

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:

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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.