shall Live When Not All Can Live?

In his article "Who Shall Live When Not All Can Live?", bioethicists James Childress advocates for a two-tiered process of selection in reference to organ recipients. Childress states: "medical acceptability should be used only to determine the group from which the final selection will be made." (643). The final selection, Childress believes should be a process of random selection. He feels this idea best preserves equal opportunity, which is more 'just' than what he believes are the other two alternatives: letting everyone die or using Utilitarian calculations based on social worth.

There are aspects of Childress's argument that I find problematic. One problem is the dichotomy he creates of 'either' all die or Utilitarian social criteria are used. I do not agree with Childress's argument, which is that random selection and Utilitarian calculations are the only two ways in which resources can be allocated. This argument lacks moral imagination in that it does not promote a "both-and" approach to philosophical inquiry but instead an "either-or" (Campbell).

Childress references the work of Leo Shatin who acknowledges that "our medical decisions are already based on an unconscious scale of values (usually dominated by material worth)" (644). Childress states that obtaining moral consensus (by which objective determinations might be made) is not possible due to the diversity of people and cultures. I am sympathetic to the need to be practical about what individuals and humanity are capable of. However, I am not willing to concede that the best humanity can hope for is individuals that are unwilling and incapable of accepting limits upon their person or understanding their transcendence, interdependence, and participatory obligations.

Expecting the best from people instead of accepting the worst is not an unreasonable position to occupy. In this pursuit, I employ the concept of *Recognition* as understood by Amy Oden, "Recognition is more than just seeing. Recognition is seeing deeply, seeing beyond what appears to be" (10). I acknowledge that achieving fully objective criteria may be beyond what humans can overcome due to inherent bias but I am not willing to abandon the pursuit of minimizing bias. I believe that individuals are capable of *Recognition*, of seeing myself in others, my vulnerable finite self in others. The issue of bias invading

determinations of medical acceptability need not be framed, as if acknowledging the bias means this cannot be something we strive to overcome and *should* be something we strive to overcome. Historically there are many examples of discriminatory behavior that are supported by policies, practices, law, and culture. Instead of the mindset that this is the best humanity can hope for or expect, we rightly expected more from humanity.

Childress's examination of who shall live and who shall not is important, because it highlights the dangers of social determinants influencing scarce resources. Childress's response is random selection after a determination of medical acceptability. Childress states: "my contention is that rejection can be accepted more readily if equality of opportunity, fairness, and trust are preserved, and that they are best preserved by selection by randomness or chance" (352). The work of Mohrmann does not lead me to question the second tier of selection proposed by Childress, but rather the first. The concept of "medically acceptable" is problematic. As Mohrmann states, medical determinations are not so easily extricated from normative values. Medical acceptability may not be the straightforward matter Childress represents it as. Further complicating determinations of medical acceptability is the issue of moral luck.

Section 5: Moral Luck

5.1 Moral Luck: Richard Miller

"The more alive we are to the chanced nature of our lot, the more reason we have to share our fate with others" (Sandel, "The Case Against Perfection", 11).

The 'chanced nature' of the human lot is a component of healthcare that is, at times, overlooked. The denial of the chanced nature of human existence is yet another fiber in the web of myths that are the foundation for the healthcare system in America. The myths that I am referring to are those that deny relations of interdependence, speak in terms of mastery over nature and death, and are in denial of the finitude and vulnerability of the human condition. In "Justice, Reason, and Luck in Rationing Lifesaving Medical Resources," Richard Miller establishes the way moral luck is at play in healthcare allocation currently, and references the work of Childress's engaging the question: who shall live when not all can live. While Miller does challenge aspects of Childress's argument, he ultimately endorses a modified form of Childress's two-tiered lottery selection model. Lottery selection is a way to avoid social determinants invading medical determinations, in that as Miller states: "using a lottery ignores features about the eligible candidate except for the barest essential fact, namely, membership in the human race" (317). Miller correctly identifies that such claims have metaphysical implications:

Random selection thereby implies some metaphysical claims, insofar as it presupposes the distinction between essential and accidental dimensions of human personhood. That distinction enables us to make sense of the fact that the lottery ignores certain features of medically acceptable applicants – features such as inherited wealth, proven talent, social position, or potential social value – as irrelevant when determining how medical resources should be rationed (317-318).

Miller then critiques Childress for not robustly defending his position against what such a metaphysical claim would mean for people who do not endorse a distinction between essential and accidental dimensions of human personhood. While I am

sympathetic to both Miller and Childress's desire to formulate a system in which allocation determinations were based upon purely medical determinations, Mohrmann's insights into the difficulty in the line of demarcation between social and medical determinations problematizes such distinction. A lottery system such as Childress envisions may not be accomplishing the equal opportunity that he hopes for. Miller next examines Childress's argument, in light of the argument of philosopher John Rawls, for whom the outcomes of a social lottery are:

arbitrary from a moral point of view...they distribute advantages or disadvantages to a person for reasons entirely beyond their control.

Allocating resources without taking measures to correct for the lottery's effects will only replicate distributions and advantages that are already in place. Those allocations would be fair, then, only if the original distribution is fair (319).

A lottery system after a determination of medical acceptability both ignores the fact that a determination of medical acceptability may not be as value neutral as it is represented and is replicating already present advantages and disadvantages. The luck at work, as Miller examines, is the bad luck of needing a scarce medical resource and potentially another level of bad luck in not being selected in the lottery system, after being determined to be medically acceptable in the first round. To this point Miller states: "The tragedy in this biomedical case consists of the fact that some patients will be the victims of bad luck in more than one kind of particular lottery" (Miller, 327). I recognize that Rawls is referring to the Natural Lottery, however I find it informative for this situation. In this selection process, consider

those persons whose condition or circumstances eliminates them by a determination that they are not medically acceptable. The equal opportunity that is critical for Childress's argument in defense of random selection via a lottery system is denied to this population. For example, those excluded might be:

- People whose socioeconomic status makes accessing basic healthcare impossible or extremely difficult.
- People suffering from addiction or untreated mental health issues, who cannot access the assistance they need, or live in communities where those services are overwhelmed.
- People who are not considered medically acceptable, based on their addiction or inability to cooperate in their treatment.

These populations denied entrance, even into the pool of medically acceptable candidates, know webs of inequality, which become difficult to escape. The "randomness" of random selection seems to evaporate in the presence of webs of inequality. I am not advocating for an allocation process that includes people who have been determined to be medically unacceptable. I do think that a change in the standard of care at the end-of-life would allow for a different distribution of recourses, such as addiction services and mental health resource, which would mean people in those populations, would have more opportunity to become medically acceptable. Moral luck is an important consideration because of the praise and blame attached where moral luck is at work. Thinking back to Case A the IV drug user and Case B the patient receiving futile care, there seems to be an aspect of moral luck involved in Case A for which the patient is being blamed for.

5.2 Moral Luck: Thomas Nagel

In his essay “Moral Luck,” philosopher Thomas Nagel helps take the concept of moral luck from the abstract to the concrete. Nagel’s work examines how external factors shape the way people are praised or blamed. Nagel begins his argument with a statement about moral judgment that is easily acceptable: “Prior to reflection it is intuitively plausible that people cannot be morally assessed for what is not their fault, or for what is due to factors beyond their control” (322). Nagel quickly points out that that statement is not consistent with the way we actually assign praise and blame and does not account for external factors. To demonstrate external factors in determination of praise and blame, Nagel discusses the difference between reckless driving and manslaughter. A driver can be distracted for many reasons - crying child, ringing phone, and fatigue - but the difference between reckless driving and manslaughter is the presence or absence of a person in the bike lane, in the driver’s path at the moment of their distraction. Nagel also points out that some people live in a time and a place where they will have to make a decision few others will ever encounter. To highlight this fact, he uses the example of someone living in Germany in the 1930’s versus someone who leaves Germany for Argentina for business reasons. The opportunities and choices those two individuals will face are dramatically different. These are examples of moral luck, which Nagel describes as: “where a significant aspect of what someone does depends on factors beyond his control, yet we continue to treat him in that respect as an object of moral judgment, it can be called moral luck. Such luck can be good or bad” (323). Nagel’s essay makes it easier to identify with people who find themselves in situations where

society deems them “reckless” or “negligent.” As Verhey pointed out in his work, it is easier to identify with the heroic Samaritan in The Parable of the Good Samaritan instead of the vulnerable condition of the injured traveler. However, the work of Nagel enable one to identify with a more vulnerable condition; that of distracted driver.

Nagel’s work on moral luck is informative from a social justice perspective, because it forces the examination of the external factors over which a person has no control or minimal control for which praise and blame are assigned that have real material consequences. A child has no control over whether they are born in an affluent country or an impoverished one. A child has no influence upon the level of education or access to healthcare that their parents provide them. A child has no control over whether they are born into an environment free from teratogens or are born and raised in a community disproportionately polluted. Yet all these factors influence the adult who will be assigned praise and blame. According to Nagel: “there are roughly four ways in which the natural objects of moral assessment are disturbingly subject to luck”:

- Constitutive luck: The kind of person you are, where this is not just a question of what you deliberately do, but of your inclinations, capacities, and temperament.
- One’s circumstance.
- Luck in how one is determined by antecedent circumstances.
- Luck in the way one’s actions and projects turn out. (Nagel, 324)

Temperament, capacity, and circumstance are not typically things on the moral radar. Society tends to think if you hit a biker due to a ringing phone, you are a bad person, deserving of whatever judicial punishment is handed down. If you are an intravenous drug addict who needs a valve replacement due to endocarditis as a result of drug use, you are a bad person, deserving of whatever healthcare justice is handed down. The presence of blame could mean that the IV drug user is denied a second heart valve replacement as a form of health care justice.

Nagel points out the inconsistency between the idea that people are not to be praised or blamed for things beyond their control and the ways in which praise and blame are actually assigned: “The things for which people are morally judged are determined in more ways than we at first realize by what is beyond their control. And when the seemingly natural requirement of fault or responsibility is applied in light of these facts, it leaves few pre-reflective moral judgments” (323).

Nagel’s revealing of moral luck has serious implications especially in light of Mohrmann’s “casual chain” in healthcare, which describes the connection between socioeconomic status that limits access to healthcare and is a risk factor for things such as obesity, diabetes, hypertension and many other health conditions (Mohrmann, 340). Nagel also points out the unintelligibility of praise and blame without considering moral luck.

Perhaps it is true that what is done depends on more than the agent’s state of mind or intention. The problem then is, why is it not irrational to base moral assessment on what people do, in this broad sense? It amounts to holding them responsible for the contributions of fate as well as for their own – provided they have made some contribution to begin with. If the object of moral judgment is the person, then to hold him accountable for what he has done in the broader sense is akin to strict liability, which may have its legal uses but seems irrational as a moral position (325).

Our healthcare system does not account for moral luck that is described by Nagel. Nagel's work is problematic for medicine in general. A person has no control over where they are born geographically; whether a tornado hits their town and financially devastates their community; whether their parents are drug addicts; whether they are pre-disposed genetically to addiction or diabetes; or whether a person might be born cautious or a risk taker. I acknowledge that there is still an ongoing debate regarding the line of demarcation between nature and nurture as they influence behavior. I am willing to concede that psychological and anthropological debate in this area persists. However, both nature and nurture are vulnerable to Nagel's critique. A person has no control over what behaviors or temperaments will be encouraged, modeled, or discouraged by the people they are in relationship with in childhood. Compound layers of moral luck with any act seen as contributing to fate, such as breaking the law or encountering health complications due to drug or alcohol abuse, and an individual is not only unlikely to be considered medically acceptable in many calculations, but they are a person deserving of blame.

I am not advocating for one form of allocation over another. I am saying that when looking at meeting the needs of a community accounting for moral luck at work provides even greater motivation to address matters of social justice and think about how scarce medical resources are allocated. We must seek out the voices of those who, due to bad moral luck and causal chains, have been potentially denied equal access to healthcare and whose voices are absent from public dialogue about

appropriate criteria for allocation of scarce resources. Considering Case A and Case B in light of moral luck, the presence of blame seems to deny the idea of moral luck as articulated by Nagel. Consideration of antecedent conditions that precede allocation determination seems to require a rich conception of the human condition.

Section 6: Limitations of a Purely Secular Debate

6.1 Biologically Reductive Accounts of the Human condition

In “Toward a Personalistic Ethics of Limiting Access to Medical Treatment: Philosophical and Catholic Positions”, Josef Seifert founding Director of The International Academy of Philosophy in Texas, offers a picture of human dignity reduced to an issue of individual rights: “If all knowability [sic] and public relevance of content-full human rights and moral imperatives were denied, for the public world nothing would remain but principles of non-coerciveness [sic], informed consent, and tolerance” (97). Principles of non-coerciveness and tolerance seem insufficient for understanding human rights and the human condition. Such an account seems biologically reductive and leaves out essential aspects of the human condition. By biologically reductive account I mean reducing the human condition to a body that is an aggregate of parts fully explainable and understood in purely scientific terms. In “Facing the Challenges of High-Technology Medicine: Taking the Tradition Seriously,” Mark Cherry examines the limits of a purely secular debate regarding healthcare ethics and more specifically allocation of scarce resources. Mark Cherry is the Dr. Patricia A. Hayes Professor in Applied Ethics at St Edward’s University in Texas and editor of The Journal of Medicine and Philosophy.

In very general terms: secular axiology cannot provide a unique meaningful account of pain, disease, disability, suffering, and death; beyond the firing of synapses, the collapse of human abilities, and the mere end of life. As a result, most contemporary bioethical accounts are remarkably thin. Populated with the jargon of duty and obligation, equality, autonomy, virtue, and beneficence – without careful analysis of the deep theological and moral significance of health care – they are able to encourage us to expand choice, eliminate suffering, and reduce death, but unable authoritatively to determine which choices to make, which kinds of suffering to eliminate, or which deaths to postpone (20).

What I particularly appreciate in the way Cherry unpacks this issue is that he does not say, “which deaths to prevent,” but rather “which deaths to postpone”, a critical distinction. Cherry’s framework requires that allocation decisions be made in the presence of human finitude. Medicine cannot prevent death it can only postpone it. Days, minutes, hours of life cannot be a moral “good” on its own. While many religions, Catholicism included, have been represented as prioritizing human life over all other considerations I feel this is the least charitable interpretation of Christian and particularly Catholic thinking. There are moral limits accepted and expected with regards to end-of-life care in Catholic moral teaching. Respect for human life is about the dignity of human life. The dignity of human life is not based upon longevity of life and extending life for the sake of time alone but should be proportionate to other considerations. Proportioned means are explained in the *Ethical and Religious Directives for Catholic Health Care Services* or ERD’s. “Directive 56” of the ERD’s states: “A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the

community.” The discussion of proportionate means is framed within a discussion of benefit and burden for the individual but also for the family and community. I recognize that benefit and burden are terms that require context and should not be reduced to monetary concerns. Balancing of benefits and burdens is not meant in a utilitarian manner. Decisions about benefits and burdens seem most appropriately made in relationship with one’s physician and family members.

6.2 Physician as Gatekeeper

With a frontier narrative, which has pervaded society, including healthcare based upon denial of relations of dependence, concepts of mastery over self and situations, and supported by an intoxication with autonomy, physicians are often forced into the role of gatekeeper. The role of gatekeeper is inconsistent with any form of the parable of “The Good Samaritan.” Responding as the Samaritan would be to heroically do all for the patient and this is not a possibility within the current health care system. Seeing one’s self as the injured traveler also seems at odds with contemporary ideology. The orientation of physician to patient has become very limited in the current healthcare system. Catholic bioethicist Joseph Boyle’s, “Limiting Access to Health Care: A Traditional Roman Catholic Analysis” demonstrates how the role of gatekeeper is inconsistent with the virtues of a physician:

Physicians seem duty-bound by virtue of their professional obligations toward their patient to act only in their interests, and certainly not to refuse to offer treatments, because of the impact on other people. At the very least, it seems to me that physicians should not (as the helpers of the patients they serve) function as gatekeepers to medical treatment or as triage officers. If those functions must be fulfilled, then others, or physicians at arms-length, or

with significant procedural cautions and oversight, should carry them out” (93).

The nature of medicine will likely always have an element of rationing that as just stewards of finite resources, physicians must always participate in. However, the current healthcare system has stripped the physician of much of the opportunity to practice the art of medicine, and reduced the role of physicians to merely a medical delivery system. The contemporary ideology of the A-Samaritan which has an individual focus a little concept of solidarity has restricted much of medicine to the terminology of mere physiology. “In an era of medical progress, in which the “technological imperative” (Jonas 1979) suggests that everything that is technologically possible is also ethically legitimate, or, even more, ethically mandatory., the criteria for deciding what constitutes an appropriate use of high-technology medicine cannot be driven from the logic of strict physiological utility” (Taboada, 67). An understanding of the human condition as the body alone, an aggregate of parts restricts conversations about human flourishing or an understanding of what it means to be in a state of health.

When a patient is understood as mere functions of organ systems, and the physician is making determinations about who should have access to critical care in an ICU setting, and in what order, the art of medicine, the healing mission of medicine is stripped away. A biologically reductive understanding of the human condition makes it difficult to set or prioritize goals beyond who might gain the most minutes or hours of life through the intervention available in the ICU. Joseph Boyle makes the claim that it is not a matter that the physician may refuse patient

requests for certain types of care, but that they ought to. “Physicians morally ought to refuse to cooperate with patient requests for treatments that medical consensus judges strictly futile or so unlikely to benefit as to warrant a similar verdict” (Boyle, 86). Determination of what constitutes futile care is the burden of a “just” physician.

6.3 “The New Medicine & The Old Ethics” by Albert Jonsen

In chapter two of *The New Medicine & The Old Ethics*, by Albert Jonsen, “The Good Samaritan as Gatekeeper,” Albert Jonsen’s primary concern is how one might be a “just” physician in an unjust system (43). In his exploration of this question, he details the position of physicians in contemporary medicine: “Hardly a physician today is immune from the demand to ration, whether that demand comes in the mild form of cost-effective ordering or in the extreme form of explicit restrictions on availability of services or referral. Indeed, the decisions of the physician dealing with the patient are the primary rationing device” (43). Jonsen details that the practice of rationing causes a conflict within the physician and this conflict is a matter of conscience for the physician (44). Jonsen does not make the claim that physicians have no place in the process of allocation or rationing. The practice of medicine necessarily requires some level of rationing. Jonsen refers to the physician as device. This is a powerful statement when you unpack the characteristics of a device. A device is a mechanism; there is not art or interpretation to the work of a device. A device dispenses objects or delivers services according to some set programming. Jonsen’s use of the term “device” reminded me of an intensivist who once said to me “I am a medical vending machine”. When physicians are reduced to

a device, a gatekeeper, a medical vending machine, they are limited in their opportunity to practice the art of medicine.

Jonsen suggests policy makers need to take that burden of allocation of scarce medical resources from the physician, as it places the physician between obligations to a specific patient and broader social justice concerns: “Scarcely a physician today has failed to experience some conflict between the principle of service to the sick and the solvency or profitability of the institution or practice in which he or she works. Allocation of resources is not only a philosophical problem of health policy; it is – or should be – a problem of conscience for the practitioner.” (44). Engaging this philosophical problem in a purely physiological manner seems to limit the available responses of the physician.

Jonsen also asks an intriguing question: “Who is the patient?” (49). The patient in front of the physician is always in competition with other unseen or unacknowledged patients. This can be a specific patient within the same institution or patients understood more broadly as a people make a community claim on health care resources. “Justice in health care has no actual patients: it seeks a principle of distribution that will, in anticipation of actual need, count some person as worthy of attention and count others out” (44). Social justice claims can be about one patient directly in front of the physician or a claim based on 10,000 unknown or potential patients. Because some level of allocation will always be the duty of the physician, maintaining the art of medicine is critical.

Jonsen emphasizes the “Art” of medicine, which is difficult to understand in purely empirical terms: “The clinician’s judgments are always in the realm of

probability: they are calculations of prudence, not of mathematical science” (55). Emphasizing the art of medicine would require an emphasis on “calculations of prudence,” which would seem to necessitate a strong relationship of trust between the physician and the patient or relevant stakeholders (stakeholders can be surrogate decision makers, family or friends etc.). The physician as a medical vending machine seems inconsistent with a strong relationship of trust.

Jonsen also makes an interesting argument based upon the Hippocratic tradition, which states that medical treatment is appropriate for some patients, while others need to be cared for in another manner (52). Jonsen acknowledges the concern for quality of life judgments that might arise from this concept of medical care. However, Jonsen does feel that such an understanding of medicine is appropriate and consistent with the Hippocratic tradition that is focused upon the resulting benefits of a given intervention as well as avoiding injustice (53). “The Hippocratic essay entitled “The Art” says that the work of medicine is to lessen the violence of disease, relieve pain and avoid attempts to cure those whom disease has overcome” (Jonsen, 53). This “old ethic” that Jonsen references would support a change in ideology from “do everything possible for this patient to do everything reasonable for all patients” (58).

Many critiques are made about the physician/ patient relationship in contemporary medicine. Jonsen’s examination of new medicine, in light of the old ethics, provides insight into how the contemporary physician/patient relationship was formed. If much of the art of medicine has been stripped away, humans are understood in a biologically reductive manner. With a biologically reductive

conception of the human condition, the goal of medicine is primarily to achieve the most minutes, hours, days of life at the cost of almost all other concerns. As a provider of goods (the physician) and the patient (as consumer of goods) seems almost the most likely orientation of physician to patient. When the physician expressed to me that she felt like a vending machine, I took her statement to mean she was denied the opportunity to operate the art of medicine. The art of medicine as I understand it includes determinations of prudence and the developing of a relationship with the patients and their family members so that those calculations of prudence can be made with the patient and family. The physician is given the opportunity to offer their skills beyond empirical data to care for their patient and to accompany the patient, even when they are overcome by disease or injury.

Recently I was asked to consult on a patient and facilitate a discussion between the different disciplines caring for a patient. In a conference room outside the ICU, the entire care team gathered to discuss the situation. The nephrologist listed the different medications he needed to administer. The cardiologist became irritated and said, "Those meds will tank my heart." The two physicians went back and forth, negotiating which medications would be administered. In a break in the bickering I asked, "What does all this mean for Mark"? The cardiologist looked at me confused and said, "Who is Mark"? To which I replied, "the patient."

Such conversations are typical of contemporary medicine, as well as informative. When a patient says "my heart," the cardiologist refers to the heart as a matter of possession. Neither physician knew the patients name. The person represented by empirical data in the form of blood pressure and lab tests had been

lost. These are two well-meaning and skilled clinicians. However, both physicians were not seeing this patient as a person or considering what all these interventions might mean for “Mark.” When the physicians were confronted with Mark, as a whole person, they determined that they could not fix the kidneys without injuring the heart and vice versa. They decided that comfort care should be recommended to Mark. As the care team adjourned the room, I asked both the physicians who would like to accompany me to speak with Mark. The nephrologist replied to me “My work is done.” When the physicians determined they could no longer postpone death, they no longer felt an obligation to the patient. This situation reflects a very reductive concept of the field of medicine and the human condition. I share this story, not as an ethical case as it pertains to allocation of resources, but to demonstrate the tendency in health care, to think of patients and the human condition more broadly in a biologically reductive manner.

6.4 Religious Ethics and Secular Ethics are not Incompatible

Many times, secular ethics are viewed as incompatible with religious ethics. While the language or justificatory framework may be different, there are significant areas of agreement. For example, The American College of Physicians (ACP) in their Ethics Manual addresses the issue of futile treatment.

In the circumstances that no evidence shows that a specific treatment desired by the patient will provide any medical benefit, the physician is not ethically obliged to provide such treatment (although the physician should be aware of any relevant state law). The physician need not provide an effort at resuscitation that cannot conceivably restore circulation and breathing, but he or she should help the family to understand and accept this reality. The more common and much more difficult circumstance occurs when treatment

offers some small prospect of benefit at a great burden of suffering (or financial cost...), but the patient or family nevertheless desires it.

The position of the ACP states that a “physician is not ethically obliged to provide such treatment,” which is not the same statement as the physician is morally obligated not to offer treatment. Catholic moral theology is not inconsistent with the ACP, but takes a more robust position in reference to futile treatment or minimally beneficial treatment, precisely because of the manner in which Catholicism understands human dignity. Human dignity means persons are entitled to things but also there are requirements of you. It requires that you participate in a community of solidarity to include collaborating about what reasonable limitations in medicine might mean in a spirit of rich solidarity. In “The Allocation of Medical Services: The Problem from a Protestant Perspective,” Dietrich Rössler addresses the issue of limitations, specifically the idea of intensive care as a goal in itself:

We must remember that from an ethical perspective intensive care itself cannot be a valid treatment goal. Intensive care is only a means; the goal must be something different. Intensive care is a therapy that should be used in order to make itself superfluous. There may be circumstances that prevent this goal from being reached in particular cases, but there can be no moral grounds for deeming intensive care in itself desirable as an end (Rössler, 270).

Societal acceptance that intensive care (as such) cannot be a valid treatment goal, would profoundly alter the way medicine is practiced. Such a shift would require that society change the way it thinks about medical intervention. Changing the way medical intervention is understood would mean adapting the goals of medicine to potentially include a shift away from exponentially increasing the amount of

intervention at the end-of-life. I am not advocating denying treatment to any person for whom extraordinary or aggressive intervention could provide benefit. I am advocating for thinking critically about the appropriateness of interventions deemed to have some effect, but not necessarily be of benefit. I am using the terms 'effect' and 'benefit' as described by Paulina Taboada in "What Is Appropriate Intensive Care? A Roman Catholic Perspective" who states: "Physicians must distinguish between an effect, which is limited to some part of the patient's body, and a benefit which appreciably improves the person as a whole" (59). The distinction between effect and benefit is applicable to both the patient of Case B, the permanently unconscious patient close to death, and Mark, the patient recommended for comfort care. I take Taboada's use of the phrase "whole person" not to be limited to the whole-body system, but instead a more transcendent concept of person. Making the distinction between effect and benefit would allow for a different distribution of scarce medical resources away from futile care.

Section 7: Four Pillars of Catholic Social Teaching

7.1 Human dignity

The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problems or social status. The respect for human dignity extends to all person who are served by Catholic health care (Ethical and Religious Directives for Catholic Health Care, 23).

For a richer unpacking of Catholic social teaching and insight into antecedent considerations to allocation decisions, I used the work of John Coleman in "American Catholicism, Catholic Charities U.S.A., and Welfare Reform" who offers an

outline of four of the pillars of Catholic social teaching: human dignity, common good, subsidiarity, and solidarity.

Human dignity

To speak of the human dignity of the person is to appeal to his or her “sacred” worth or value as a concrete existing human being. It is never permissible to use a human being merely as a means toward some ulterior aim or purpose. Human dignity evokes corollary concepts of human responsibility, moral agency, and freedom. To root its meaning concretely, Catholic social thought anchors it in appeals both to the concepts of *human rights* and *human needs* (Coleman 76).

The Catholic concept of human dignity is anchored in human needs. Human needs include: “an appropriate standard of living (food, clothing, a home, education, health care, unemployment aid, help in old age) consonant with human dignity” (Coleman, 76). The needs required to fulfill the obligations of human dignity bring to mind the conditions that precede determinations of medical acceptability; conditions where moral luck is operative. Consider “appropriate standards of living” in-light-of the patient in Case B; the IV drug user. I understand that certainly there are drug addicts who have a standard of living that would be considered appropriate according to Catholic social teaching. I am saying that the majority of the IV drug users that I encounter are caught up in webs of inequality. They frequently live under one or more of the following conditions:

- Inadequate support system
- Are typically unemployed or underemployed
- Some level of depression and/or mental illness

- Homeless or sub-optimal living conditions (i.e. staying with friends)
- Lacking college education
- Victims and/or perpetrators of either sexual or physical violence
- Serious health complications as a direct result of drug use

Appropriate standards of living, as a necessary condition of human dignity, provides support for prioritizing macroallocation of health care funds toward such ends.

In addition, human dignity consistent with Catholic social teaching is a matter of both rights and responsibility. Catholic social teaching recognizes rights in three ways: positive, negative, and participatory. An example of a positive right is the obligation that medical staff has to offer aid in a hospital emergency room. Negative rights are things people must abstain from, doing such as not forcing a person to have a surgery they do not wish to have. Participatory rights are “rights to participatory access to political and cultural life, that is, rights to take genuine part in the process of work and the formation of political opinion” (Coleman, 76-77).

Human dignity is understood as providing a person with rights, but also that having an element of responsibility is important for considerations of subsidiarity, common good, and solidarity.

The Catholic Church underwent a radical change in practice and doctrine in 1962 during the Second Vatican Council; a process that took years and the collaboration of the entire hierarchy of the Church. One significant area of change that arose from the Second Vatican Council was the emphasis on the individual Catholic conscience. An individual Catholic conscience meant a move away from a paternalistic emphasis in the Church and toward individuals of the Catholic faith,

forming their own moral conscience and participating in the world. This shift has implication for the participatory aspect of human dignity. “The radical claim of Catholic social thought is that my humanity is bound up in yours” (Clark, 8). Recognizing that “my humanity is bound up in yours” would require that I acknowledge the intrinsically relational human condition and abandon the narrative of the individual. The Catholic understanding of my dignity being bound up in others is the foundation for moral requirements, such as accepting limits but also ‘participation’. Catholic social teaching requires a richer conception of human dignity, which cannot have its foundation in individual rights alone.

7.2 Subsidiarity

Because all healthcare is delivered locally, the healthcare system should be designed locally. It is at the local, community level where we are most likely to innovate and implement new healthcare delivery solutions (Siegl, np).

Given the real potential for a misuse of human abilities, individual states can no longer ignore their responsibility for planning, coordination, oversight and enforcement within their respective borders (*Laudato Si'*, 177).

I advocate for a local re-set of regional standards of care, in part as connected to the Catholic principle of subsidiarity first mentioned by Pope Pius XI in *Quadragesimo Anno*. “It is an injustice, and at the same time, a grave evil, as well as a disturbance to right order, to transfer to the larger and higher collectivity functions which can be performed and provided for by lesser and subordinate bodies” (79). At best, doctrine and principles are trying to capture what is happening in society. For this reason, it makes sense, both practically and according to the Catholic principle of subsidiarity, that health care issues should be first addressed locally. In

addition, out of the Second Vatican Council arose the emphasis on the individual Catholic conscience and lay vocations. This shift has implication for the social teaching of subsidiarity, in that all Catholics were called to respond to the moral obligations of respect for human dignity, common good, and solidarity. It is no longer acceptable for the individual Catholic to wait for the Church to respond to issues in a community, but rather the moral obligation is now for the individual to respond. *Pacem In Terris* is a papal encyclical, written by Pope John XXII in 1963 on “Establishing Universal Peace In Truth, Justice, Charity, and Liberty.” This papal encyclical is significant because it was the first encyclical addressed, not to members of the Catholic, but “to all men of good will.” In the encyclical, Pope John XXII writes: “It is useless to admit that a man has a right to necessities of life, unless we also do all in our power to supply him with means sufficient for this livelihood” (32). These are the words that come to mind when I consider the necessary conditions for appropriate standard of living and importantly they are not addresses to a purely Catholic audience. The Second Vatican Council was responsible for the expansion of Catholics moral obligation from just others of Catholic faith to all of humanity. Contemporary issues, such as global climate change, can seem insurmountable and individuals may feel like their contribution to both the problem and potential solutions is minimum. For these reasons, people feel the obligation to participate is not their own and such issues are better addressed by larger agencies such as the federal government. However, as a matter of human dignity, participation is not optional but necessary, according to Catholic social teaching. “Participation is participation in the humanity of the other so that when we sacrifice them, or allow

them to be sacrificed, we are sacrificing ourselves. Our common humanity is the risk, benefit, and demand of human dignity; it requires human rights and solidarity” (Clark 106).

When considering Case A and Case B, my original question was “what about contemporary ideology allowed for a social justice claim in Case A, but not Case B?” In Case A, people did not seem to be responding as if a person was being sacrificed. Perhaps, this is partially due to the fact that a denial of a heart valve will not necessarily result in immediate death, whereas a withdrawal of ICU care typically results in immediate death for the patient. Case B involving futile care in the ICU may be more dramatic. I am not even necessarily talking about the determination to proceed with the second heart valve surgery, but systemic issues preceding such a decision. I think that society has already sacrificed this person.

While human rights apply to individual human persons, they are in no way individualistic. The rights one holds as an individual human person cannot be properly understood without the responsibilities attached to those rights. Recognizing and living out one’s own individual human rights is not sufficient; all human rights include the primary duties of reciprocity and mutual collaboration. We have a profound obligation to promote the human rights and flourishing of others as part of the common good (Clark 13-14).

Clark shifts the way rights are understood by recognizing that I cannot flourish in an environment when that flourishing is denied or restricted to others. Clark highlights the necessary connection between what it means to be entitled to rights and therefore obligated: “if a man becomes conscious of his rights, he must become equally aware of his duties (PT 44, qtd Clark 16). Recognition of my own rights places requirements upon me with regards to others. Solidarity, as Clark proposes,

requires an abandonment of contemporary concepts of rights and freedom based upon an emphasis on individualism and autonomy.

The social teaching of subsidiarity places a primacy upon community level engagement with social problems “This tenet holds that nothing should be done by a larger and more complex organization which can be done as well by a smaller and simpler organization.” (Bosnich, np). The stakeholders involved in a situation at the local level, can recognize the call to participate in their own community. By participation I mean engage in dialogue about appropriate allocation of health care resources.

I recently attended the Catholic Healthcare Association’s Theology and Ethics Colloquium, whose theme was “Field Hospital: An image for Catholic Health Care in the U.S.” At this colloquium, the objective was to unpack Pope Francis’s metaphor of the Catholic Church as a field hospital. Professor of Systematic Theology and Chair of the Department of Theology at Boston College Richard Gaillardetz spoke about “The Merciful and Missionary Church of Pope Francis.” One key aspect of understanding the metaphor of the field hospital that Gaillardetz returned to again and again was nearness and proximity. Gaillardetz said, “We cannot deny the institutional reality of the Church, but instead we must call for a new version of service.” A key aspect of this new version of service is adaptability and ongoing reform. Gaillardetz stated this work requires that those of us in healthcare “empty ourselves of privilege and protection...we must abandon our protected spaces. Relationships of solidarity with the poor or those in need, are not just addressing the needs of that population but learning from them”.

Gaillardetz's concept of solidarity calls for radical inclusion that he says is truly consultative in-order-to avoid becoming an ecclesiastical echo chamber. This consultation requires going beyond pragmatic public gestures, but listening to the voices in exile. This collaboration would allow for all stakeholders to participate in the conversation about criteria for allocation of scarce medical resources. Such collaboration speaks to the work of Bradford and Sartwell: I will have no voice in some decision if I do not know it is being made, or cannot get into a place where I could speak up (Bradford & Sartwell, 194:II). When we do not critically examine the issue of moral luck and exile people on the periphery of society, we not only deny them access to conversation regarding health care allocation, but we also deny ourselves the opportunity that being in relationship would provide. Finally, Gaillardetz states that the Church comes to know itself by 'going out.' Paradoxically, the center of the Church is found at the periphery in what Gaillardetz calls a transposition of institutional presence; to go where people are wounded. While Gaillardetz is speaking to the Catholic Church, his message is intriguing and applicable to a wider audience.

A way in which as Gaillardetz states, "The Church comes to know itself by going out," I propose, would be the preferential option for the poor. The preferential option for the poor is giving preference to marginalized populations and is historically and contemporarily consistent with Catholic social teaching as seen in papal encyclicals. Pope John Paul II, in *Centesimus Annus*, first used the term "preferential option for the poor." *Centesimus Annus*, written in 1991, is seen as a continuation of *Rerum Novarum*, written one-hundred years earlier by Pope Leo

XIII. Pope John Paul II references the encyclical *Rerum Novarum* as a continuation of the idea of preferential treatment for the poor.

Re-reading the Encyclical [*Rerum Novarum*] in the light of contemporary realities enables us to appreciate *the Church's constant concern for and dedication to* categories of people who are especially beloved to the Lord Jesus. The content of the text is an excellent testimony to the continuity within the Church of the so-called "preferential option for the poor", an option which I defined as a "special form of primacy in the exercise of Christian charity" (*Centesimus Annus*, 11).

The preferential option for the poor is also present in the Catholic ERD's that can be read in directive three:

In accord with its mission, Catholic health care should distinguish itself by its service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination. Such people include the poor, the uninsured and the underinsured, children and the unborn, single parents, the elderly, those with incurable disease and chemical dependencies, racial minorities, and immigrants and refugees. More specifically, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

The preferential option for the poor includes a commitment to radical proximity.

Rev. Myles Sheehan offers insight into both what radical proximity says "to humanity and about humanity": "Our credibility is on the line when we care for the marginalized, how well are we doing this....we must enter the darkness where our brothers live...I must enter the dark and dangerous places which requires that I be conscious of my own wretchedness and sins." This sort of solidarity that requires a radical proximity allows no retreat into platitudes.

When moral luck is not considered in an examination of social justice, we exclude those voices, voices who positionally could offer insight into their needs in a

way in which many, myself included, do not have access. The voices that are excluded might provide an avenue for escape from what we are currently experiencing that Meghan Clark calls a “crisis of solidarity,” which is a tightfisted or impoverished form of solidarity. True solidarity must pervade “every level of human society” (Clark, 30).

7.3 Common Good

A Catholic health care organization should be a responsible steward of the health care resources available to it (Ethical and Religious Directives for Catholic Health Care, 6).

The common good is not the same as a utilitarian concept of the greater good. The greater good allows for the violation of individual rights in pursuit of the greater good. The common good cannot make allowances for violation of individual rights as a matter of respect for human dignity. Common good is a matter of human flourishing.

The Catholic notion of a common good reflects its belief about the essentially communitarian character of human existence. Persons flourish only in community and the good of each person is bound up with the good of community. The common good is a social reality in which all persons should share through their participation in it. It is not simply the arithmetic aggregate of individual goods suggested by the utilitarian formula “the greatest good for the greatest number.” Catholicism desires a thicker and more substantive (not merely procedural) notion of the human and social good (77-78)

Common good, as understood in Catholic social teaching, situates individual flourishing within the broader flourishing of a community. “Commitment to the

common good rejects individualistic presuppositions in some forms of modern liberal thought with their one-sided emphasis on human autonomy" (77).

Flourishing within a community that prioritizes the common good is not a rejection of autonomy but a situating of autonomy within other moral considerations.

Catholics argue that "the common good," as sociologist Philip Selznick has insisted, "is the state of the system, not an attribute of individuals." The common good is an institutional reality. It looks to creating the societal conditions to enhance and justly distribute common or public goods (Coleman, 78).

Health care is a complicated web of institutions, policies, and laws, which are supported both ideologically and financially by the public. Health care is a public social good meaning it is a finite shared public resource. In "The Vision of Catholic Social Thought: The Virtue of Solidarity and the Praxis of Human Rights," Meghan Clark references the work of Amartya Sen, who outlines the concept of common good and makes an argument for why public health should be considered a public good:

Major components of social support necessary are public goods, which are those goods that, if they exist, are present for all, such as a system of traffic lights. A system of traffic lights and infrastructure exist for all members of the community. Sen contends that public health should be understood within the framework of public goods. For example, a social program for eradicating malaria is a public good, not a private one, even if it is due to the actions of an individual: "I may be willing to pay my share in a social program of malaria eradication, but I cannot buy my part of the protection in the form of a 'private good' (like an apple or a shirt). It is a 'public good,' malaria-free surroundings, which we have to consume together. Indeed, if I do manage to organize a malaria-free environment where I live, my neighbor too will have that...without having to 'buy' it from anywhere." These public or semipublic goods require "social provisioning that arises from the need of basic capabilities, such as elementary health care and basic educational opportunities," and cannot simply rest on a market mechanism of development (Clark 82-83).

Just as a system of traffic lights benefits the entire community, health care is a system that should benefit the entire community, understood as a common good. Contemporary health care emphasizes individual rights and seems inconsistent with understanding health care as a common public good. “The fair use of health care resources is a problem that cannot be solved by purely individual initiative. That is because health care is organized and paid for through a complex social system that frames and limits the impact of individual health care decisions“

(Boyle, 89). Because I believe Boyle is correct, in that “the fair use of health care resources is a problem that cannot be solved by purely individual initiative” and each member of a community is a healthcare stakeholder, state level examination at how health care resources should be allocated seems appropriate.

The common good in the Catholic context cannot be reduced to utilitarianism accounts of greater good. Utilitarianism is based upon maximizing utility and some forms of utilitarianism allows for the violation of individual rights in the pursuit of the greater good. The Catholic concept of common good does not make allowances for violation of individual rights.

7.4 Solidarity

It is important to realize that complex solidarity in Catholic social thought goes further than a first order descriptive acceptance of humanity as “socially constituted” (as stated almost tritely by some communitarian thinkers). Rather, it is a para-norm for personal life and society. It plainly goes much wider than the “given, tight,” often parochial conservative groupings of blood, place, memory, and religion. As for reading solidarity as simple homogeneity or identity, there lies perhaps the greatest travesty; for its essence is to be unity in diversity, difference not flattened but bridged or mutualized (Coleman, 81).

As Coleman states, Catholic solidarity embraces a “unity in diversity” which is an important consideration for solidarity, particularly in the unique culture present in Oregon. Within Mission Services at the hospital I work for, there are full time spiritual leaders from diverse backgrounds: Unitarian, Protestant, Catholic, and Pagan. Every morning, Mission Services begins with a huddle where census information for the hospital is shared and each person is given an opportunity to share any personal or professional needs for the day. Whoever is facilitating the huddle shares a non-denominational reflection or poem and then the group disperses to their assigned floors to meet the needs of the patients and families in the hospital. I see this as a demonstration of the Catholic Church’s commitment to serve the needs of the entire community and not just a Catholic community. Meghan Clark provides an outline of the concept of solidarity and for Clark, human rights and respect for human dignity cannot be an individual concern, but must be understood as a community matter: “For Catholic social thought, human rights and solidarity cannot be at odds, as one cannot truly be present without the other. The two are intrinsically connected in the human person and mutually dependent upon one another for fulfillment” (Clark 3). Accepting the inherent link between human rights and solidarity would profoundly impact the principle of social justice in medicine.

Few would attempt to make an argument against human rights; while specific rights may be a matter of discussion, the inherent human dignity of every person typically is not. Clark makes the connection between the strong moral claim of human rights and that same level of claim on solidarity:

Humanity, characterized by socially embedded freedom and rationality, as well as the dignity of being created in the image and likeness of God, requires both universal human rights and solidarity. Solidarity...then, is grounded in that same human dignity, that same philosophical and theological anthropology as grounds for human rights. As a result, if human rights are inherent, inalienable, and universal, so too is the call to solidarity (Clark, 105).

This is a very strong claim. According to this statement, solidarity is not supererogatory but a moral requirement. Clark's account of solidarity is historically consistent with the teaching of the Catholic Church as seen in *Sollicitudo Rei Socialis*: the virtue of solidarity "is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is a firm and persevering determination to commit oneself to the 'common good': that is to say to the good of all and of each individual because we are really "all responsible for all" (SRS 38, qtd Clark 110). *Sollicitudo Rei Socialis* written by Pope John Paul II, is understood as a continuation of the work of *Populorum Progressio* written twenty years earlier by Pope Paul VI. Both *Sollicitudo Rei Socialis* and *Populorum Progressio* engage the topic of the development of humans and the required conditions of that development. Solidarity, as described by Clark and Pope John Paul II, requires a radical proximity; not a positional proximity but a moral proximity. Proximity is only obtainable if we are willing to enter uncomfortable spaces in the pursuit of solidarity that according to Clark is both a chance and a risk (145).

It may seem idealistic to propose that solidarity re-imagined could be the foundation for regional change to standards of care in the ICU specifically, and eventually health care more generally. The Catholic understanding of solidarity is an important voice in the conversation on allocation because the Church does not

understand individual rights as morally overriding or in opposition to community obligations or social justice but rather as inherently linked:

As secular ethics and society become more focused on the individual and individual freedom, Catholic social teaching emphasized the complexity of social relationships and the common good. Without eliminating freedom, it develops an account of freedom within society through human rights but also turning to solidarity as the answer to the complex social relationships of the modern world.... Solidarity, as it develops, engages both persons and institutions...solidarity is a normative theological reflection on the way human persons and human communities were created and intended to develop and flourish. It is a call for that community to live and act in particular ways (Clark, 18- 20).

For Catholic social teaching, there is no opt in/opt out for solidarity. Because personal flourishing is bound up in the flourishing of our community of people, solidarity is the appropriate response to the complex social issue of a failing health care system. As Clark articulates, solidarity is a matter of setting and accepting limitations and recognizing the obligations that arise from a Catholic conception of solidarity. Clark references the work of Karol Wojtyla's personalism: "solidarity with others includes both accepting the duties and responsibilities imposed by the community and opposing unjust forms of exclusion and oppression" (Clark 26). The Catholic Church's robust concept of solidarity makes me consider the possibility that not prioritizing marginalized populations may be an unjust form of exclusion. For Clark, "solidarity is a response to interdependence with a deep and abiding commitment to the equality, mutuality, and dignity of every member of the human family" (Clark, 29).

To understand what such solidarity might look like, Clark references the work of Marciano Vidal Bilgien who offers the following seven elements of solidarity:

- 1) Interdependence is a fact and solidarity emerges through the consciousness of that actuality
- 2) Solidarity is based on the reality of our human equality and dignity
- 3) Solidarity works for the common good of all
- 4) Solidarity must be practiced with an awareness of the poor
- 5) Solidarity must be a firm and perserving determination
- 6) Solidarity is not just a virtue of individual persons, but also of groups and nations.
- 7) Compassion, empathy, and mercy move solidarity into action and help sustain disposition. (Bilgrien, Solidarity 105-6, qtd Clark 41).

There is room for improvement in health care if these are the virtues of solidarity, which would provide the foundation for allocation decisions. An overemphasis on autonomy or individual rights, which are understood as inconsistent or adversarial with the notions of the common good do not seem to support “the reality of our human equality and dignity.” Further, it would prove difficult to substantiate a claim that health care is “practicing with an awareness of the poor.” The idea that solidarity is a “preserving determination” and a matter of action is consistent with the Catholic social teachings on the participatory aspects of human dignity.

Accepting the relations of dependence as inherent to the human condition and the formation of contemporary society is the foundation for an argument for a new concept of solidarity that Clark makes clear when she says: “there is an intimate connection between relationality and participation” (Clark 70). “The human person as an isolated, unsituated “self,” truly detached from society, is an illusion...the

primary vice of deficiency is “excessive individualism,” which presumes that human persons are fundamentally isolated, atomized individuals or blank slates” (Clark, 69, 115).

Clark calls for a form of solidarity that creates an institution where mercy is operative. She uses Jesuit Father James Keenan’s definition of mercy: “entering into the chaos of another.” Clark also pulls a richer understanding from the Samaritan parable that discusses how we are not automatically neighbors, but must become neighbors. In order to get into relationships with people, we must go out and seek the voices in social exile, which Clark rightfully identifies as an additional form of vulnerability. Health care requires we commit ourselves to radical proximity and accustom ourselves to being uncomfortable. The call for radical proximity has a lot in common with the work of Richard Gaillardetz, who calls for people to vacate all protected spaces, of emptying ourselves of privilege.

The work of Clark and Gaillardetz acknowledge that difficulty in the task of solidarity realized through radical proximity that requires a level of discomfort. Stakeholders, I propose, must engage in meaningful conversations regarding allocation:

- To acknowledge there are medical and moral limits to what should be offered,
- To begin changing standards of care regionally that are consistent with professional integrity for a particular field,
- To acknowledge the finitude of the human condition,

- To acknowledge our own vulnerability and the vulnerability of those around us,
- To open one's self to risk and leave protected spaces, whether those are physical or metaphysical,
- To acknowledge my dependence upon others and theirs on me, and
- To acknowledge the obligations and required participation that arises from these matters of fact.

"The virtue of solidarity is not a naïve vision of utopia. Instead, it is the recognition that through practicing human rights, as the right kind of actions and emotional reactions, individuals and communities can develop solidarity as a firm and persevering disposition" (Clark, 124). A firm and persevering disposition toward solidarity can be accomplished by rejection of overemphasis on autonomy and individualism, and acceptance of the dependent nature of the human condition. The a-Samaritan is not the being of the Catholic Church and is not the only possibility for human social formations.

Dr. Paul Farmer and economist Amartya Sen share a concern regarding the nature of a population that becomes accustomed to current conditions; conditions which have produced the a-Samaritan. Farmer speaks of being "socialized for scarcity and failure such that another system in which human flourishing is the goal, not mere survival, seems inconceivable" (Clark, CHA note, 10). Sen calls it downward adaptation. Downward adaptation is a form of underdevelopment, which is a result of "situations of conflict, [and] scarcity" (Clark, CHA note, 10). If one can become conditioned to situations of conflict, scarcity, and failure, then so

too can a person become conditioned for collaboration, human flourishing, and success.

I recognize that regional standards of care are subject to the same downward adaptation as national or global standards of care. I think that changing of regional standards would be easier logistically to implement than national standards of care. Doctrine or principles are trying to capture what is actually taking place, national standards are trying to capture what is happening regionally. Historically medicine was very paternalistic until that paternalism was questioned and standards of care were adapted. The Catholic social teaching of subsidiarity also advocates for regional responses to issues in health care as they are there. The pillars of Catholic social teaching of Respect for human dignity, subsidiarity, common good, and solidarity are a significant contribution by the Catholic Church in the field of medical ethics. In addition, Oregon's position on the forefront of health care change demonstrates the states' ability to adapt and reform.

Section 8: Words from the Pope

A Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral traditions of the Church (Ethical and Religious Directives for Catholic Health Care, 1).

In the 2015 encyclical *Laudato Si'* Pope Francis calls for radical solidarity and personal reflection, in light of the dire environmental conditions humanity is currently facing. While *Laudato Si'* specifically addresses climate change, the issues of common goods, community, and solidarity are addressed by Pope Francis. The

Pope critiques the West's attitude of 'disposable populations' who disproportionately deal with the burdens of inequality in the allocation of scarce resources and common goods. The Pope critiques ideas of a throw-away, consumptive and commodified society, and confronts the issue of what he titles "Weak Responses" to climate change when he says, "The problem is that we still lack the culture needed to confront the crisis" (LS, 53). I propose that Oregon has the culture, or at least the potential to create the culture that might be prepared to confront aspects of the health care crisis. I previously listed the ways in which Oregon has historically been on the forefront of health care change. Oregon's position on the forefront of healthcare change may provide the culture necessary to initiate health care change.

In *Laudato Si'* the Pope cautions against market rule: "whatever is fragile, like the environment is defenseless [sic] before the interest of a deified market, which becomes the only rule " (LS 6). Health care systems that rely upon the market to set boundaries results in what I consider 'Hunger Games' style ethics: the strongest, fastest, luckiest survive. There is no conversation of moral luck or unified effort to avoid reproducing advantages and disadvantages that accompany moral luck. There is almost no evidence of personal discernment regarding use of scarce resources and a paradox in the way humanity consumes scarce healthcare resources and the ideology that supports those choices. Humans proceed as if we are not finite beings, while at the same time gratifying instant or immediate needs as if there will be no one around in need of such resources in the future.

Pope Francis describes human relationship with the material world as "confrontational" in humanity "extracts" from the material world. I think these

insights are critical because they are also applicable for the way society has constructed our healthcare system. Pope Francis raises concerns over the way humanity is living in a culture of ever-increasing consumption and endless choice, increasing demands for more options without critical thought to this mode of being (LS, 203). I recently had a critical care Physician's Assistant say to me, "I feel like I am serving buffet-style medicine. I list almost unlimited options and the patient chooses. I am open all hours of the day and night, and I am only limited by what the patient or the family demands of me. I am not a person of expertise but a mere delivery system." I have grave concerns about a system in which physicians feel like medical vending machines with almost no safeguards but the law. It is doubtful that what the public hopes for when they think about health care is a place that delivers medicine in this manner. I think the public wants and deserves a healthcare system re-imagined.

I am not suggesting a purely religious dialogue regarding solidarity but rather what Pope Francis calls "Religion in Dialogue with Science."

It cannot be maintained that empirical science provides a complete explanation of life, the interplay of all creatures and the whole of reality. This would be to breach the limits imposed by its own methodology. If we reason only within the confines of the latter, little room would be left for aesthetic sensibility, poetry, or even reason's ability to grasp the ultimate meaning and purpose of things. I would add that religious classics can prove meaningful in every age; they have an enduring power to open new horizons...Is it reasonable and enlightened to dismiss certain writings simply because they arose in the context of religious belief? It would be quite simplistic to think that ethical principles present themselves purely in the abstract, detached from any context. Nor does the fact that they may be couched in religious language detract from their value in public debate. The ethical principles capable of being apprehended by reason can always reappear in different guise and find expression in a variety of languages, including religious language (*Laudato Si'*, 199).

Pope Francis calls for science and religion to be in dialogue. I believe that Catholic social teaching has something to offer regarding concepts of solidarity and collaboration as it applies to allocation of health care resources. I think Pope Francis's concept of science in dialogue with religion is important for the unique culture in Oregon and the concept of solidarity. Oregon is unique in that it is considered "unchurched" and also has pockets of Libertarian conservative populations. And as Meghan Clark stated solidarity does not need to be diversity flattened. Pope Francis's message of solidarity speaks to a dialogue between what can at times be considered disparate groups such as religion and science in the pursuit of solidarity

Conclusion

Dependence that goes unacknowledged is still not independence. Independence, except in certain actions and functions, is a fiction, regardless of our disabilities, and the pernicious effects of this fiction are encouraged when we hide the ways in which our needs are met in relations of dependencies (Feder-Kittay, 268).

We need not wait until health care issues are addressed at a federal level. Policies and principles at best are trying to sum up what is happening on the ground. This suggests that change is most appropriately and practically undertaken on a smaller scale, at a local level consistent with the Catholic social teaching of subsidiarity. Hopefully national standards, policy, or broader principles will be written to capture the success at the local level. Focusing on one's immediate community is consistent with Catholic teaching regarding solidarity as well as Oregon statutes regarding health care standards of care: "A physician licensed to

practice medicine or podiatry by the Oregon Medical Board has the duty to use that degree of care, skill and diligence that is used by ordinarily careful physicians in the same or similar circumstances in the community of the physician or a similar community” (2015 ORS 677.095 Duty of care). Despite this area of agreement between Oregon statute and Catholic teaching, local changes to standards of care are usually subverted by talk of broad federal change.

I believe there is significant evidence to support the claim that Oregon has previously been on the forefront of medical and ethical innovation. We are standing on morally and medically fertile ground, so-to-speak. Conversations around what is considered appropriate end-of-life care are already taking place in Oregon. The number of people dying at home vs. in a hospital is trending toward the utilization of hospice to facilitate in-home death, consistent with the stated wishes of not just Oregonians but the population nationally. Looking at the way historically people came together across many disciplines, fields of expertise, religious backgrounds, and cultural affiliations in the spirit of renewed solidarity to affect real change in the state speaks loudly to the possibility of further change. The change I am referring to is the passage of the Death with Dignity Act, the Medicaid Priority List, and the development of the POLST form. I acknowledge that many still consider Oregon’s Death with Dignity act and Medicaid priority list controversial, and I am not taking the position that Oregon is always correct in its approach to ethical and medical questions. However, I feel that there is evidence that the state has historically been a leader, not just in initiating conversations about difficult and complex topics, but implementing change to law and policy. Evidence of this leadership model can be

seen by other states following in the footsteps of Oregon, in the passage of laws that are similar to Oregon's Death with Dignity Act.

A change in the standard of care for end-of-life care is not just morally permissible but morally overriding. A change in the standard of care would require a radical shift from the ideology that created and supports the a-Samaritan. Such a shift would necessitate a commitment to radical proximity and solidarity. This change in health care culture would extricate the physician from being the role of gatekeeper and resurrect the art of medicine. With a shift in priorities and goals in health care, moral luck could be accounted for in considerations of how health care is allocated. Common goods, communities oriented around solidarity and consideration for the necessary requirements for human flourishing require an acknowledgment of participatory obligations and relations of dependence. These changes could be the foundation for a shift in priorities. However insurmountable this list may seem, humanity is capable of great change.

I see iterations of the case of the IV drug user every day, or similar cases, such as a homeless person who is mentally ill that spends months in the hospital. Their health is restored while social work and Mission Services desperately try to find a facility that can offer them shelter. The patient does not meet the requirements for State guardianship or placement. Either their behaviors or inability to participate in their care renders them impossible to place in other facilities. After several months, the hospital can no longer justify keeping the patient, as medical intervention is no longer being offered and the patient is merely being housed. Eventually, the patient is discharged back to the streets.

The role of physician as gatekeeper is problematic for me partly because I am so anguished myself in my role as gatekeeper. I respond to ethics orders that represent the extremes between excess and deficiency. Excess in the cases of futile care in the ICU. Deficiency is the cases of those patients whose appropriate standards of life cannot be met. I realize that health care cannot own responsibility for all the elements of standard of life such as education and housing. However, health care can do better in meeting the needs of patients, in regards- to services such as addiction and mental health. With a regional reset of standard of care, consistent with the principle of subsidiarity, funds allocated for end-of-life care could be distributed in other areas of health care. My role as gatekeeper in microallocation decisions allows me no distance from considerations of human dignity, solidarity, and common good.

My humanity, being bound up in yours, in every persons', necessarily means my complicity in any system which allows others to be sacrificed, as that also sacrifices some part of myself. With the rich concept of Catholic solidarity, a more robust concept of the human condition, and the unique culture of Oregon at the forefront of health care change I think a regional reset of standard of care at the end-of-life is possible.

"We approach the edge of the unfamiliar and cross it, if only by a step"
- Amy Oden 10

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