Looking Back, Looking Forward: Ethical Challenges for the Ministry

Reflections

Editor's Note: In reflecting on the end of one year and the beginning of a new decade, we asked four ethicists to share some of the issues that consumed a good deal of their time and energy during 2009 and what they thought might be the focus of their attention in 2010. The four ethicists are:

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Their responses follow. We think you'll find their observations interesting and invite you to reflect on your own experience.

1. **What were the ethical issues of 2009 that consumed the majority of your time and energy?**

Dunklee: Casting a look back at the ethical challenges of the past year, two issues immediately come to mind: (1) the revision of Directive #58 of the *Ethical and Religious Directive*s for *Catholic Health Care Services* (ERDs) and (2) applying the principles found in Part VI of the ERDs, dealing with partnering with non-Catholic institutions.

In terms of clinical issues, the revision of Directive # 58 that deals with medically assisted nutrition and hydration (MANH), particularly as it applies to patients in a persistent vegetative state, occupied a great deal of my energy and attention. With the revision of the directive, there needs to be ongoing education and dialogue to properly explain and apply the principles of Catholic moral teaching to clinical situations. Participants in these discussions should include clinicians, ethicists, bishops, the lay faithful, and, very

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importantly, our clergy. If this educational dialogue does not happen, there is a danger that people will misunderstand the church's teaching on end-of-life issues, particularly as they apply to the use of MANH.

In looking at organizational ethics challenges confronting our institutions, a good deal of my time was spent pouring over contracts, lease agreements, and partnership arrangements with a view to applying the principles found in Part VI of the ERDs. With regard to the challenges of partnerships and affiliations, there is a risk that we may become afraid to enter into any partnership for fear of being involved in some type of immoral cooperation or creating scandal. Partnerships are an inevitable part of health care, however, and "can be viewed as opportunities for Catholic health care institutions and services to witness to their religious and ethical commitments and so influence the healing profession" (ERD, Part VI, Introduction).

On the other hand, if we become too lax and enter into partnerships without careful scrutiny, we run the risk of compromising our institutional Catholic identity. Early and consistent dialogue between the diocese and the institution is paramount in dealing with these complex arrangements.

Iseminger: As I ponder this last year, I have had the opportunity to facilitate the resolution of a plethora of organizational and clinical ethical concerns in a wide variety of settings, in addition to providing education and preventative ethics programs.

On average, I receive about five to six clinical ethics consults per week. Given this, it is quite understandable that direct clinical ethics consumes significant amounts of my time. These consults so often arise because health care today is steeped in technical and financial challenges that may conflict with principled care for individuals balanced with our obligation to the common good.

Many consults involve exigent decisions regarding end-of-life issues, especially related to disagreement among associates and families regarding cardio-pulmonary resuscitation and other elements of "care at all costs." Generally speaking, health care needs to be more deliberate about using medical advances as a bridge toward reasonably certain therapeutic goals rather than exploiting extensive technology because of a refusal to acknowledge death. The situation is even more challenging in our neonatal and pediatric intensive care units where we are challenged to decide how much technological support to provide our society's youngest members who have not had the opportunity to live, cannot speak for themselves, and for whom prognostication is difficult.

Another area of concern has been to provide health care and social support for "marginalized" patients (the mentally ill, developmentally delayed, pregnant substance abusers, undocumented foreign patients, and those with limited health

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care literacy and poor preventative care). Many individual ethics consults serve as a stimulus for organizational ethics discernment processes to develop improved practices to prevent future patients from facing similar dilemmas.

Middleton: The ethical issues that consumed the majority of our time and energy in 2009 fell under the rubrics of clinical, organizational, and social ethics. The clinical ethics issues related mostly to end-of-life care, including assisting our market-based organizations (MBOs) to develop palliative care programs; artificial nutrition and hydration concerns; pacemakers and implantable cardioverter defibrillators (ICDs) at the end-of-life; and issues around donation after cardiac death.

In the realm of organizational ethics, we were involved in facilitating the "CHI Discernment Process" at MBOs in relation to proposed business transactions and issues of divestiture. We also provided guidance and counseling at both national and MBO levels regarding reduction-in-force decisions.

Under the umbrella of social ethics were several Grand Rounds presentations for medical staffs and senior teams on "Ethical Dilemmas in Healthcare: Economic Crises in Uncompensated Care."

Carney: Since the publication ten years ago of David Blake's article "Reinventing the Healthcare Ethics Committee" in which he outlines St. Joseph of Orange Health System's "Model for the Next Generation Healthcare Ethics Committee" (NGHEC), many hospitals and health care systems across the country (e.g., Veterans Administration, Catholic Healthcare East, Catholic Health Initiatives, and Ascension Health) have worked to incorporate aspects of this model into the development of their overall health care ethics programs. PeaceHealth has been on this journey for a number of years and continues to struggle with the challenge of how to successfully build in NGHECs as part of an overall health care ethics program in order for these committees to be proactive agents of systemic change for the improvement of patient care. This has been a major effort over this past year.

A Catholic health care system, PeaceHealth is located in three states (WA, OR, and AK) with bed sizes ranging from 10 to 420, located in remote, rural, and urban settings. In attempting to develop successful NGHECs in each of its facilities, there is no lack of agreement regarding the four principles that undergird these entities and their primary focus. However, successfully incorporating NGHECs into an overall health care ethics program for any health care system cannot be achieved without actively addressing ongoing systemic issues, specifically appropriate and adequate human, financial, and infrastructure support, and stakeholder engagement. These four components are in constant tension.

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In order to have effective NGHEC committees, one needs staff that are appropriately trained and adequately resourced. Infrastructure, in the form of administrative, computer, and analytics support is needed to be able to track consults and other work being done so that one can provide concrete documentation of the "added value" of a NGHEC and clinical consult team in improving the quality of patient care. Equally critical to the success of the NGHEC, is stakeholder engagement. Without administrative and clinical leaders and staff supporting the value of a NGHEC and clinical consult team, the work of the NGHEC will continue to be isolated and ineffective. The NGHEC and ethics consult team cannot do the work without the appropriate resources and, in turn, it is then difficult for leaders and staff to see the value of the work, when it is not meeting expectations. These are some of the challenges that we experienced over the past year in one area of our work.

2. **Looking forward to 2010, what ethical issues do you think might rise to the surface? What might be the challenges and opportunities they'll pose?**

Dunklee: In the year ahead, I believe that issues related to organizational integrity will become even more important. Patients and families are expecting a greater integration of services among physicians, clinics and hospitals. But how do we continue to maintain our ethical standards in this ever increasing market-driven society?

Critical to this process will be balancing our many and varied obligations to the poor and marginalized, to the community at large, and to patients, physicians and employees. We also have an obligation to the institutions in which we work to be good and prudent stewards of our resources, enabling us to remain fiscally sound and thereby helping to ensure the growth and development of technologies and services necessary to meet the increasingly complex medical demands of the 21st century.

This balancing of obligations requires a vision which looks beyond what is good only for our own individual department or institution, and focuses on what is in the best interests of the entire Catholic health care ministry of which we are a part. Critical to this will be education of our sponsors, boards, administrators, physicians, and other health care professionals regarding our call to effective and faithful stewardship, while striving for ever more visionary leadership in a manner consistent with Gospel values and the commitments intrinsic to Catholic health care.

While the church has a long and rich tradition of dealing with clinical ethical issues, organizational ethics is presenting us with new questions, challenges and dilemmas. I believe that these challenges will be among the most critical that we face in the decade which lies ahead.

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Iseminger: My experience as director of ethics integration leads me to champion a three-fold approach to ethics integration for Catholic health care. We need to: maintain our faith-based approach to health care, which embodies compassion for value differences in every scenario; assist our associates in dealing with the moral distress that they experience as a result of balancing mission, technical competence, patient and family advocacy, and economic margins with their personal values; and continue to heighten levels of ethical sensitivity requisite to quality clinical and business practices. Consequently, I believe that one of my primary goals for the next year is to be "present" to associates and families during their times of angst and vulnerability. Human contact and interaction are vital if patients, families and associates are to benefit from the resolution of ethical dilemmas embedded in clinical care.

Other ethics issues I expect to arise or continue in 2010 include our struggle to assist the marginalized regardless of how government ultimately achieves health care reform. Building upon St. Thomas Aquinas's belief, "action flows from being," I believe that the best way for us to prepare for these challenges is through education, prayer, and giving associates a voice on issues that concern them. Furthermore, I hope that our associates will view themselves as having abundant ethics and mission resources within themselves, within their clinical milieu, and throughout St. Vincent Health.

Middleton: As we explore a number of new business and research opportunities with their increasing complexity, we will be challenged to provide ethical analysis and oversight to ensure that potential partners and their activities comply with our mission and are consistent with the *Ethical and Religious Directives* (ERDs). It will be important for us to teach our senior teams/boards, "just-in-time" organizational and social ethics with a focus on Catholic social teaching, and remind them that mission and ethics need to be at the table in making these business/ministry decisions.
As health care undergoes continued change, progressive health care systems are pursuing varied initiatives that will require analysis of potential business transactions (e.g., contracting, partnership) based not only on prudent strategic and business decisions, but also on evaluative criteria that reflect the ethical, religious, and socially responsible and justice commitments of the organization. There is a responsibility to safeguard the "good name" (reputation) of CHI and its position as a health ministry of the church.

Carney: The challenge for PeaceHealth and for other health care systems attempting to incorporate a NGHEC is, put simply, to **continue the journey** of striving to build health care ethics programs and NGHECs that are "proactive agents of systemic change" for the improvement of patient care (Blake,2000:10). We must continue to

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find ways to engage key stakeholders so that we can build the human, financial, and infrastructure support needed. This task will continue to be a difficult, but important, commitment in the context of the current budgetary constraints and competing demands on limited resources faced by all of our systems and facilities as we strive to provide compassionate quality care reflective of the mission of Catholic health care.

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