CHA
Catholic Health Association
of the United States

THE ETHICS ROLE

IN CATHOLIC HEALTH CARE

CONTENTS

PREFACE

SOME YEARS AGO, THEOLOGIAN AND ETHICIST John Glaser, S.T.D., observed that there are "no ethics-free zones;" that is, virtually everything that we do in Catholic health care (and elsewhere) has an ethical dimension. Whenever decisions are made or actions performed that affect human dignity and well-being, ethics has a role. This suggests that ethics is an ever-present reality in the day-to-day operations of Catholic health care, not just at the bedside, but throughout the organization. Ethics is central to an organization's identity and integrity.

Among those who have responsibility for "doing ethics" in Catholic health care are professional ethicists. This collection of previously published materials explores the role of the ethicist in Catholic health care, identifies some of the challenges facing the ministry with regard to the ethics role, and suggests some competencies and qualifications for facility and system ethicists moving into the future. Ideally, this booklet will provide some insight into the ethics role for individuals exploring a career in ethics in Catholic health care as well as provide a stimulus to the ministry itself for conversations about the role of ethics in our health care organizations and how we might ensure a vital ethics role for the future.

RH

Strengthening the Role of Ethics in Turbulent Times

STRENGTHENING THE ROLE OF ETHICS IN TURBULENT TIMES

The theme of the 2010 Assembly — "Forging our Future: Strengthening the Ministry in Turbulent Times" — provides an opportunity to consider the role of ethics in Catholic health care and to find ways to strengthen its presence and its contributions.

RON HAMEL

Ethics may not be the first thing that comes to mind when thinking about "strengthening the ministry in turbulent times," or perhaps even the second or third thing. But it is critical. It is critical because beneath the many factors that make up "turbulent times" are the *identity* and *integrity* of Catholic health care.

Above all, through turbulent times, Catholic health care must remain true to itself — true to who it is and claims to be, and true in what it does and should do. Identity and integrity are the ultimate goals of whatever strengthening occurs. If the ministry loses either, it probably should not exist, at least as "Catholic" health care.

Ethics is critical to promoting and supporting the identity and integrity of Catholic health care as a whole, and of individual Catholic health care organizations. "Catholic health care ethics ... is central not only to helping shape the culture of an organization, its identity, but is also central to guiding the organization's decision-making and behavior, its integrity. Ethics should assist the organization to be what it claims to be in regard to identity, character and culture, and to discern what it ought to do (and not do) in light of who it claims to be. It should help Catholic identity to permeate the entire organization and to be integrated throughout the organization."[1] Ethics in Catholic health care, then, has a dual focus (as it does generally) — identity and integrity, character and behavior, who Catholic health care is and should be, and what Catholic health care does and should do. The first has much to do with forma-

tion, and the second with discernment, decision-making and action.

One of ethics' primary roles, in collaboration with mission, is to help nourish, sustain, promote and even challenge the culture of the organization and to engage in the ongoing formation of leaders and staff into the desired culture. Ethics is central to these efforts because ethics deals with the very substance of culture — values, beliefs, practices and policies. Especially in turbulent times, the issue of culture is paramount. Will the culture of the organization and the ministry be one informed by the values and beliefs of the Gospel and of the sponsors, or will the culture instead predominantly reflect the values, beliefs, practices and dynamics of the marketplace and of the broader American culture? In challenging times, there may be a tendency to address immediate threats, to "put out fires," to the neglect of fundamentals. But in the long run, this will exact a high price. Dealing with the challenges as well as continued efforts to strengthen identity must go hand-in-hand.

Helping to create a culture reflective of the organization's identity is not the sole formative contribution of ethics. It should also seek to form communities of moral discourse, places where ethical issues are acknowledged and taken seriously, where conversations can take place about ethical concerns and issues, and where ethical discernment can take place. "[E]thics practice provides a means for creating communities of concern and meaning. Although ethics in Catholic health care certainly helps with complex clinical and business decisions, it is also, and importantly, about cultivating an environment in which meaningful conversation about values can occur, and

from which values-based actions arise."[2] Ethical discourse on critical issues also has the ability to change hearts and minds in ways that are better aligned with the identity of the organization.

The contribution of ethics in ethical discourse is not to provide answers, but to be a resource — to help people identify ethical issues, to bring knowledge and an understanding of ethical principles including the *Ethical and Religious Directives*, the church's moral teaching and Catholic social teaching. Even more deeply, ethics brings a perspective on what it means to be human and what it means to be part of a larger society. When ethics comes out of a theological perspective, all of this is seen in the context of the Hebrew and Christian scriptures and the church's theological tradition.

The second of ethics' primary roles is to support decision-making and behavior that express and further strengthen the desired culture. This might consist of raising to awareness the ethical dimensions of particular decisions, behaviors, practices, plans or policies. As theologian and ethicist Jack Glaser has pointed out, "There are no ethics-free zones." Whenever we are dealing with decisions or actions that affect human dignity and well-being, in addition to being in the realm of business, strategic planning, business development, human resources, delivery of care and the like, we are also in the realm of ethics. So often, the ethical dimension of these everyday organizational and clinical decisions is not recognized. The concerns, the concepts, the thought patterns and the language of the particular discipline bury it. Raising to awareness the ethical dimension can help ensure that what is decided or done is consistent with the identity claims of the organization and will, in fact, respect the dignity and promote the well-being of those who will be affected.

In this role, ethics might assist boards, leadership and others in discernment or decision-making processes. These processes generally have built in a consideration of the organization's mission and core values, as well as the core commitments of Catholic health care. They also urge consideration of relevant moral principles and the *Ethical and Religious Directives*. These can be helpful in ensuring consideration of a range of factors when making such significant business decisions as new partnerships, initiating or discontinuing service lines, downsizing and the like. These are decisions that directly affect people and the identity and integrity of the organization in profound ways.

Strengthening the role and contributions of ethics in Catholic health care organizations is ultimately dependent on the sponsors and on senior leadership, especially the CEO. Unless ethics is valued at the top, it will always struggle to achieve its place and credibility. On the other hand, those doing ethics in the organization — whether a professional ethicist, a mission leader who also does

Above all, through turbulent times, Catholic health care must remain true to itself — true to who it is and claims to be, and true in what it does and should do.

ethics, and/or an ethics committee — must work diligently to gain the respect and the trust of administrators and clinicians. Competency, ongoing efforts at quality improvement and significant contributions to the culture and activities of the organization are essential.

Strengthening the ministry in turbulent times is an opportunity to strengthen ethics in our organizations and to allow it to play the role that it can and should play. A vibrant ethics presence (in the many forms in which that can occur) should greatly contribute to a vibrant ethical culture and, if it is deeply integrated into the very fiber of the organization, will do much to strengthen its Catholic identity and its integrity.

NOTES
1. Ron Hamel, "Health Care Ethics: Changes on the Way," *Health Progress* 89, no. 5 (September-October 2008): 5.
2. Sr. Patricia Eck and John Wallenhorst, "The Emerging Role of Ethics: A Sponsorship View," *Health Progress* 90, no. 2 (March-April 2009): 36. See also Jack Glaser, "The Community of Concern," *Health Progress* 83, no. 2 (March-April 2002): 17-20.

RON HAMEL, PH.D., is senior director, ethics, Catholic Health Association, St. Louis. Write to him at rhamel@chausa.org

Reflections on the Role of Ethicists in the Catholic Health Ministry

Reflections on the Role of Ethicists in the Catholic Health Ministry

Editor's Note: We invited five colleagues recently to provide reflections about the role of ethicists in the Catholic health ministry. We're pleased to present their insights and appreciate the contributions of our five authors below:

John W. Glaser, STD
Senior Vice-President
Theology & Ethics
St. Joseph Health System
Orange, CA
Jack.Glaser@stjoe.org

Susan McCarthy, MA
Clinical Ethics Director
Ministry Health Care
Milwaukee, WI
susan.mccarthy@ministryhealth.org

Brian O'Toole, Ph.D.
Senior Vice President
Mission & Ethics
Sisters of Mercy Health System
St. Louis, MO
brian.o'toole@mercy.net

Kate Payne, RN, JD
Director, Ethics
Saint Thomas Hospital
Nashville, TN
kpayne@stthomas.org

John Paul Slosar, Ph.D.
Senior Director, Ethics
Ascension Health
St. Louis, MO
jslosar@ascensionhealth.org

_____

John W. Glaser, STD

It is a comfort to know that other ethicists have been invited to gather their thoughts on this topic. Such a gathering of diverse views allows readers to experience one of ethics' major contributions to organizational life—promoting fresh, multi-perspective viewing of complex issues. A self-unaware and constricted consciousness is one of ethics' great adversaries.

Some Assumptions

The following assumptions underlie my remarks:

1) Ethics is the discipline of translating the single Christian commandment of love of neighbor (cf. Rom. 13, "All the commandments are summed up in this single command…."; Mt. 25, "When you saw me hungry….) into the thousands of corners of life where it must live.

2) It helps to distinguish four realms of life where this love of neighbor must be translated:
   a. Structures and behaviors of our global community;
   b. Structures and behaviors of societies;
   c. Structures and behaviors of organizations;
   d. Habits and behaviors of individuals.

My focus in this reflection will be on items b and c, the structures and

behaviors of societies and organizations.

3) Items a, b and c cover the reality that Catholic Social Teaching has begun to explore primarily in the concepts of dignity and justice, rather than love of neighbor.

4) This love of neighbor is always love-in-a-situation-of-limits. It is always a hard choice—a choice that can say yes only by saying no to many other possible loving actions.

5) Ethical wisdom—love of neighbor wisdom—is primarily the gift of the appropriate community, enabled for discernment of a given issue, rather than the gift of ethical experts.

Observations about Ethicists and the Catholic Health Ministry

The Ethicist as Enabler of "Community of Concern"
Rarely will the ethicist be the source of wisdom on a given issue. Far more often her role will involve the facilitation of the "community of concern."

This has two key dimensions:
1) Identifying the "community of concern," i.e., who is needed in the discernment community to make present the essential aspects of the specific complex issue in question, and
2) Identifying the tools, processes, information, etc. needed to make this diverse community effective in discernment.

A major contribution of an ethicist should be to foster a culture in which the spontaneous first step in addressing complexity is to ask: *what community do we need to do justice to this issue?* A further element of such a culture will be a variety of processes and tools needed by this community to carry on discernment with skill and efficiency. Consistent and effective practice of such moral authority could serve the larger Catholic community with a fruitful complement to its current behavior.

The Ethicist as Expander of Our Idea of "Ethical Issues"
Both as Americans and as Catholics we have inherited an idea of ethical/moral issues that is far narrower than it should be. For example, during the health care reform debate a Catholic publication listed a series of contested issues—cost, access, inflation, social insurance, etc.— and then said: "then there are the moral issues"—abortion, conscience, etc.

Clearly, both lists of issues are ethical/moral concerns, but we have a national and religious tradition of fixating on a narrow band of bright-line questions. This can lead us, in biblical terms, to pick moral nits while swallowing moral camels. That we can treat tubal ligations as a *moral leviathan* while considering hundreds of billions of dollars of health resources wasted on administration as an *economic issue* needs a moral corrective. The ethicist can help us weigh the enormous range of moral issues on the fundamental scale of Romans 13 to grasp

their relative weight. By positioning us to view accustomed scenes through the lens of love of neighbor, the ethicist can bring us to some surprising vistas.

The Ethicist as Advocate of Three Realms and Their Relationships

The ethicist can promote a culture in which there is a growing awareness that ethics is only adequate when it recognizes and attends to three realms of ethics—societal, organizational and individual. Our religious and secular culture tends to build a social ethic with the bricks and mortar of individual philosophy and theology. The ethicist can break open the wisdom of John Courtney Murray when he said: "It follows, then, that the morality proper to the life and action of society and the state is not univocally the morality of personal life, or even of familial life. Therefore, the effort to bring the organized action of politics and the practical art of statecraft directly under the control of Christian values that govern personal and familial life is inherently fallacious. It makes wreckage not only of public policy but also of morality itself."

The ethicist can help us recognize an iron law that rules the relationship between these realms and its importance for health ministry. The iron law is this: *mainstream organizations get their moral character primarily from the structures of society within which they succeed.* The ethicist can sharpen our recognition that our moral character is more *given to us by society, than created by us from an inner vision.* She can hone our awareness that our billing conduct should be done in a spirit

of the Gospel, but also that our, currently necessary, but vastly bloated billing and contracting capacity is a waste and Gospel insult necessitated by the irrational structures of American health care. She can help our conscience recognize that the radical, long-term reform of health care belongs to our mission as much as compassionate and quality care, because our moral identity is fiercely constrained by the thick walls and narrow gates of U.S. health structures. She can help us face the double challenge of both sailing successfully despite unjust winds and raising the winds of justice.

The Ethicist's Mantra: "Don't Just Do Something, Stand There"

U.S. health care is one of our culture's most complex, tumultuous and severely demanding arenas of activity. The stakes are life and limb; the pace is frantic; the timeframe is 24/7. Rafting such a whitewater of operational urgency is not conducive to reflection and contemplation. But without a robust dimension of consistent withdrawal, absent a carefully crafted architecture of continuous formation and learning, health care will survive. However, in a short time, there will be only the flotsam of health ministry. Where there is always too much to do and too many voices demanding still better outcomes, the ethicist must help reveal the deep truth of Dan Berrigan's adage: Don't just do something, stand there! The ethicist can be the poet and patriot of contemplation's power to help ministry leaders accomplish the complex task of both succeeding

within unjust structures and bending the unjust structures toward justice.

Continuum of Roles—Call for Community

The continuum of the roles of ethicists is long. It stretches from schlepping the team's baggage to being a lone voice in the wilderness. Each of us will only be strong at select times and places on this broad horizon. Therefore, it will be important to build a community of support, challenge, and creative sharing among this scattered group of poet-patriot-porters.
offices.

———————————————

Susan McCarthy

The invitation to reflect on what ethicists contribute to their organizations is a unique opportunity to go beyond the triathlon of case consultation, policy development and education that we all engage in and reflect on the less measurable impact of our work in the institutions that employ us to "do ethics."

I am the clinical ethics director for Ministry Health Care, a regional health care system in Wisconsin sponsored by the Sisters of the Sorrowful Mother. Our system consists of 15 hospitals, more than 20 clinics and a variety of other health services including home care/hospice, dialysis, behavioral health and long-term care. I began my work in the mission and culture department in 2000 shortly after completing a master's degree in bioethics at the Medical College of Wisconsin. When I began work on that degree, I spent many hours doing case consultations

with experienced physician-ethicists in the hospitals affiliated with the Medical College. Over the past several years I've furthered my education in moral theology at Saint Francis Seminary in Milwaukee and completed course work specific to Catholic health care ethics at Loyola University-Chicago.

After reflecting on my role and talking with a number of the people with whom I work most closely, I see the following contributions that ethicists can (and should) make to their organizations.

First, it has become clear to me that my mere presence on staff demonstrates the values of the Sisters of the Sorrowful Mother to the clinicians, chaplains and administrators with whom I work. When I began my career at Ministry Health Care, there were only a handful of ethicist positions in Wisconsin, the majority of which were in academic medical centers. The fact that Ministry's interest in ethics went far beyond compliance with regulations shows a commitment to the highest ethical standards in every clinical encounter.

Although geographic distance between facilities in our system prevent my being on site for every ethics committee meeting or case discussion, I am accessible nearly 24/7. Like everyone who lives "above the shop," I am available for emergency situations at any time. Having ready access to a trained ethicist, rather than having to go through a consult service outside of the organization, has helped to

make ethics conversations a part of everyday practice.

The role of the ethicist strengthens the Catholic identity of the organization. Part of my job is the obligation to stay current on Catholic teaching and thought through a variety of sources including periodicals, memberships and conferences. With smaller numbers of vowed religious among us, it is important for ethicists to remain in tune with the sometimes highly nuanced positions of the Catholic Church in matters pertaining to health care ethics.

If all system ethicists are not currently participating in leadership training at their organizations, they should be. We have a unique area of expertise and perspective to offer. I have been on the faculty of the Foundations of Catholic Health Care Leadership course and the Ministry Basics course for mid-level managers for most of my tenure at Ministry. This allows me to meet staff members early in their careers, establish relationships and increase the likelihood that they will call on me for support.

Finally, and perhaps most importantly, is the support that an ethicist can provide to all members of the health care team as they struggle with some very difficult, seemingly irresolvable cases. When there are persistent disagreements over care between the team members or between the team and the patient and/or family members, the situation may quickly become polarizing. The ethicist can help re-frame the issues, find some common ground, and help preserve relationships between people who will have to work together long after the particular case has resolved. With a collegial, non-judgmental approach, an ethicist can be a sympathizer and cheerleader, negotiator and educator, patient advocate, listener and respectful questioner, and a reminder of common goals. My role is often just to be the one to say that we can't fix everything, we're not even going to always agree on what the fix should be, and to remind my colleagues that sometimes all we can really do is our best. As Thomas Merton said, "the desire to please God does in fact please God."

The work of the ethicist can be measured quantitatively in number of consultations, scores on CME evaluations, speaking engagements, publications, and so on, but the value to the institution and to those who provide care to our patients is immeasurable.

_____

Brian O'Toole, Ph.D.

In the Sisters of Mercy Health System (Mercy) we have two full-time and one part-time ethicist serving at three of our larger health care facilities. While some may view an ethicist as a luxury that few hospitals can afford, for a number of years at Mercy we have believed – especially in our larger facilities – there is not only a need for having an ethicist on staff, but also clear benefits which we try to quantify in terms of satisfaction and financial cost savings. For this to occur, we have developed an understanding of the distinct competencies and function of a hospital ethicist which are needed to

achieve the desired benefits and justify the extra cost.

In hospitals without an ethicist, traditionally it is the role of an ethics committee to provide ethics consultation on difficult cases, educate physicians and caregivers, and address policies (such as end-of-life) which have particular ethical dimensions. In Mercy hospitals where we have an ethicist, we are able to increase the occurrence and quality of these functions. Ethicists in Mercy hospitals are to spend most of their time rounding on the floors. The goal is for them to build relationships with physicians and caregivers and to learn as soon as possible about potential ethical issues. We do not want them sitting in an office waiting for a referral for an ethics consult. By being visible and interactive on the floors, an ethicist in Mercy provides "curb-side" and informal ethics consults with physicians and caregivers as issues begin to develop, and will regularly check back to stay abreast of developments in particular cases and intervene as needed. This continual and ongoing presence and involvement by the ethicist gradually heightens the sensitivity of staff to recognize potential or actual ethical issues. This presence affirms the appropriateness of or gives permission to involve the ethicist regularly into cases, and enables the ethicist to be perceived as a resource to help address challenging ethical decisions rather than as an indication of wrong-doing by the physician or staff.

While a Mercy ethicist provides formal ethics education within the hospital, by far we believe the greatest amount of education with physicians and caregivers occurs individually one case at a time. Through actual encounters with the ethicist, physicians and staff learn what are ethical issues, when and how to approach patients or families or other physicians, how to lead a difficult discussion, and what constitutes good outcomes to challenging situations. Similarly, while the ethicist may be involved in the development of policies that have ethical dimensions, we believe that affirming or changing practice patterns of physicians or caregivers occurs less through actual policies and more often through the ethicist intervening in specific challenging cases that prove to be instructive and which then shape future practice patterns by physicians and staff.

For an individual to be successful in the ethicist role in Mercy, some very clear competencies are needed. Along with formal ethics education within the Catholic tradition (we require at least a master's degree and prefer a doctoral degree), the ethicist must be comfortable with and capable of functioning within a hospital culture and setting, possess strong interpersonal skills, be perceived as a team player by physicians and staff, and be viewed as a credible and professionally competent ethicist.

We have identified personal characteristics which are critical to the success of an ethicist in Mercy:

- It greatly helps if physicians and caregivers experience the ethicist as

being a positive and constructive problem-solver

- Pastoral and generous with their time with a patient and/or family but expeditious in their interactions with physicians and staff
- Flexible in their approach with different physicians and families while recognizing that a successful resolution to problematic ethical issues is not always achievable.

We justify the extra cost of an ethicist within our larger facilities through a number of informal ways. We find that positive feedback or satisfaction occurs with many of the caregivers and physicians in the hospital critical care units and other clinical areas where the ethicist works. When the ethicist proactively addresses challenging clinical ethical issues, time-consuming problematic situations and moral distress experienced by staff as they witness ethical issues arising or lingering while under their care can be greatly reduced. We also find that patient and family satisfaction increases when the ethicist helps them to be comfortable with their difficult treatment decisions to minimize or avoid inappropriate treatments and to introduce or emphasize palliative care for the benefit of improved quality of life.

We believe that an ethicist creates significant cost savings to a hospital. Most clinical ethical issues still evolve around end-of-life decisions. Unrealistic or misguided expectations, the ability to over-treat and the challenge in learning

about and working towards patient goals and acceptable quality of life can delay or derail expedient treatment plans in complicated situations. When this contributes to or results in the difficulty for consensual agreement among the patient, family and physician, patients often linger in critical care or in the hospital for extended periods of time at considerable financial cost to the hospital. The ethicist plays a critical role in helping parties achieve consensual agreement for earlier and more timely resolutions to difficult decisions which can provide considerable cost-savings to the institution. We are developing formal tools in satisfaction and finance to support what we believe to be the benefits of having a hospital ethicist in Mercy.

In Mercy we have remained committed to providing strong clinical ethics support in all of our hospitals. We have been blessed with capable ethicists who by their practice continually reinforce our belief in the value they provide to our larger facilities. We have committed to exploring how we might best extend the expertise and value of our ethicists to our smaller hospitals and physician offices.

––––––––––––––––

Kate Payne, RN, JD

My path to ethics was through critical care nursing practice, then the study of law, followed by a fellowship in clinical medical ethics at the University of Chicago in 1993. The fellowship training was really that of a sub-discipline of medicine. Centered upon the doctor-patient relationship, the focus was on identification, analysis and problem

solving for ethical issues that arise in the practice of medicine. Six months of that formative year were spent deconstructing everything I thought I knew about ethics, both personally and professionally. Then, the rest of the year was about putting the pieces of what I had experienced, learned and rethought back together.

In the first years after my fellowship, I envisioned the primary role of the ethicist to be seeking out and confronting ethical dilemmas. Armed with knowledge and process, I would ride in on the ethics "steed of virtue" to slay the dragons of paternalism, futility, bias and all manner of other evils. Therein was the value of the ethicist to the organization. A seeker of truth, a fighter of injustice, a champion for the common good hoisting high the banner of mission and values. Such battles were waged for the mutual benefit of both individual and organization. Those encounters were often dramatic. Certain dragons (certain issues) could not be easily conquered. Nevertheless, people were grateful that I came and tried, even if I was unsuccessful. Thus, I learned that the value of an ethicist is intrinsically as much about presence as the battle itself.

Ethics practice is less the province of knights or saints and more that of a weaver. It is transformative work—a praxis. Weavers take various elements, and through a knowledge base and skill set, infuse their own creativity to produce something more than the materials used. The texture of the fabric, the pattern of the weave, the design and its intended purpose are all part of the artisan's

contribution. The value is in both the weaver and the weave. So too for ethics. The contribution is from both the ethicist and what they do.

I have come to agree with Margaret Urban Walker,[1] that ethicists are architects, a different type of weaver if you will. Consultation, education, ethics policies, quality work, coaching, mentoring, presence—are the tools and materials of ethics craft. With them the ethicist creates moral spaces that prompt and allow for conversations and interactions that stretch moral imagination. Interwoven into organizational life, they support the development of a community grounded in shared values and mutual support. The ethicist contributes to the texture of relationships, the patterns of interaction that support authenticity and integrity. The process of building that space is caring made visible as action. Ethical issues can be troubling and emotionally laden. The space created needs to be a place of comfort, support, compassion, and, hopefully, one of peace.

Having an ethicist is not so much an end in itself, but a statement and part of an ongoing process to develop a genuinely ethical organization. Leading with an ethicist shows a tangible commitment to engage in the often-times messy and uncomfortable struggle for organizational and personal authenticity. The organization says through this person, "We care about our moral health; we think value and integrity are important. Here is someone to help." Integration of ethics into every part of an organization,

however uncomfortable, is a visible sign of the organization's dynamism, relevance and viability. The ethicist says with the organization, "Our values are important; here is what we stand for." Providing space for the question and encouraging transparency in the search may not always yield a mutually acceptable result, but it enhances the moral character of the organization and those who work and live in it.

Strong arguments have been made for quality metrics in ethics consultation practice and competencies for ethicists.[2] Such standards will be helpful to determine what the role contributes to the organization. At the same time, ethicists have to model the values they uphold, be versed in recognizing opportunities and places for connection—they have to be good weavers. The contribution is in the praxis, in the interweaving of ethics so it becomes a first thought not an afterthought. Real value is obtained when ethics is not just a thread, not just a part of the organization, but the fabric of the organization itself.

References
1. Margaret Urban Walker, "Keeping Moral Space Open: New Images of Ethics Consulting" *Hastings Center Report* 23, no.2 (1993):33-40.

2. Mark Repenshek, "Attempting to Establish Standards in Ethics Consultation for Catholic Health Care: Moving Beyond A Beta Group" *Health Care Ethics USA* 18, no.1 (2010):5-14. See also, Jenny Heyl, Brigitta Sujdak-Mackiewicz, and Alan Sanders, "Responses From Beta Group Participants," *Health Care Ethics USA* 18, no.1 (2010):15-19.

John Paul Slosar, Ph.D.
Underlying my reflections are two assumptions. The first is that the ultimate role of an ethicist is to support the integration of the organization's values and Catholic identity with the processes, practices and decisions through which the organization lives out its mission and vision, while protecting patient rights and promoting the best interests of the patient.

In my experience, the ethicist does this through three primary functions:
1) Fostering disciplined processes of decision making that account for organizational values, relevant moral principles, and right intention;
2) Clinical consultation and policy development; and
3) Education.

Directly related is my second assumption that this understanding of the ethicist's functions is mistaken, inadequate or naive, if these functions are understood as ends in themselves rather than as means of creating a culture of reflection and dialogue regarding how best to promote and defend human dignity, contribute to the common good and foster justice.

Disciplined Processes of Decision-Making

A substantial value derived from fostering disciplined processes of decision-making is often a shift in how we understand an issue and our responsibility for addressing it. Frequently, this shift is from the presumed stance of "we either should or should not do action X" to the new

realization that the central issue is really more a question of "*how* ought we to do action X so that we can optimally protect human dignity, promote the common good and foster justice in the communities we serve." Of course, sometimes the shift is in the opposite direction. Where it was once presumed that practice X is something we automatically should do, because it is the "industry standard," for example, a formal decision-making process can elicit multiple perspectives and perhaps previously undiscovered alternatives that provide unique opportunities for the organization to distinguish itself as a healing *ministry.* Either way, the result is often new positions of appropriate permissibility on issues where previously held assumptions, shared misunderstandings or even individual biases would otherwise prevent sound decision-making.

Clinical Consultation and Policy Development

Though some might argue they should be considered separately, my reflections on the value of clinical consultation and policy development will consider them as a single contribution of the ethicist. While two distinct activities, they are very closely related. The value of clinical consultation is the support it provides to patients, families, physicians and other care providers in reasoning through difficult medical decisions by identifying the range of justifiable treatment options in light of the norms of general medical ethics, the identity of the organization as rooted in the Catholic moral tradition and, of course, the best interests of the

patient viewed through the lens of that person's unique life-story understood as a particular instantiation of the image of God. In much the same way, policy review and development guides clinical care and organizational decisions in light of the very same considerations, though the guidance is at a level of much greater generality. Still, if done well, both activities can be effective means of advancing a culture of dialogue and reflection on how best to promote and defend human dignity in the clinical and organizational contexts of health care delivery.

Ethics Education

It seems almost self-evident to say that the value of ethics education resides in the increased capacity of individuals and teams to make ethical decisions on their own and to convene and carry on their own conversations regarding ethical issues within their particular community of concern. While this might at first seem like a self-defeating contribution for an ethicist (insofar as there is the potential of reducing the need for an ethicist in the first place), it has been my experience that building ethics capacity does not result in a decreased quantity of consultations, but in an increased quality and sophistication of the issues surfaced and questions asked.

Conclusion

Based on these reflections, I would propose that there are three primary contributions that a system ethicist can and should provide:

1) Ensuring that the organization is asking the right questions even, or especially, when they are the "hard" ones;

2) Convening and leading meaningful conversations in a way that fosters a culture of reflection and dialogue aimed at promoting human dignity, contributing to the common good and fostering justice;

3) Building the ethics capacity of the organization so that individuals and teams can more fully participate in decision-making and, ultimately, be empowered to advance the mission, vision, values and Catholic identity of the organization.

The Emerging Role of Ethics: A Sponsorship View

The Emerging Role of Ethics: A Sponsorship View

Implementation of Ethics Throughout Catholic Health Care Promotes Values-Based Actions

The story of Catholic health care is one of innovation and adaptation, and one in which ethics has had a featured place. In response to changes in the church, in religious life and in health care, Catholic health systems grew dramatically during the 1970s and 1980s in the United States. Building on a long tradition of care, independent Catholic hospitals and nursing homes increasingly came together to form stronger and more integrated systems.

In order to ensure vital community presence and service, sponsoring religious congregations recognized the importance of maintaining an intentional ministerial focus during these changing times. Catholic hospitals came to form systems, and sponsors built formal methods for nurturing the unique dimensions to religiously motivated health care. Leaders created structures to ensure mission integration, pastoral care, care for poor and underserved persons, and dynamic community outreach.

In line with these important dimensions of Catholic identity, founders of new systems also put ethics structures and processes into place. The emerging role of ethics in Catholic health care provides one important frame for understanding the sponsors' commitment to ministerial identity, organizational values and charitable mission.

This article outlines themes in the recent history of ethics in Catholic health care, and some specific experiences of ethics practice at Bon Secours Health System.

REINFORCING EXISTING FOUNDATIONS
As Catholic systems developed, existing institu-

issues and decision-making related to advances in medical technology and to support an expression of Catholic identity. In line with the development of ethics committees in hospitals throughout the United States, Catholic systems ensured that their institutions maintained committees for evaluating ethical dilemmas related to delivery of care.[1] Of course, many Catholic hospitals already had ethics structures in place. The evolution of Catholic health care systems provided an opportunity for wider sharing and uniformity of best practices and for engaging in ministry-wide ethics reflection.

Many noteworthy legal cases in the 1970s and 1980s regarding treatment decisions, including the highly publicized Karen Ann Quinlan case in 1976, and related governmental recommendations, supported institutionalization of ethics committees.[2] Professional organizations, including the American Hospital Association and Catholic Hospital Association, also strongly endorsed the role of institutional ethics structures.

EXPRESSING CATHOLIC IDENTITY
In establishing ethics structures, Catholic systems also sought to express and reinforce Catholic identity. Emerging systems understood that ethical commitments have an explicitly theological source and focus, and that promoting sound ethical decision-making is a matter of engaging the tradition. Attuned to Catholic moral theology, these systems sought to shape ethical dialogue in a distinctive way. Dialogue here acknowledges the role of ethical principles, but has foundations in an understanding of natural law and the human person.

Beginning with an understanding of the person in the community, and focusing on the virtues that advance thoughtful decision-making,

BY SR. PATRICIA A. ECK, CBS, & JOHN F. WALLENHORST, Ph.D.

Sr. Eck is chairperson, board of directors, and Dr. Wallenhorst is vice president, mission and ethics, both at Bon Secours Health System, Inc., Marriottsville, Md.

theological.[3] Serving in communities with diverse religious and cultural perspectives, Catholic systems seek respectful dialogue on matters of ethical importance. The traditional Catholic understanding of natural law supports such a conversation. The natural drive of human reason to seek the truth, and a natural inclination to do good, provide a starting point.

During the evolutionary period, there was also focus on application of the *Ethical and Religious Directives.*[4] Based on guidelines developed by the Catholic Hospital Association in 1948, the 1971 document, then titled *Ethical and Religious Directives for Catholic Health Facilities,* was published by the United States Catholic Conference. Newly formed systems routinely engaged Catholic moral theologians to assist in understanding and applying the directives. Some hired full-time ethicists to oversee the work of theologians and of ethics committees that assist the organization in applying the directives.

> ## The emerging role of ethics in Catholic health care provides one important frame for understanding the sponsors' commitment to ministerial identity, organizational values and charitable mission.

Although, from a sponsorship perspective, ethics was viewed as an important dimension of a system's Catholic identity, much day-to-day work focused on clinical ethics at the facility level. Educational programs were created to develop the skills of ethics committee members. In this period, ethics policies tended to be facility based. An integrated system-wide approach with a focus on organizational identity was not the norm.

As the number of system ethicists grew, attempts were made to establish more consistent ethics structures and practices, to increase the scope of education, and to develop some system-wide policies. By the 1980s, system ethicists and consultants routinely came together in both formal and informal meetings to discuss emerging trends and issues and to share best practices. Systems developed guidelines for forming and developing ethics committees and consultation practices, and work on competencies for ethicists and committee members began.[5] At this time, ethics was seen as the province of academically

trained ethicists, and ethics dialogue as expert-driven.

As in many other systems, ethics was viewed at Bon Secours Health System as an essential element of mission integration. The place of ethics in the organization was formally protected in two sponsor-approved policies related to Catholic identity and mission interests. Like others during this foundational stage, there was certainly variation in the way ethics work was carried out in local ministries. From early on, however, a commitment was in place to provide oversight and adequate resources. A system ethicist was hired during the system's formative years to advance clinical ethics practice, define organizational values, and even to lead what might be seen as a prelude to organizational ethics. Work on values-based decision-making, and education for providing a sponsorship and mission perspective on business practices were part of the ethicist's responsibilities.

LOOKING AT THE NEXT GENERATION

The next stage of ethics in Catholic health care involves the intersection of two important developments: the 1995 revision of the *Ethical and Religious Directives for Catholic Health Care Services* and emergence of the next generation model. Each had a unique influence on the way in which Catholic systems understood their ethical responsibilities and their social and religious commitments.

After a lengthy and inclusive consultation process, the United States Catholic Conference published a revised version of the directives in 1995. This edition thoughtfully articulated the ministry's social responsibility and included for the first time a section on forming new partnerships. The consultation process itself and the publication of the revised directives provided an opportunity to engage Catholic health care leaders in dialogue about moral commitments and ways of advancing Catholic identity in an environment increasingly requiring collaboration with other-than-Catholic organizations.

In addition to the revised directives, this stage saw increasing concern about the role and effectiveness of ethics structures. From early on, questions arose about the ability of hospital ethics committees to deal effectively with complex decision-making. In addition to important questions

about the skills needed for committee members, critics suggested that existing structures might actually impede ethics integration, decision-making and organizational effectiveness.[6]

Among responses to these concerns were the establishment of core competencies for ethics committee members, empirical studies on case consultation outcomes, and proposals for a "next generation" model of health care ethics committees. Core competencies, focused on ethical assessment, facilitation and interpersonal characteristics, were put forward by the American Society for Bioethics and Humanities.[7] The purpose of ethics committees and the case consultation process here is to assist with mediation and help promote principled decision-making.

Also addressing concerns about committees, the next generation model goes beyond dealing with difficult decisions. Employing quality improvement techniques, the model calls for identifying patterns of ethical concern, proposing solutions, monitoring outcomes and ensuring focused executive involvement and ownership.[8] Both the competencies and next generation model gained some foothold in Catholic health care and have prompted continued reflection on the purpose and desired outcomes of ethics committees and their relationship to executive leadership.

From a sponsorship perspective, these developments served to strengthen commitments to ethical structures and processes and to raise questions about their robustness and integration into the life of the ministry. In this, it became clearer that, although technical theological and ethical expertise provides important support for ethics practice, it is insufficient. Work on competencies, the quality improvement focus of next generation ethics, and the revised directives all pointed to the need for integrating ethics into the fabric of the organization.

Developing Organizational Ethics

The third wave of development occurred in response to increased interest in business or organizational ethics in health care. In 1995, the Joint Commission for Accreditation of Healthcare Organizations included new standards on "organization ethics" as a requirement for accreditation. These standards focus on a number of specific ethical issues, such as those related to billing, marketing and conflicts of interest. Equally importantly, the joint commission outlined a number of dimensions for supporting an ethical climate in an organization. Well understood mission and values, practical behavioral expectations, sound practices related to salary and promotion, and ongoing education are just some of these components.[9]

A significant increase in academic and professional reflection on organizational ethics followed introduction of the new standard. Building on conventional business ethics and professional codes, organizational ethics in heath care goes beyond them. The themes of organizational ethics resonate well with some of the classic values and concerns of the Catholic health ministry. Emerging from a tradition of service and community presence and commitment, Catholic health care is concerned principally with care for people and community health.

The question naturally arises: Can we continue the ministry with integrity, and not just goodwill, in a climate that may not be supportive?

Relating the nature and purpose of a health care organization to observable behaviors and practices is a dimension of organizational ethics that also fits well with the Catholic tradition. Insofar as it is concerned with caring for people, the *business* of health care has unique contours. In providing a necessary service, health care organizations are bound by important social obligations.[10] Health care, in every form, is more than a commercial enterprise. With this understanding, intentional cultivation of ethical discourse and communities of ethical practice is an obligation of health care leaders.[11]

The emergence of organizational ethics provides an affirmation and a challenge to Catholic health care. Putting the charitable mission of the organization at the center of ethical reflection affirms the heritage of religiously motivated care. At the same time, the challenge is to carry forward this tradition in an environment that sometimes promotes unhealthy competition, individual and corporate gain, and a view of health care as a commodity rather than a necessary service. The question naturally arises: Can we continue the ministry with integrity, and not just goodwill, in a climate that may not be supportive?

Although ethics in Catholic health care certainly helps with complex clinical and business decisions, it is also, and importantly, about cultivating an environment in which meaningful conversation about values can occur, and from which values-based actions arise.

From a sponsorship point of view, this ethical struggle is well worth the effort. Organizational ethics, thoughtfully undertaken, promotes dialogue about how values are practically applied in the workplace. Quality of care, human resource practices, resource allocation, investments, marketing and communication and environmental responsibility are all in the mix. Health care ethics here is directly linked to organizational mission, and, more importantly, to its practical manifestation.

The 2001 edition of the *Ethical and Religious Directives for Catholic Health Care Services* also had a bearing on this stage of development. Based on significantly less consultation than the preceding revision, this version of the directives includes changes related to the formation of new partnerships and replaces an appendix on principles governing cooperation with additional directives. While acknowledging that partnerships may provide opportunities for the ministry to serve, the directives also warn against dilution of Catholic identity and potential promotion of questionable practices.

Having important responsibility for the advancement of mission, values and identity, sponsors understood that this change in the directives encouraged a deliberative and thoughtful approach to new ventures. A clear implication of the revised directives is ensuring that partnerships with non-Catholic facilities include appropriate reserved rights, board representation, and distinguishing marks of Catholic health care, such as charity care, holistic and pastoral care and community focus.

During this stage of development, Bon Secours Health System created a system-wide ethics quality plan, which required reasonable standardization of structures and practices in clinical and organizational ethics, and defined approaches to ethics leadership and education. In addition, based on earlier system practices, a "mission due diligence" process was put into place for assessing the organizational culture of potential partners as reflected in their mission, leadership style, employee relations practices and social commitments, and for evaluating compatibility with those of our organization.

Assessing Emerging Trends

As the ministry continues to develop, so too does the contribution of health care ethics. From a sponsorship perspective, among the many issues that will shape ethics dialogue in the future are health care justice and public policy, ministry leadership and board formation in light of emerging sponsorship models, and succession planning for ethicists and their emerging roles. Here is a closer look at each area:

Health Care Justice & Public Policy The virtue of justice is concerned with respect for the rights of persons, and promotion of right relationships and the common good. Within the Catholic tradition, health care justice raises important questions about systemic health care reform, allocation of limited resources, medical research, and special concern and outreach for persons who are poor and underserved.

Engaging in public dialogue and advocacy for systemic health care reform and for universal access to care continues to be a priority of Catholic health care. In the important debate about the appropriate balance of incremental and systemic change, the voice of the Catholic health ministry needs to be heard.[12] Despite the complex nature of health care delivery and financing in the United States, ensuring adequate care to all is clearly an obligation of justice.[13] Being present, engaged and persistent in helping to find solutions is an important expression of the ministry's ethical commitments.

As part of this commitment to social justice, Catholic health care ethics also has a potentially important role to play in influencing practice patterns and models of care delivery. A current focus

on specialty care and concerns related to overtreatment, including questionable tests and surgeries, highly aggressive treatments and related deaths, is a matter for increased scrutiny and ethical dialogue.[14] Ensuring that persons have a medical home for primary, preventative and chronic care may be overshadowed in the current environment by reimbursement and practice models that reinforce less conservative, and potentially more dangerous, approaches.

Related to this, the increasing prevalence of so called "consumer-driven" and "retail" models of health care should prompt deeper analysis. An approach that suggests health care is a commodity rather than a necessary service is of ethical concern and conflicts with the Catholic tradition of care. Such models have the potential of limiting access to primary care, and shortchanging those who are most in need of well-integrated services.

Research ethics will continue to be an important area of focus. As medical research is increasingly being conducted in community hospitals, Catholic systems will need to ensure that satisfactory institutional review board processes are in place, and that respect for the dignity of the person and commitment to the common good remain components of ethical analysis.

Ministry Leadership & Board Foundation As sponsorship of Catholic health ministries moves beyond traditional boundaries, ministry leadership formation assumes an important role. In order to ensure a lively continuation of the mission, leaders and board members will need to be prepared in key dimensions of the Catholic tradition, including moral theology, Catholic social teaching and spirituality.

Because ethics practice should not be the exclusive province of academically trained ethicists, an understanding of the tradition and practical development of moral sensitivity should also be part of a comprehensive formation program. This need is particularly important, not simply to build technical expertise, but in order to form communities of discerning leaders.[15]

The religious motivation that is at the heart Catholic health care needs to be evident in the decisions that are made, and in the *manner* of decision-making. Thoughtful ethical discernment, therefore, needs to be a defining characteristic of the ministry.

Ethicists in the Future It is important to consider the sources, formation and role of ethicists in the future. Appropriate philosophical and theological training, preferably including a sound understanding of the Catholic tradition, should be expected.

In line with overall ministry formation, special attention should be given to affective and spiritual formation, and to the integration of ethics leaders into the broader leadership community. Because ethics leadership requires technical expertise *and* the ability to influence, participate in and facilitate decision-making, ongoing coaching and mentoring by successful ethicists and non-ethics leadership peers should also be available.

Ethicists will be most effective in promoting reflection and thoughtful decision-making if they are respected by other leaders for their knowledge of ethics and the Catholic tradition, and for their understanding of the practical realities of health care leadership. Like sponsorship and mission leaders, ethicists should have a good working knowledge of health care operations, finance, planning and human resources.

In carrying out the ministry in the name of the church, sponsors have an obligation to ensure that ethics practice is integrated deeply into the life of the organization. It should never be viewed as an interesting but peripheral activity. In this, ethicists should have routine, formal and significant interaction with executive leaders and should work in concert with sponsors and mission leaders in advancing Catholic identity in a thoughtful and inclusive way. A reasonable and important question for today and tomorrow is: Should an ethicist or theologian be a member of the executive team in order to influence decision-making, model ethics reflection and contribute to organizational direction?

CONTINUING THE TRADITION

Precisely because the story of Catholic health care is part of the story of the church, ethical reflection involves an engagement with the tradition and an ongoing discovery of the truth which tradition reveals. Ethics is a way of looking at and understanding the world. Ethical discernment is a creative activity, an exercise of moral imagination, based on God-given gifts.[16]

The role of ethics in Catholic health care, from

a sponsorship perspective, is one that both safeguards tradition and creates it. Like emerging sponsorship models themselves,[17] ethics practice provides a means for creating communities of concern and meaning. Although ethics in Catholic health care certainly helps with complex clinical and business decisions, it is also, and importantly, about cultivating an environment in which meaningful conversation about values can occur, and from which values-based actions arise.

Ethics practice matters to sponsors precisely because it contributes to organizational integrity, and is a profound and creative expression of our living tradition. ■

Comment on this article at www.chausa.org/hp.

N O T E S

1. See Francis Bernt et al., "Ethics Committees in Catholic Hospitals," *Health Progress* 87, no. 2 (March-April 2006): 18-25.
2. Judith Wilson Ross et al., "History of the Bioethics Movement" in *Handbook for Hospital Ethics Committees* (Chicago: American Hospital Association, 1986), 6-8.
3. See Kevin O'Rourke and Dennis Brodeur, *Medical Ethics: Common Ground for Understanding* (St. Louis: Catholic Health Association, 1986), and Benedict Ashley, Jean deBlois and Kevin O'Rourke, *Health Care Ethics: A Catholic Theological Analysis,* 5th ed. (Washington, D.C.: Georgetown University Press, 2006) for a consideration of the theological dimensions of Catholic health care ethics.
4. *Ethical and Religious Directives for Catholic Health Care Services,* 4th edition (Washington, D.C.: United States Conference of Catholic Bishops, 2001) is the current authoritative version. Available online at www.usccb.org.
5. Margaret John Kelly and Donald G. McCarthy, ed., *Ethics Committees: A Challenge for Catholic Health Care* (St. Louis: Catholic Health Association, 1984).
6. See Kevin Murphy, "A 'Next Generation' Ethics Committee," *Health Progress* 87, no. 2 (March-April 2006) 26-30, for a summary of some relevant literature and an overview of one system's experience.
7. *Core Competencies for Health Care Ethics Consultation* (Glenview, Ill.: American Society for Bioethics and Humanities, 1998).
8. Judith Wilson Ross et al., *Health Care Ethics Committees: The Next Generation* (Chicago: American Hospital Association, 1993).
9. Joint Commission on Accreditation of Healthcare Organizations, *Ethical Issues and Patient Rights Across the Continuum of Care* (Oakbrook Terrace, Ill.: Joint Commission Resources, 1998).
10. Leonard J. Weber, *Business Ethics in Healthcare: Beyond Compliance* (Bloomington, Ind.: Indiana University Press, 2001), pp. 4-7.
11. Carol Taylor, "The Buck Stops Here," *Health Progress* 82, no. 5 (September-October 2001): 37-40.
12. John W. Glaser, "'Covering the Uninsured' is a Flawed Moral Frame," *Health Progress* 87, no. 2 (March-April 2006): 4-9.
13. Philip S. Keane, *Catholicism and Health-Care Justice* (New York: Paulist Press, 2002), esp. 5-18.
14. See Shannon Brownlee, *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer* (New York: Bloomsbury USA, 2007), and Elliott S. Fisher, "Medical Care — Is More Always Better?," *The New England Journal of Medicine* 349, no.17 (Oct. 23, 2003): 1665-1667 for a consideration of the dynamics of unnecessary treatment.
15. John W. Glaser, "The Community of Concern," *Health Progress* 83, no. 2 (March-April 2002): 17-20.
16. Philip S. Keane, *Christian Ethics and Imagination: A Theological Inquiry* (New York: Paulist Press, 1984), 99-105.
17. See Francis Morrisey, "Toward Juridic Personality," *Health Progress* 82, no. 4 (July-August 2001): 27-31, and *Core Elements for Sponsorship: A Reflection Guide* (St. Louis: Catholic Health Association, 2006) for ways of thinking about contemporary dynamics of sponsorship.

At the Table Together: Mission and Ethics as Partners

At the Table Together: Mission and Ethics as Partners

Dynamic and Effective Teamwork Between Ethicists and Mission Leaders at Ascension Health Helps Strengthen the System's Ministry

Recognizing the continued advances in leadership roles in mission integration and ethics within Catholic health care, and the fact there may be related questions about the reporting structure between the mission leader and the ethicist, this article shares a perspective on the essential collaboration of these leaders and its potential impact on the ministry.

We start by exploring the development of these roles in the context of strategic leadership for the sake of the identity of Catholic health care as ministry. We follow by reflecting on the leadership styles and qualities that allow a collaborative relationship to have maximum impact and how that, in turn, creates the pathway for both the mission leader and the ethicist to be "at the table" in multiple ways, able to utilize their respective areas of expertise to the full. This takes place in the overall area of mission integration, and so we then share the experience of a departmental approach in which the many gifts of leaders in areas such as formation and spirituality along with ethics create a vital presence and participation in the overall organizational strategy.

Next, we go on to share specific examples from our experience of working together. We conclude with a reflection on this overall experience and on why it works.

In recent years, mission leaders in Catholic health care systems have collaborated to strengthen a shared sense of the significance, requirements and impact of the mission leader role. For example, clarity about the role of the mission leader as strategy leader has evolved. A strategic plan or direction is in essence the way in which

each Catholic health care system or individual entity lives — incarnates — its particular sense of the larger mission. Seen in the context of Catholic health care as a "ministry living a mission," the system mission leader and the system ethicist collaborate to build in multiple ways the capacity of the organization to be a ministry (defined as the service of health care done in the name of Jesus and the church for the sake of the reign of God) both now and into the future. So, we begin with questions of identity (being ministry), which lead to the implications for strategy and action (living the mission).

STRENGTHENING CATHOLIC IDENTITY

Strengthening Catholic identity is the shared responsibility of the health ministry's senior leadership team, which looks to a department of mission integration, whatever its size and composition, for the necessary technical expertise and accountabilities to help build that capacity. Seen in this light, the contributions within that department — of ethics, theology, workplace spirituality and leadership formation — create an integrated approach. They are at the service of the organization's ability to direct the evolution of its culture, make decisions, prepare leaders and inspire all its members, engaging their gifts.

The mission leader depends on the expertise of the other members of the mission integration department to fulfill its overall goals in service of the ministry's mission and strategy. The role of the mission leader, precisely as leader, involves assuring that persons with the needed qualifications are in the appropriate positions and are then encouraged to place their gifts at the service of the organization through their full participation and unique contributions. The mission leader acts neither as a filter nor as surrogate for the other members of the department. Rather, he or

BY SR. MAUREEN McGUIRE, DC, & DAN O'BRIEN, Ph.D.

Sr. McGuire is senior vice president, mission integration, and Dr. O'Brien is vice president, ethics, both at Ascension Health, St. Louis.

she acts as a thought partner with them in ways that rely on and transcend their specific areas of technical expertise to a broader shared agenda and responsibility for leadership. In order for such relationships to work, the individuals need to be secure in their roles and strengths, aware of and at ease with their professional scope and limits, to trust one another, and commit to fostering the gifts and success of the others.

This mutual respect, trust and celebration of each other's giftedness, combined with an organizational leadership commitment to a culture of creativity and innovation, means that we must be free to make mistakes. We are encouraged to take risks, assuming our hearts are in the right place, and assuming we have made a reasonable case for a given proposed action.

Having set this context, we would like to share our perspectives on the relationship between the ethicists and the mission leader at Ascension Health, a Catholic health system with 65 hospitals and dozens of related facilities in 20 states and the District of Columbia.

BEING "AT THE TABLE"

THE MISSION LEADER'S PERSPECTIVE

Sr. Maureen McGuire: The professional competency, experience and relational style of our system ethicists in clinical, organizational and social ethics, as well as in ecclesial relationships, supports system leadership at all levels. They are directly engaged with our local CEOs and mission leaders, for whom they play a developmental role as well as a consultative one. As a member of the senior leadership of Ascension Health, I realize there are many ways of "being at the table" and it is critical for our ethicists to relate directly and regularly with our leaders throughout the system in order to engage our shared agendas and to identify opportunities for contribution and for their continual learning. Also, such opportunities arise because annual departmental and individual goals are set in relation to the strategic direction and participation on various teams and in work groups.

THE ETHICIST'S PERSPECTIVE

Dan O'Brien: Many ways to be "at the table" and to contribute to the organization's progress are available without participating directly in *every* conversation and decision that transpires within various leadership circles. To think otherwise would seem petty or absurd in light of everything we all have to do and to accomplish. Under the successful mission leader's guidance, each member of the mission integration team feels empowered within our respective roles to seek new and more effective ways of strengthening and supporting other leaders and the organization as a whole in its capacity to be ministry. This requires profound trust in one another and recognition of the differences in our roles. This trust and recognition stems not only from our place in relation to "the table" but also from our unique gifts, competencies, contributions and *relationships* — in particular, our relationships with other leaders throughout the organization. These relationships are every bit about "being at the table."

The mission leader encourages those relationships and acts as a "connector" precisely because Sr. Maureen understands that "being at the table" takes place in various ways under many circumstances.

One of the most critical roles of the mission leader for such a department as ours is to foster an atmosphere of mutual respect, trust and freedom, where each member appreciates and celebrates the unique gifts of others, and is not in anyway threatened by their gifts or success. It goes back to Saint Paul's analogy of the body:

> "If the whole body were an eye, where would the hearing be? If the whole body were hearing, where would the sense of smell be? But as it is, God placed the parts, each one of them, in the body as he intended. If they were all one part, where would the body be? … If [one] part suffers, all the parts suffer with it; if one part is honored, all the parts share its joy." *(1 Cor 12:17-19; 26)*

This mutual respect, trust and celebration of each other's giftedness, combined with an organizational leadership commitment to a culture of creativity and innovation, means that we must be free to make mistakes. We are encouraged to take risks, assuming our hearts are in the right place, and assuming we have made a reasonable case for a given proposed action. We do not simply stand by waiting for the next request or project. Nor does Sr. Maureen expect us to wait for her lead on everything that needs to be addressed.

The strategic role of our mission leader is of vital importance, in particular, in the context of

this article, for the ethicists at our system office. As an integral member of the leadership team, Sr. Maureen is responsible for anticipating, under changing circumstances, many of the multiple practical implications for the focus of our mission integration department, combined with her ability to inspire and encourage us to see ourselves and our roles within the strategic vision. This actually frees the ethicists, as other members of the department, to participate more fully in and to pursue activities and services that contribute more robustly to that vision. We are encouraged to serve and to advance that vision in ways that even she could not anticipate.

What we experience is participatory leadership which fosters and engenders creativity in the department, and truly recognizes we each have unique gifts, competencies and perspectives to contribute. The result is that we all spot opportunities for one another to engage in existing or potential initiatives in which we can play a significant role or make a contribution. This enables Sr. Maureen to be more systematic in seeking, welcoming and incorporating different ideas from every member of the mission integration team, and then developing her perspective and vision in response to our interaction and participation. Everyone in the department learns and grows together.

I have come to appreciate all the above as essential characteristics of an effective mission leader and department. They are necessary conditions for the success of our endeavors as ethicists and for the other members of the mission integration team. They are part of what it means to "be at the table."

A more detailed discussion of the collaborative relationship between mission and ethics follows.

THE ETHICS CONTRIBUTION

A MISSION LEADER'S PERSPECTIVE

Sr. Maureen McGuire: I think of ethics as the pathway to living our mission in practice, from articulating the ideals and principles of justice, morality and integrity that guide our strategic thought and decision-making, to the specific application in clinical and business decisions. For example, it is of great significance to me that Dan serves on our major transaction teams. By "major transaction" I am referring to major business affiliations or partnerships of various sizes, whose transactions can have enormous impact upon the communities we serve and in fulfilling our mission. Dan's role in helping to shape these

Under the successful mission leader's guidance, each member of the mission integration team feels empowered within our respective roles to seek new and more effective ways of strengthening and supporting other leaders and the organization as a whole in its capacity to be ministry.

transactions in light of church teaching and the diocesan bishop's concerns are a vital contribution. His work supports my participation in the senior team's consideration of these matters and also provides support to the local health ministry, CEOs and mission leaders as they exercise their leadership in these strategic business decisions, including working through the complexities of implementation.

I have also come to a deep appreciation of the educational and formative dimensions of the work of ethicists. This is directly exercised in providing educational sessions by request of health ministries and teaching in our formation programs.

The work is formative because it invites the whole person. Yet, a specific style characterizes the work done by Dan and by John Paul Slosar, Ph.D., director of ethics for Ascension Health. I have seen the highly nuanced way in which they engage people in a process of discernment, and that results in individual and shared ownership, not only of a decision, but also of the ethical principles and elements of church teaching that are explored in coming to that decision. People come away with a sense of peace even in a hard decision because they know they have acted with an integrity that engaged their minds and also their hearts, values and intuitions.

The same is true in working through complex ethics consultations. Rather than simply offering a solution, our ethicists lead a thoughtful and deliberative exploration of an issue that extracts the wisdom of those seeking consultation. It becomes educative and formative because it is participatory and respectful, especially in working through differences of opinion.

Ascension Health vice presidents for mission integration, as well as hospital CEOs, regularly engage with our ethicists and highly value the support they receive and the attention given to the advancement of their competencies in their accountability for Catholic identity.

A significant example occurred when leaders in finance and information technology identified a possibility of exercising positive influence and

concretely expressing our Catholic identity and social teaching in significant vendor and partner relationships in global outsourcing. Those leaders, already familiar with the work our ethics department had done in developing *Socially Responsible Investment Guidelines, Ethical Guidelines for Major Transactions* and the *Organizational Ethics Discernment Process* asked our ethicists to lead an initiative. During the past year, John Paul Slosar led a process aimed at developing a set of principles to help shape performance of non-U.S. companies doing work on behalf of Ascension health. For example, our contractual arrangements now ask sources to provide information on their employment and wage practices as well as on their efforts to improve social conditions in their communities.

> **We do not seek other religious or scientific perspectives simply out of respect for other points of view; rather, we quite literally *depend* on them to deepen our understanding. We all *need* each other.**

AN ETHICIST'S PERSPECTIVE

Dan O'Brien: The collaborative style of our mission integration department is a great practical example of theologian Fr. Bernard Lonergan's theory of consciousness at work. Lonergan identified four levels of consciousness. First, there is the level of our experience, leading us to the second level of inquiry and understanding, which in turn leads to further questions arising from the first level. Third, there is the level of judging, where we test the truth of the answers we discover. In the fourth stage of consciousness we decide on a course of action that we have finally judged to be true. It is a tentative, dialectical process that distinguishes between *absolute* truth, which resides only in God and which theological formulas might adequately grasp but never fully capture, and our *experience* of the truth, which is always a dynamic, unfolding process. Once we mistake our experience of the truth for the truth itself, we make the fatal error of locking truth into that one moment of time, that one moment of insight, where we come to believe that no one else has anything more to say to us.

Our experience with the *Organizational Ethics Discernment Process,* which so many Catholic systems use in one form or another,

demonstrates this important theory in action. First, we each approach a problem or a challenge in light of our limited experience. Second, through dialogue, and sharing of each other's perspectives and experiences, we reach a new level of understanding, which, in turn, leads to further questions about our experiences and about the problem or challenge that lies before us. Third, through this dialogue of new insights, we reach yet a deeper level of understanding, of judging, where we are better positioned to test the truth of what is unfolding us. Fourth, we are then in a better position to choose the best course of action that resonates with the deepest levels of our consciousness.

This process does not lead to moral, religious or empirical relativism. Rather, it is rooted in the recognition that the deeper truths to which God is calling us can be revealed only in an ongoing dialectic. We do not seek other religious or scientific perspectives simply out of respect for other points of view; rather, we quite literally *depend* on them to deepen our understanding. We all *need* each other.

REFLECTIONS

In reflection, we've come to realize this approach is our desired way of carrying out our system mission department's activities and understanding of what it means to live our mission and Catholic identity. It is the essence of the relationship among all throughout Ascension Health who are involved in mission leadership, and whose expertise, gifts, daily leadership challenges and experience are woven into the very fabric of the tools and processes we have created to foster Catholic identity, ethical discernment, workplace spirituality and formation. They are participant leaders in shaping the direction and approaches to mission integration for Ascension Health.

By way of another example, in our leadership formation program, we engage participants in reflections and conversations about their religious and faith experiences, and ask them to compare and contrast those experiences with the readings provided on Catholic theological, moral and social thought. The resulting dialogue among the participants leads to new insights and appreciation for the unique ways in which God is working in their lives, as well as to a deeper appreciation for and commitment to the mission and identity of the Catholic organization through which they are called to serve and to lead. Far from a conversation marked by religious relativism, it is a dialogue that invariably leads participants to a deeper commitment to the calling of God in their lives.

From any particular point in time, we stand gazing at the horizon of knowledge and truth always from the perspective of our experience. We can never see the *whole* truth about even those truths that are articulated by Catholic doctrine. Rather, they always present themselves as *experienced* truths. In order for us to understand more profoundly the significance of the knowledge that lies before us and the truth to which we are called, we absolutely *must* rely on the experience of others — including the religious, secular, scientific and seemly oppositional experiences of others.

This "dialectic of contraries," Lonergan tells us, is in every instance the path to the good, while the distortion of this dialectic is at the heart of the mystery of evil. Theologians tell us that heresy is not really the opposite of truth. Rather, it is taking one dimension, one aspect, one experience of the truth, and making that the *whole* truth.

The practical importance of this theoretically nuanced discussion permeates the depth and scope of the work of a mission department and provides a working framework for understanding the interrelationship between all the members of the department, and between the department and other leaders and our ministry as a whole. The mission department's work is never seen as transmitting knowledge into "empty vessels"; such a view violates the dignity and integrity of others. Rather, the work of the mission department is essentially the work of dialectical engagement, of participatory leadership. It is about learning and exploring together the mystery of God's salvation, and coming to appreciate the multiple ways in which God is drawing us to himself and into faithful service of others. ◼

Recommended Qualifications and Competencies for System Ethicists in Catholic Health Care and for Facility/Clinical Ethicists in Catholic Health Care

Facility/Clinical Ethicists

EDUCATION AND EXPERIENCE

REQUIRED:

M.A. in one or more of the following:

- health care ethics/bioethics, and courses in Catholic theology,

- theology/theological ethics with a concentration in health care ethics/bioethics,

- philosophical ethics with a concentration in health care ethics/bioethics, and courses in Catholic theology.

Candidates need to be able to demonstrate knowledge of the Catholic moral tradition, including Catholic social teaching.

PREFERRED:

Ph.D. or equivalent in one or more of the following:

- Catholic theology/moral theology with an expertise in health care ethics/bioethics,

- health care ethics with a master's degree in theology,

- philosophical ethics with an expertise in health care ethics/bioethics and a master's degree in theology,

- related field with master's level work in health care ethics/bioethics and in theology,

- an MD, or a JD with master's level work in health care ethics/bioethics and in theology, particularly Catholic moral theology.

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of the Catholic moral tradition, including Catholic social teaching.

- Knowledge of Catholic health care ethics, including bioethics, clinical ethics, organizational ethics; the Ethical and Religious Directives; the mission and charism of the founders of the communities which comprise the system or organization; demonstrated ability to understand, communicate, and apply the Church's teaching and moral principles to medical, social, and management issues.

- Familiarity with ethics committees (types, composition, and functioning), and the process of clinical consultation; health care law, especially the classic cases.

- Demonstrated ability to teach, present, and write clearly and effectively; knowledge of and ability to employ adult learning models.

- Demonstrated ability to develop educational programs and resources, to conduct research for internal resources and communications, and to contribute to the discipline of health care ethics through research and publication; maintain currency in bioethics generally, and Catholic bioethics in particular.

- Demonstrated ability to communicate effectively with diverse groups (e.g., clinicians, patients and families, administrators, employees, and the media); ability to use a variety of media, including computers and standard computer programs;

- Demonstrated ability to engage in critical thinking and creative problem solving; expertise in moral reasoning and the ability to engage others in a discernment process.

- Demonstrated ability to facilitate meetings and groups with ease, to employ mediation techniques, and to build consensus.

CHARACTER TRAITS

- Shows respect, empathy, and compassion toward others; listens well; demonstrates self-confidence; collaborates; motivates and inspires others; builds trust and trustworthiness; and engages and appreciates multiple points of view.

- Actively demonstrates a commitment to the Catholic health care ministry, to the work of health care, to the mission and values of the organization, to serving others, and to the profession.

- Shows respect for the Church and the Church's teaching, while furthering theological and ethical inquiry.

- Demonstrates respect for all, including those with different points of view; is able to be objective with an awareness of one's biases; is able to set appropriate boundaries; maintains confidentiality.

- Demonstrates the critical personal qualities of honesty and integrity, humility, prudence, courage, a tolerance for ambiguity, open-mindedness, balanced judgment and demeanor, initiative and accountability, and good stewardship of resources, human, financial, and environmental.

System Ethicists

EDUCATION AND EXPERIENCE

REQUIRED:

Ph.D. or equivalent in one or more of the following:

- Catholic theology/theological ethics with an expertise in health care ethics/bioethics,

- health care ethics with a master's degree in theology,

- philosophical ethics with an expertise in health care ethics/bioethics and a master's degree in theology,

- related field with master's level work in health care ethics/bioethics and in theology,

- an MD, or a JD with master's level work in health care ethics/bioethics and in theology, particularly Catholic moral theology.

Candidates without a degree in theology need to be able to demonstrate knowledge of Catholic theology and of the Catholic moral tradition.

The desirable candidate will have experience in health care, preferably Catholic health care, and experience in the clinical setting, especially working successfully with ethics committees and clinicians, and performing ethics consultations.

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of the Catholic moral tradition and Catholic social teaching; Catholic systematic theology, in particular anthropology, ecclesiology, Christology, sacraments, and theological methods; and, Scripture.

- Knowledge of philosophy, especially moral philosophy, metaphysics, and epistemology.

- Knowledge of Catholic health care ethics, including bioethics, clinical ethics, organizational ethics; the Ethical and Religious Directives; the mission and charism of the founders of the communities which comprise the system.

- Demonstrated familiarity with and understanding of the world of health care, including health care systems and institutions; canon law as it affects health care and health care systems; health care law, especially the classic cases; health care administration, including finance health policy, ethics committees (types, composition, and functioning), and the process of clinical consultation.

- Demonstrated ability to teach, present, and write clearly and effectively; knowledge of and ability to employ adult learning models.

- Demonstrated ability to contribute to the discipline of health care ethics through research and publication, and to develop educational programs and resources.

- Demonstrated ability to communicate effectively with diverse groups (e.g. administrators, trustees, church hierarchy, clinicians, patients and families, employees and the media); ability to use a variety of media, including computers and standard computer programs.

- Demonstrated ability to engage in critical thinking and creative problem solving; expertise in moral reasoning and the ability to engage others in a discernment process; capacity for systems thinking.

- Demonstrated ability to facilitate meetings and groups with ease, to employ mediation techniques, to build consensus; ability to mentor.

CHARACTER TRAITS

- Shows respect, empathy, and compassion toward others; listens well; demonstrates self-confidence; collaborates; motivates and inspires others; builds trust and trustworthiness; and engages and appreciates multiple points of view.

- Actively demonstrates a commitment to the ministry, to the work of health care, to the mission and values of the organization, to serving others, and to the profession.

- Shows respect for the Church and the Church's teaching, while furthering theological and ethical inquiry.

- Demonstrates respect for all, including those with different points of view; maintains objectivity when called for and is aware of personal biases; is able to set appropriate boundaries; maintains confidentiality.

- Demonstrates the critical personal qualities of honesty and integrity, wisdom, humility, prudence, courage, a tolerance for ambiguity, open-mindedness, balanced judgment and demeanor, initiative and accountability, and good stewardship of resources, human, financial, and environmental.

A Critical Juncture

A Critical Juncture

Surveys of Ethicists and Mission Leaders Indicate Concerns about the Future of Ethics in the Catholic Health Ministry

BY RON HAMEL, Ph.D.

Dr. Hamel is senior director, ethics, Catholic Health Association, St. Louis.

What is the future of ethics in Catholic health care? This may seem to be an odd question. Many assume that ethics and Catholic health care are natural partners; where Catholic health care exists, ethics is present. This assumption, however, is not necessarily valid, and could lead to taking ethics for granted, which in turn could lead to lack of attention and neglect. For the most part, ethics does not just happen. Just as a mission-permeated health care culture is built on commitment and care, ethics requires deliberateness and nourishing.

So why question the future of ethics in Catholic health care? Some years ago, theologian and ethicist John Glaser, S.T.D., observed that there are "no ethics-free zones"; that is, virtually everything that we do in Catholic health care (and elsewhere) has an ethical dimension.[1] Whenever decisions are made or actions performed that affect human dignity and well-being, ethics has a role. This suggests that ethics is an ever-present reality in the day-to-day operations of Catholic health care, not just at the bedside, but throughout the organization.

Given that ethics is so central, so critical to the organization's identity and integrity,[2] is Catholic health care according ethics the explicit attention it deserves in daily decision-making? Equally important, are ministry leaders sufficiently attending to the *quality* of ethics in our organizations today and into the future?

Although ethics, in a sense, is the responsibility of all, some in our organizations are charged with this responsibility in a particular way — ethics committees; mission leaders who, in addition to doing mission, also are expected to fill the ethics role; and professional ethicists.

The latter are a relatively recent phenomenon in Catholic health care, appearing initially as "clinical ethicists" in hospitals. As Catholic hospitals and other health care facilities joined together to form health care systems, ethicists began to work at the system level. Some ethicists serve in both capacities. In comparison to mission leaders, professional ethicists who work directly in Catholic health care are relatively few in number — about 55.[3]

Interestingly, and of some concern, almost nothing has been written about the role and expectations of ethicists in Catholic health care, nor does there appear to be any clearly defined picture of their role, or of the ethics function in those places where it is carried out by mission leaders.

In response to this lack of information, the Catholic Health Association in fall 2008 conducted two ethics surveys that sought information from ethicists in Catholic health care, and mission leaders who carry out the ethics function.[4] The purpose of the surveys, published under the title *CHA Ethics Survey, 2008*, was not only to get a better picture of those who do ethics in Catholic health care (excluding ethics committees), but also to obtain the kind of data that might be helpful for hiring and recruiting, standardizing qualifications and competencies, providing educational and development programs, doing strategic planning, and planning for the future.

Some of the following information obtained from the surveys raises significant concerns for the future of the ethics role and the future of ethics in Catholic health care.

SURVEY OVERVIEW

CHA invited individuals from two groups to participate in almost identical online surveys. The first group consisted of professional ethicists and included system (national and regional) and facility

ethicists, as well as ethicists from several Catholic bioethics centers and academic institutions who contribute significantly to Catholic health care in a variety of ways. This group totaled 79. The overall response rate was 62 percent, though not all respondents answered every question. Unfortunately, technical glitches prevented some from accessing or completing the online survey, and not all respondents answered every question.

The second group consisted of mission leaders who also carry out the ethics function within their organizations. Because CHA did not know specifically who these individuals were, an e-mail was sent to all system and facility mission leaders inviting them to complete the survey only if, as part of their responsibilities, they also filled the ethics function. Although we believe that the actual number of mission leaders who cover ethics within their organizations is considerably larger, 179 replied to the survey. Here, too, technical glitches prevented some from accessing or completing the online survey.

What follows is an overview of the results of each survey, with some emphasis on the survey results from the professional ethicists. The overview is divided into four parts:[5]

■ The people "doing ethics" in our organizations
■ What they do — their roles, responsibilities, activities and concerns
■ Their perceptions about ethics in their organizations
■ Considerations for the future

WHO IS RESPONSIBLE FOR ETHICS?

1 GENDER, RELIGIOUS AFFILIATION, AND EDUCATIONAL PREPARATION

Among the professional ethicists, the majority is male (63.3 percent), lay (77.8 percent), Roman Catholic (77.8 percent), and hold a Ph.D. or S.T.D. (73.5 percent). Of those holding these terminal degrees, 10 respondents have their degree in moral theology, 10 in health care ethics, seven in philosophy, two in historical theology, and one each in canon law, education, religion, philosophy of medicine, and bioethics. Three respondents hold an M.D.; one holds a J.D.

Each of these disciplines undoubtedly makes its particular contributions to ethics in the ministry. However, if there is an assumption and/or a

desire that ethicists in Catholic health care be steeped in the Catholic moral tradition at minimum and, ideally, be able to bring a theological lens to their work and to the issues they address, it is fair to note that, according to the survey, those who hold a doctorate in a theological discipline are in the minority. Quite likely, most of these are from an older generation of ethicists who were seminary trained. (Some ethicists whose Ph.D. is not in a theological discipline do hold a master's degree in theology.)

Given that ethics is so central, so critical to the organization's identity and integrity, is Catholic health care according ethics the explicit attention it deserves in daily decision-making? Equally important, are ministry leaders sufficiently attending to the *quality* of ethics in our organizations today and into the future?

The profile of mission leaders who do ethics in their organizations is quite different from that of the professional ethicists. They are predominantly female (72.1 percent) and almost evenly split between religious and lay (44.9 percent religious and 42.7 percent lay). They too are predominantly Catholic (88.2 percent). The vast majority (80.4 percent) hold a master's degree; 15.1 percent have a Ph.D.

When asked whether they had formal training in *ethics,* a solid majority (60.9 percent) reported they did, while a significant minority (39.1 percent) said they did not. When asked about formal training in *health care ethics,* 76.1 percent responded in the affirmative. Formal training was construed to be assorted courses for 48 percent; workshops/conferences for 59.2 percent. A much smaller number, 8.4 percent, indicated that formal training consisted of a summer workshop. Only 10.1 percent said they had received a certificate in ethics or health care ethics, and only 5.6 percent reported having a master's in these areas. In essence, only 15.7 percent of those who said they had formal training actually do, strictly speaking, meaning they hold either a certificate or a degree in ethics or health care ethics.

What this data suggests is that ethics in Catholic health care is often done by individuals who have no formal training, whether in health care ethics, the broader field of ethics, or Catholic moral theology. This is not to fault

those individuals who have been asked by leadership to shoulder this responsibility. Nor is it meant to diminish their commitment and their hard work or to ignore the financial benefit of asking one person to wear several hats. But it does raise questions about how well the role of ethics is understood within our organizations and how well it is valued, especially by leadership. Mission and ethics are not the same. What qualifies an individual to do mission may not qualify him or her to do ethics, and vice-versa.

2 LOCATION

The "location" of professional ethicists in Catholic health care has significant implications for desired qualifications and competencies of new and future ethicists. Survey results show that a majority of professional ethicists in Catholic health care function as system ethicists (63.6 percent), though some of these (those employed by a regional system) are likely to also have clinical responsibilities. Few acute care facilities and, to our knowledge, no long-term care facilities have a full-time professional ethicist.

What [the survey results suggest] is that ethics in Catholic health care is often done by individuals who have no formal training, whether in health care ethics, the broader field of ethics, or Catholic moral theology.

Unlike professional ethicists, mission leaders who have an ethics role in their organizations are almost evenly divided between acute care facilities (40.9 percent) and health care systems (41.5 percent), whether regional (27.7 percent) or national (13.8 percent). Just 9.4 percent of respondents work in long-term care facilities.

This difference in location might account for other differences between the two groups, such as professional preparation, roles and responsibilities, competencies, interests, professional development and professional needs.

3 COMPENSATION

The CHA ethics staff often receives inquiries from the ministry about salary ranges for professional ethicists. Needless to say, these vary considerably, depending on the size of the system or facility, the region of the country, and the title, responsibilities, education and experience of the candidate. The survey showed the following overall salary ranges:

- 2.3 percent of professional ethicists earn more than $300,000
- 9.3 percent earn between $200,001 and $300,000
- 20.9 percent earn between $150,001 and $200,000
- 30.3 percent earn between $100,001 and $150,000
- 37.2 percent earn $100,000 or less

As might be expected, ethicists employed by a national system earn more (63 percent earn between $125,001 and $200,000) than those employed by a regional system (approximately 61.1 percent between $50,000 and $100,000, 16.6 percent between $100,001 and $125,000, and 16.6 percent between $125,001 and more than $200,000), or by an acute care facility (75 percent indicated salaries between $35,001 and $75,000, while 25 percent indicated a salary between $125,001 and $150,000).[6]

Survey results showed the following salary ranges for responding mission leaders: 12.9 percent earn between $200,001 and $300,000; 8.4 percent between $150,001 and $200,000; 41.3 percent between $100,001 and $150,000; 37.4 percent less than $100,000. Mission leaders in long-term care earned the least (64 percent earning between "less than $50,000" up to $75,000.)

When broken down by location, survey results showed that 48 percent of mission leaders at the regional system/acute care facility levels earn between $100,001 and $150,000, while 30 percent at the national system level earn between $125,001 and $150,000. Another 30 percent at the national system level earn between $200,001 and $300,000.

4 CONCERNS ABOUT AGE

A survey result of significant concern is the age of professional ethicists in the ministry. The largest percentage, 37.8, is between the ages of 50 and 59, and 31.1 percent are 60 and above. This means that 68.9 percent of ethicists are 50 years old or older. Another 11.1 percent are in the 40-49 age range, and 20 percent are between 30-39. (We are confident there are a few ethicists in their late 20s, but they either did not respond to the survey or did not respond to this question.)

These numbers not only suggest an aging cohort of professional ethicists, but also, of even greater concern, disproportionately fewer ethicists coming into Catholic health care than those approaching retirement age. Absent some fairly aggressive measures, we are facing a shortage.[7] Leaving these positions vacant or filling them with individuals who might not have the desired qualifications, competencies and experience could eventually have a negative impact on ethics in Catholic health care at a time when the issues are becoming increasingly complex.

As with the professional ethicists, the age range of mission leaders with responsibility for the ethics function is of considerable concern (see Figures 1 & 2 below). Among these individuals, 52.8 percent of respondents are over 60 years of age and 32.6 percent are between 50 and 59. Put more dramatically, 85.4 percent are over the age of 50. Only 1.7 percent is between 20 and 29, and only 1.1 percent are between of 30-39. In the 40- to 49-year-old category, we find only 11.8 percent. In other words, only 14.6 percent of mission leaders doing ethics in their organizations are younger than 49.

When combined with the ages of professional ethicists, and barring some significant reversal of the trend, it is evident that Catholic health care is rapidly facing serious shortages of those doing ethics in the ministry.

5 TITLES AND REPORTING RELATIONSHIPS

Because titles may indicate the degree to which a particular role is valued by an organization, our survey asked about position titles of trained ethicists and the titles of those to whom they report. Position titles range from ethicist (five respondents), to director (16 respondents), to vice president (nine respondents), to senior vice president (one respondent).

As might be expected, a majority of ethicists (62.5 percent) report to a mission leader, while 30 percent report to "other," and 7.5 percent report to medical affairs. Of those reporting to a mission leader, 34.9 percent report to a senior vice president, 25.6 percent to a vice president and 11.6 percent to a director.

With regard to reporting relationships, a slight majority (51.7 percent) of responding mission leaders report to "other" (in most cases, the chief administrator of the institution), while 36.2 percent report to another mission leader and 8.7 percent to pastoral care.
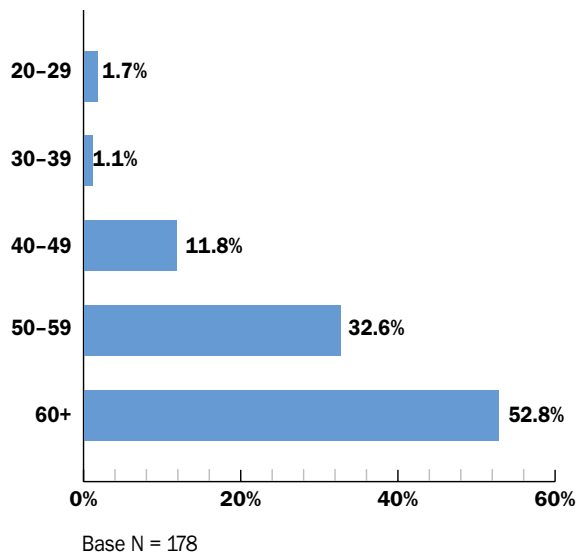
The difference in reporting relationships is telling. The majority of professional ethicists report to a mission leader, whereas a slight majority of mission leaders who carry out the ethics function report directly to the chief administrator. This could be purely by happenstance or it could say something about attitudes toward the importance of ethics within the organization and

Figures 1 and 2

Ethics: Respondent Age Range

- 30–39: 20%
- 40–49: 11.1%
- 50–59: 37.8%
- 60+: 31.1%

Base N = 45
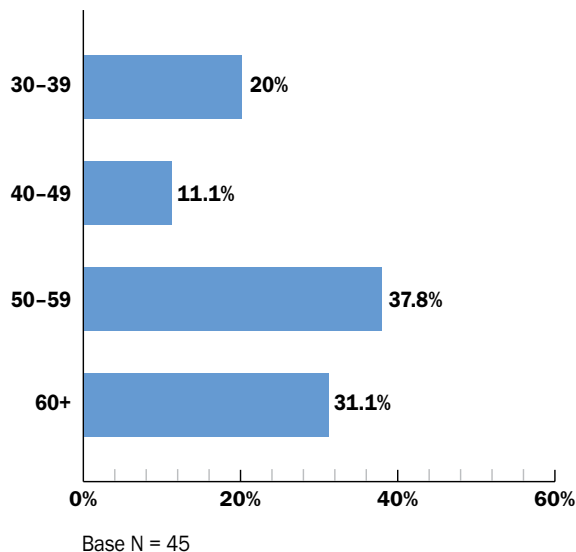
Mission: Respondent Age Range

- 20–29: 1.7%
- 30–39: 1.1%
- 40–49: 11.8%
- 50–59: 32.6%
- 60+: 52.8%

Base N = 178

the status of the professional ethicist. The difference merits further examination and discussion.

WHAT DO THEY DO AND THINK ABOUT?

1 ROLES AND RESPONSIBILITIES

In an attempt to obtain a better picture of what professional ethicists do, the survey asked them to indicate their primary roles and responsibilities from a provided list. Not surprisingly, the roles and responsibilities that rose to the top were education (89.8 percent), working with ethics committees (79.6 percent), clinical consultations (73.5 percent), development of educational resources (73.5 percent), policy development (71.4 percent), advising leadership on organizational issues (69.4 percent), and leadership development (59.2 percent). Less frequently mentioned were research (51 percent), church relations (49 percent) and writing for publication (46.9 percent).

These numbers suggest not only an aging cohort of professional ethicists, but also, of even greater concern, disproportionately fewer ethicists coming into Catholic health care than those approaching retirement age.

With few exceptions, responses from ethicists working out of a national system office were similar to those of ethicists working for a regional system or acute care facility. In all probability, however, while little difference exists in stated roles and responsibilities, differences occur among the three groups in the manner and degree in which those roles and responsibilities are carried out on a daily basis.

Mission leaders' primary roles and responsibilities in carrying out the ethics function differ just slightly from those of the professional ethicists. Their two top roles/responsibilities are working with ethics committees (76 percent) and education (65.4 percent), just the reverse of ethicists. Other roles and responsibilities are comparable with the exception of research and writing for publication. Mission leaders rank these as 6.7 percent and 6.1 percent, respectively, whereas professional ethicists rank them as 51 percent and 46.9 percent, respectively. These differences

might be explained in part by the two groups' different locations and training.

2 DAILY ACTIVITIES

By far the most frequently mentioned activity for ethicists was education (69.4 percent). Distant seconds were clinical consultations (26.5 percent), advising leadership on organizational issues (20.4 percent), working with ethics committees (20.4 percent), and development of educational resources (16.3 percent). Even lower on the scale were research, writing for publication, and policy development, each at 6.1 percent. Leadership development was at 2 percent, and church relations was almost zero. These results would seem to suggest that specified roles and responsibilities, as set forth in position descriptions, correlate only roughly with how professional ethicists actually spend their time. More importantly, they suggest something about desired competencies. It may well be that the activities that occupy ethicists from day to day should drive desired competencies rather than a general position description.

What occupies the time, energy, and attention of mission leaders as they carry out their ethics function? It should be noted that the amounts of time mission leaders spend doing ethics varies widely. The vast majority (82.2 percent) spend a quarter or less of their time in this role, and 14 percent spend 26 to 50 percent. Only 3.8 percent spend 51 to 75 percent or more of their time in an ethics role.

These results raise serious concerns. The vast majority of mission leaders who also carry out the ethics function spend a quarter or less of their time doing ethics. This is not the fault of mission leaders; most wear multiple hats and are stretched thin. This is a leadership and organizational issue. What does it say about how ethics is valued, how it is understood, and how it is done (i.e., quality), if it is receiving a quarter or less time of someone's attention, even if this person's efforts are supplemented by an ethics committee?

Professional ethicists and mission leaders are further differentiated by the activities that take priority as they carry out the ethics function. Mission leaders rank working with ethics committees (43.6 percent) higher than education (26.3 percent) — functions that are reversed by ethicists in terms of time spent. Among responding mission leaders, 45.5 percent indicated they chair the ethics committee. Another 26.6 percent serve as a

member of the committee, and 18.8 percent serve either as the responsible staff person or as a resource to the committee. Mission leaders rank leadership development higher than do ethicists, whereas ethicists rank development of educational resources higher. Writing for publication and research occupy the least amount of mission leaders' time (.6 percent and .3 percent, respectively). Both rank higher for ethicists, but leadership development is near the bottom.

Respondents in both groups were asked whether they are a regular member of the senior leadership team or the administrative council (see Figures 3 and 4 below). The vast majority of mission leaders, 77.3 percent, reported that they are, whereas 78.6 percent of ethicists reported they are not. This should not necessarily be construed to mean that ethicists have little influence on senior leadership. What it does mean is that senior leadership may need to examine the degree to which ethics is valued in the organization, as well as how ethics is brought to bear on all dimensions of organizational life, including those areas of the organization represented by senior leadership. What is important is that ethics *is* brought to bear, and not so much how it is brought to bear.

Some clarity about how the ethicist exerts influence is critical to the success of the role. Those ethicists who do not sit at the senior table might do well to examine how they exert influence on the organization as a whole as well as on senior leadership. Is it by participating in discussions on an ad hoc basis, through face-to-face conversations with senior leaders, or through the mission leader or another person to whom the ethicist reports?

3 ISSUES OCCUPYING ATTENTION

What occupies ethicists' and mission leaders' time are not only particular activities, but also particular issues that those activities address. Respondents were asked about the ethical issues that had been most pressing in the 12 months prior to the survey.[8] The most frequently mentioned issues by both groups were end-of-life care and futile treatment.

These results seem to point to a challenge that merits further exploration. Among the next top five issues, mission leaders and ethicists have two others in common, though rank them differently — education of leadership and staff (3.3 percent for mission leaders and 15.7 percent for ethicists) and contraception and reproductive issues (6.9 percent for mission leaders and 8.7 percent for ethicists). Mission leaders include physician/family conflicts (3.9 percent) and insurance and access to care issues (3.6 percent) in their top five issues, while ethicists do not.[9]

4 PROFESSIONAL DEVELOPMENT

Responses to questions relating to professional development suggest something about the professional self-identification and interests of ethicists in the ministry. A majority, 56 percent, said they attend one to three conferences per year,[10] while 34.1 percent attend four to six. These include the annual meeting of the American Society for Bioethics and Humanities
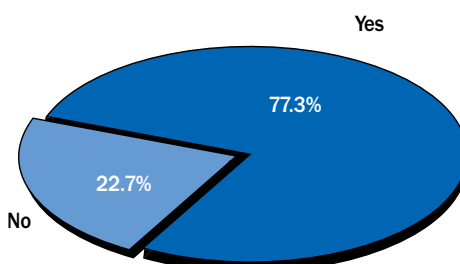
Figures 3 and 4

Ethics: Regular Member of Senior Leadership Team or Administrative Council
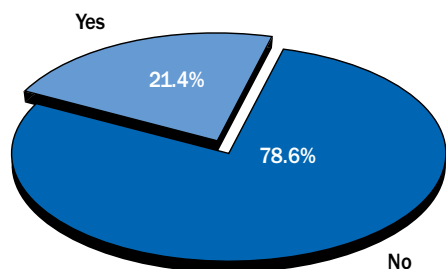
Base N = 42

Mission: Regular Member of Senior Leadership Team or Administrative Council

Base N = 154

(51 percent) and the CHA Colloquium (75 percent). Smaller numbers attend annual meetings of the Catholic Theological Society of America and the Society of Christian Ethics: 14.3 percent and 10.2 percent, respectively.

A strong majority of mission leaders (75.8 percent) attend one to three ethics-related conferences per year. Reading articles and books and attending workshops are among activities that help mission leaders keep up.

Both groups were also asked about the most critical topics for the *continuing education* of ethicists in Catholic health care. Fifteen percent of ethicist respondents noted theological foundations, 14 percent mentioned ethical issues related to research and advances in biology and science, 12.1 percent indicated the history and evolution of Catholic health care and organizational and business ethics, and 9.3 percent listed end-of-life issues and futile treatment. Mission leaders differed somewhat, listing the following in their top five: end-of-life and futile treatment issues (17.2 percent), cutting edge science/genetics/genomics (13.4 percent), the *Ethical and Religious Directives for Catholic Health Care Services* (7.5 percent), health policy and economics (6.7 percent), and organizational and business ethics (4.9 percent).

Senior leadership may need to examine the degree to which ethics is valued in the organization, especially with regard to important decisions, as well as how ethics is brought to bear on all dimensions of organizational life.

What is most satisfying to ethicists about their work is making a difference and helping others (50 percent) and education of staff and community (22.5 percent). The most oft-cited challenge was addressing structural and educational issues (38.9 percent), followed by limited time, resources, and unrealistic expectations (22.2 percent), demonstrating the value of their role (19.4 percent), and lack of organizational focus on mission to guide decisions (11.1 percent). Conversations about these challenges between ethicists and the person to whom they report might prove valuable.

Mission leaders listed making a difference and helping others (29.3 percent) as the most satisfy-

ing aspect of their work, followed by living and sharing Christian values in an ecumenical setting (22.0 percent) and respect for colleagues and the organization (17.1 percent). The greatest challenges for mission leaders in carrying out the ethics function are addressing structural and educational issues (32.5 percent), limited time, resources and unrealistic expectations (15.4 percent), end-of-life issues (8.9 percent) and demonstrating the value of the ethics role (8.1 percent).

PERCEPTIONS OF ETHICS WITHIN ORGANIZATIONS

1 ATTENTION TO ETHICS BY SENIOR LEADERSHIP
Both ethicists and mission leaders were asked about their *perceptions* of various dimensions of ethics within their organizations. One question inquired about the amount of consideration given by senior leadership to ethics in various areas; namely, mission, patient care, advocacy, leadership development, policy setting, strategic planning, human resources, budgets and medical affairs. Ethicists ranked mission, patient care and advocacy the highest; human resources, budgeting and medical affairs the lowest. Mission leaders gave a similar assessment, ranking mission and patient care the highest, and medical affairs and budgeting the lowest. The two groups differed, however, with regard to advocacy and human resources. Mission ranked advocacy among the bottom three categories, while ranking human resources among the top four. They ranked policy setting as third.

2 HOW THE ETHICS FUNCTION IS VALUED
Both groups were also asked about the degree to which the *ethics function* is valued by sponsors, mission leaders, the CEO, nurses and clinical staff, board members, senior leadership, patients and physicians.

It is encouraging that both groups ranked the CEO among the top three, but of some concern, is that they both listed physicians in the bottom three. Whether the reason(s) for the poor showing of physicians are benign or problematic, they may well be worth some discussion at the local level.

3 ETHICS IN STRATEGIC PLANNING
When asked about their perceptions of the degree to which ethical awareness is integrated into strategic planning, 30.8 percent of ethicists

said considerably/very, and 51.3 percent replied little/not at all. Mission leaders, on the other hand, perceived greater attention to ethics in strategic planning, with 43 percent replying considerably/very, and just 28.1 percent saying little to not at all. The difference could be explained by the greater proximity of many mission leaders to the strategic planning process.

4 BUDGETING FOR ETHICS
The existence and extent of a budget may indicate how a particular service or program is valued. Both groups were asked about the presence of a budget for ethics and its adequacy. The majority of ethicists (77.5 percent) responded that there is a budget, with just 42.8 percent describing it as considerably or very adequate. Mission leaders' responses were nearly reversed. The majority (77.1 percent) have no separate budget for ethics; 34.8 percent describe the ethics budget as barely or not at all adequate. These results, too, merit further exploration and discussion. It could be, at least in some cases, that the ethics budget is folded into the larger budget for mission.

5 CONTRIBUTIONS OF ETHICS TO THE ORGANIZATION
Asked to rank in order of importance the contributions ethics makes to their organizations,

ethicists chose integration of mission and values in an ecumenical setting (29.3 percent), education of leadership and staff (22 percent), and values-based decision facilitation (22 percent) as their top three. Patient, staff and family advocacy and support ranked fourth, at 14.6 percent. Mission leaders had the same top three at 25, 21, and 13.7 percent respectively, but they ranked improving patient care fourth at 4.8 percent. It seems significant that both groups agree on the top three contributions (see Figures 5 and 6 below).

LOOKING TO THE FUTURE
Survey questions related to the future of the profession dealt primarily with preparation of ethicists and the contributions of ethics to Catholic health care organizations and to the ministry.

1 DESIRED CORE COMPETENCIES
Asked what core competencies future ethicists would need in order to be effective in the ministry, ethicists cited Catholic moral theology (27.5 percent), basic, clinical and organizational ethics (16.3 percent), mediation and communication skills (12.5 percent), clinical experience (6.3 percent), business and health care policy (6.3 percent), church teaching and the ERDs (5 percent), and the core competencies developed

Figures 5 and 6

Ethics: Most Important Contribution Ethics Makes to Organization

Base N = 41
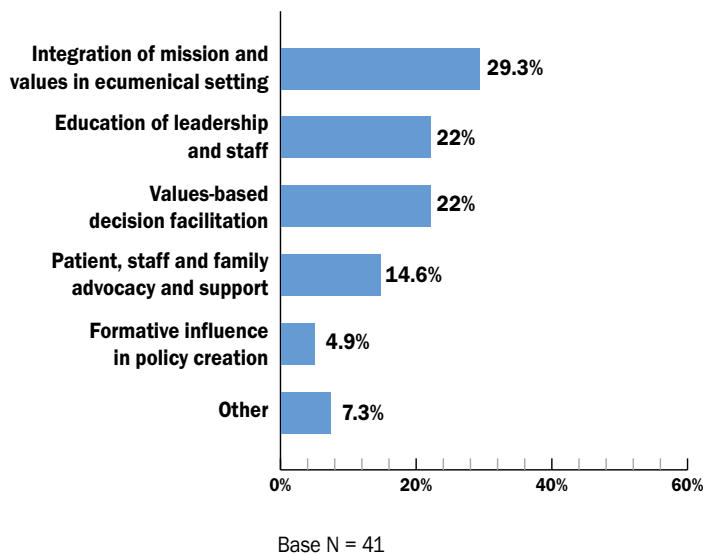
Mission: Most Important Contribution Ethics Makes to Organization

Base N = 124
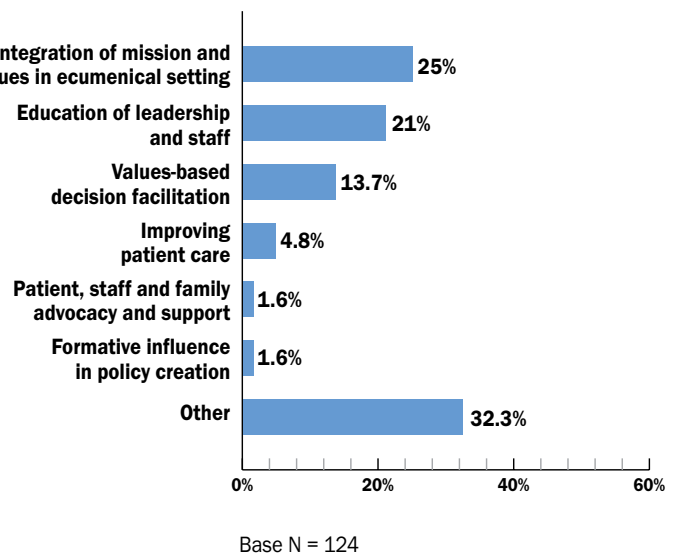
by the American Society for Bioethics and Humanities (3.8 percent).

Mission leaders mentioned church teaching and the ERDs most often at 21.3 percent, followed by mediation and communication skills (15.4 percent), basic, clinical and organizational ethics (14.7 percent), medical and technological advances (8.1 percent), Catholic moral theology (6.6 percent), values-based decision-making (4.4 percent), clinical experience (2.9 percent), cultural diversity (2.2 percent), and business and health policy (1.5 percent).

> **It would be interesting to know why ethicists ranked Catholic moral theology first and church teachings and the ERDs considerably lower, while mission leaders ranked them just the opposite.**

When broken down by location, mission leaders with national systems indicated Catholic moral theology and church teachings and the ERDs at the top, while those at the regional system and acute care levels most often mentioned church teachings and the ERDs and collaborative/mediation/communication skills.

It would be interesting to know why ethicists ranked Catholic moral theology first and church teaching and the ERDs considerably lower, while mission leaders ranked them just the opposite. The fact that both groups listed basic, clinical and organization ethics and mediation and communication skills among the top three desired core competencies is notable.

2 DESIRED EMPLOYMENT EXPERIENCE

A follow-up question asked about relevant employment experience desired for future ethicists in the ministry. The responses to this question by the two groups were interesting. For both ethicists and mission leaders, the most desired employment experience is clinical/hospital/health care experience (50.9 percent for ethicists and 54.3 percent for mission leaders). Moving down the list, however, the two groups diverged. Ethicists preferred teaching experience (12.7 percent), some experience with business and complex organizations (10.9 percent), and ethics training/mentorships/fellowships (9.1 percent). The mission leaders' responses, no doubt reflecting their somewhat different roles and responsi-

bilities, were mission and pastoral care (12.1 percent), ethics training/mentorships/fellowships (7.8 percent), ethics committee experience (6 percent), teaching (5.2 percent) and some experience with business and complex organizations (2.6 percent). Even though the rankings of each group varied, the fact that each identified similar desired employment experience is important in developing position descriptions and in assessing candidates for positions.

3 ESSENTIAL EDUCATIONAL PREPARATION

Asked about essential educational preparation for someone doing ethics in the future, a slight majority of ethicists (51.3 percent), most at the national system level, cited a Ph.D., while 35.9 percent, mostly at regional systems and acute care facilities, cited a master's degree. Another 10.3 percent indicated a professional degree and 2.6 percent a certificate in ethics. Interesting, but unsurprisingly, 49.6 percent of mission leaders believe that a master's is essential educational background and 31.9 percent believe that a certificate in ethics is essential. Only 4.4 percent of mission leaders, the majority of whom worked at the national system level, indicated a need for a Ph.D.

Determining adequate and desired educational preparation for someone doing ethics in Catholic health care is a high priority goal in planning for the future, one that merits much more discussion. Is a master's degree sufficient for a professional ethicist? Does it matter whether that individual is employed by a national system, a regional system, or an acute care facility? Is it sufficient for a mission leader who is also responsible for the ethics function to have a certificate in ethics?

4 RECRUITING FUTURE ETHICISTS

Ethicists were invited to offer suggestions for attracting/recruiting future ethicists for the Catholic health ministry, a relatively urgent issue that calls for ministry-wide attention. Their top suggestions were the following: build a pipeline to universities (19.2 percent); develop a greater understanding of the role (11.5 percent); provide mentorships and fellowships (9.6 percent); offer attractive salaries and benefits (7.7 percent); and emphasize the ability to make a difference (7.7 percent).

5 ETHICS' CONTRIBUTIONS TO ORGANIZATIONS AND THE MINISTRY

Shifting gears, the survey asked how ethics could contribute most to the responder's

organization in the next three to five years. The top five suggestions by ethicists were: education of leadership, staff and the public (30.6 percent); better acceptance and integration of ethics as a resource by the executive level (14.5 percent); influencing policy development (12.9 percent); values-based decision facilitation (11.3 percent); and providing better tools for dealing with problems (11.3 percent). Mission leaders agreed with the top major contribution (22.3 percent), but differed in their next three: linking mission, core values, and vision with everyday behavior (17.3 percent); patient, staff, and family advocacy (11.2 percent); and providing an ethical framework and ethical oversight (6.7 percent). The fifth top contribution was values-based decision-making.

A follow-up question asked how ethics could contribute most to the ministry in the same time period. The top four responses for both ethicists and mission leaders were: patient, family, and staff advocacy and support; linking mission, core values, and vision with everyday behavior; education of leadership, staff, and the public; and influence in policy development. The two groups, however, ranked these contributions in a slightly different order.

CONCLUDING OBSERVATIONS

This article began with a question about the future of ethics in Catholic health care. The results of *CHA Ethics Survey, 2008,* seem to suggest, at minimum, that far more attention needs to be paid to the ethics function in our organizations. The responses also raise some red flags about dimensions of the role as it exists today and into the future. Readers will have their own interpretations and observations regarding the results, but the following questions and observations are offered here.

1 **We have an aging cohort of professional ethicists and mission leaders with responsibility for the ethics function.** This challenge is compounded by the fact that there are insufficient numbers of younger individuals to replace them. Given this, what will happen to the ethics function in the future? And, if it continues, who will carry it on? Will they be adequately prepared?

2 **What is the appropriate educational background for those with the ethics role in Catholic health care organizations — national**

Figure 7

Ethics: Core Competencies Future Ethicists Will Need To Be Effective for Ministry
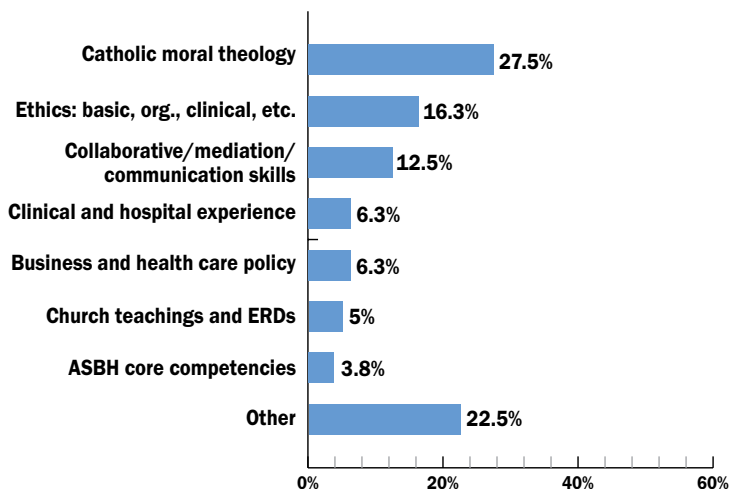
Base N = 124

and regional system offices, acute care and long-term care facilities? What are the qualifications and competencies that can be expected and that would enable those with the role to be as effective as possible? The survey suggests great variability. This is an area where there has never been sustained discussion on a national level. Related to this is the degree to which a theological background is desired in those individuals who carry out the ethics function. Again, survey responses reflect some variability. Why or why not is theological preparation a necessary qualification, especially for professional ethicists?

3 **The survey results raise the question about how much the ethics role is valued by leadership within our organizations and whether ethicists are utilized in the most effective manner.** Are ethics and the ethics role viewed as integral to the life of the organization or are they seen as nice to have around when crises develop or other difficult problems arise? How is the ethics role positioned and how is it used? What are expectations of those who hold it?

4 **What does it say about the place of ethics in our organizations when the majority of people responsible for it (mission leaders who also have the ethics function) spend less than a quarter of their time doing ethics and seem to have minimal preparation for this part of their responsibilities?** This is

not meant as a criticism of mission leaders and their hard and good work. It is a question for leadership. Would we do the same for other roles — human resources, for example, or quality assurance or strategic planning?

5 **Those who do most of the ethics in our organizations seem to spend a good deal of their time addressing clinical issues and working with their ethics committees, and devoting little attention to organizational ethics.** This is good as far as it goes, but health care ethics needs to encompass all dimensions of organizational life. The current way of doing things seems to perpetuate an outdated understanding and approach.

6 **Important similarities in the responses to a number of important issues between ethicists and mission leaders are present, but differences also exist.** What is the significance of these differences? Do they complement one another? Or do they result in working in cross purposes? What is their overall impact on ethics in the ministry? This needs further analysis and discussion.

7 **Research and writing for publication rank low for both professional ethicists and mission leaders.** It is unclear whether this is because it simply takes up less time than other activities or whether neither is being done much. The latter would be very unfortunate. No one is better positioned to contribute to the field of Catholic health care ethics than those who do it. The field will suffer incredibly and the ministry will be short-changed if we fall short in this regard.

These observations, indeed the survey results themselves, are intended to stimulate conversation in our organizations about how we understand, organize, and do ethics. They suggest we are at a critical juncture. We hope that insights, observations and conversations from readers will lead to some rethinking and to some concrete steps to enhance the ethics role in Catholic health care. Doing nothing does not portend well for the future of ethics and the ethics role in the ministry. ■

Comment on this article at www.chausa.org/hp.

NOTES

1. John Glaser, "Hospital Ethics Committees: One of Many Centers of Responsibility," *Theoretical Medicine* 10 (1989): 278.
2. For further discussion of this, see Ron Hamel, "Organizational Ethics: Why Bother?" *Health Progress* 87, no. 6 (2006); 4-5; "New Directions for Health Care Ethics?," *Health Progress* 88, no. 1 (2007); 4-5; and "Ethics — Fostering an Ethical Culture: Rules Are Not Enough," *Health Progress* 90, no. 1 (2009); 10-12.
3. Some systems and facilities do not have a full-time ethicist, but employ the part-time services of an ethicist who is generally based in a bioethics center or a university or seminary department. By "professional ethicist," we mean someone who holds a graduate degree in ethics and whose profession is ethics.
4. These mission leaders are to be distinguished from those who have oversight responsibility for ethics (e.g., overseeing the ethicist, the ethics consultant, and/or the ethics committee), but do not themselves "do ethics."
5. The two surveys and the complete results for each can be found at www.chausa.org/ethicssurveyresults. Many of the insights and comments from both groups are woven into this article.
6. American Society for Bioethics and Humanities, "Salary Survey," www.asbh.org/salary.html.
7. This is true not only in Catholic health care, but also in academic institutions (with the exception of those that have bioethics centers). There are fewer academics recognized as specializing in bioethics or health care ethics. One consequence of this is that few graduate students in Catholic universities are specializing in bioethics.
8. This was an open-ended question. For this reason, the responses were extremely varied. In addition, respondents often used different language to express the same or a very similar issue. In compiling and reporting the results, we grouped similar responses into categories. There were many single responses. These were grouped under "other." The listing of all responses under "other" can be found on the CHA website, www.chausa.org/ethicssurveyresults, with the survey results. What is true of this question in the survey is also true of several others.
9. Both groups were also asked what they believed the key issues would be in the next three to five years. Results can be seen on the CHA website, www.chausa.org/ethicssurveyresults.
10. Both groups were also asked what publications and what websites they rely on for information on health care ethics. These results can also be viewed on the CHA website, www.chausa.org/ethicssurveyresults.

FOR MORE INFORMATION, VISIT:

www.chausa.org/ethics