

Ministry Responses to CHA's Ethicists' Survey

Editor's Note: The following are observations of ministry ethicists on the results of the 2014 Ethicist Survey.

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As in the 2008 original, this survey paints an interesting portrait. Ron Hamel expertly calls our attention to the chiaroscuro of individual strokes and trends, most of which raise more questions than providing answers. Particularly stark is the contrast between the present and prospective state of ethicists themselves. Hamel notes: "It seems unlikely that there will be sufficient numbers to replace ethicists retiring in the next five to ten years" (pg. 42). Hamel echoes his original encouragement of pipelines for people to find and contribute to Catholic health care ethics; I too have sounded this trumpet and take this opportunity to do so once again.¹

At the same time, I raise one point of observation: the canvas of this portrait is limited. Beyond its frame are two considerations which are essential to its full intelligibility and our consideration thereof. The first has to do with the *effect* of ethicists: whether, and to what degree, the current model is successful. One might argue—with good reason—that survey information regarding an ethicist being "valued and integrated" serves as a proxy measure of effectiveness. One might also argue that effectiveness should be

measured upon the conformity of institutional decisions with the various sets of norms, such as the *Ethical and Religious Directives*. Whatever one's answer, it presumes the answer to a second, more fundamental consideration: what is the *purpose* (final cause) of an ethicist? Success implies an objective. Thus, only in the light of purpose can we appreciate the full effect of the portrait upon which we now gaze.

Might this survey be an opportunity to discover again our *raison d'être*, our reason for being? As I understand it, the purpose of a Catholic health care ethicist is to foster the moral identity of the health care ministry of the Catholic Church—that vessel through which we encounter Jesus Christ. In simple terms this means ethicists are culture builders in their Catholic institutions: *ethos* is our vocation and Christ is our object. This disposition aligns with the framework for what has been called by Popes St. John Paul II, Benedict XVI, and Francis, the "New Evangelization."

This light of purpose brings the issue of decreasing numbers of ethicists into different relief. The numbers are not important *in themselves*, only insofar as they are necessary to achieve the objective better and more effectively. Decreases may not be an existential cause for concern if said ethicists were highly effective in capacitating non-ethicist employees with

theological and ethical competencies and capacities. The survey, self-admittedly, does not measure the efficacy and impact of ethicists in their efforts and presumes their purpose. Perhaps, then, it is time to explicitly reexamine the purpose of a ministry-based Catholic health care ethicist at some future Theology and Ethics Colloquium.

However it is accomplished, I would like to think such ressourcement, carried out under a rubric of the New Evangelization, would reveal a human face of ministry-based Catholic health care ethicist that radiates with “The joy of the gospel [that] fills the hearts and lives of all who encounter Jesus,” the only authentic quality that will attract new members.²

¹ Elliott Louis Bedford and Elizabeth Johnson, “Building a Pipeline: Connect Young Talent with the Ministry,” *Health Progress* Vol. 93, No. 3 (May-June 2012): 20-3.

² Pope Francis, *Evangelii Gaudium*, no. 1, http://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html (access 3/20/2015)

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In the introduction to the summary of CHA’s 2014 survey of ministry ethicists, Ron Hamel reviewed the initiatives that CHA undertook as a result of reflection upon an earlier (2008) survey. Those initiatives included: the development of desired competencies and qualifications for ministry ethicists, fostering

relationships with graduate students in ethics and developing educational opportunities for mission leaders who either carry out the ethics function or are responsible for ethics in their organizations. Given the results of the 2014 survey, what might CHA do over the next 5 years or so in support of ethicists and the ethics function in Catholic organizations, particularly if, as Hamel suggests (p. 42), “[e]thics is at the heart of mission”? Below are some initial thoughts.

1. **Provide publications, webinars and conferences that respond to the expressed need to integrate a deeper knowledge of and skill in organizational and business fundamentals with the already-honed skills of the practicing ethicist.** As the emphasis on population health quickly moves the delivery of health care beyond the walls of the acute care setting, what are the emerging ethical questions in the wider organizational sphere? What are the key ethical issues that should be addressed as new partnerships are being considered? How are these ethical questions formulated and integrally articulated in specific settings in service to the decision-making process? How do the organization’s leaders develop the needed sensitivities to the wider ethical questions? (It is worth noting that in a CHA 2013 survey, mission leaders indicated a need for similar skills.)

2. **Assist in identifying the most effective place for ethicists in organizational structures in which they often experience themselves as outside the sphere of influence.** How might decision-making processes (e.g. discernment models), particularly around partnerships, new delivery models and so forth, systematically include and engage the ethicist? What are the fora in which ethicists might most effectively contribute? How is the ethicist's role distinct from, aligned with, complementary to and/or confused with the role of the mission leader in a Catholic health care organization?
3. **Attend to the consequences of the changing, perhaps diminishing, role of the ethics committee in the acute care hospital and the implications of the same for ethics sensitivities across the Catholic health care delivery system.** What does that shift signal for the ethicist who often uses the setting of the ethics committee to educate a variety of clinicians? What, if anything, can take its place? In the new world of health care delivery what are the settings in which the ethicist can regularly contribute to the ongoing education of institutional decision-makers as well as nurture the moral conscience of the organization?
4. **Continue to provide a "safe forum" in which the ethical dimensions of new reproductive technologies and other emerging medical practices can be explored.** Where do

practicing ethicists in Catholic institutions find support and challenge in dealing with thorny questions? Do they sometimes struggle with the sense that they are perceived by some as merely the gatekeepers for Catholic orthodoxy? Can CHA effectively harness the combined experience and skills of ethicists from member organizations to provide insights to the evolution of Church guidance on these matters?

While this list is surely a partial one, perhaps it will stimulate further ideas about the ways in which the role of the ethicist might be strengthened across the ministry of Catholic health care.

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CHA provides a valuable service to its members with this survey. Having read the results of the previous survey, I eagerly reviewed the results of the most recent one. I summarize my reading of these findings in three points.

First, the retirement avalanche poses significant challenges. For the past two to three decades, the strength of Catholic health care ethics has been built on the shoulders and expertise of these women and men. While dying and rising is a natural part of the Catholic worldview, 30 percent retiring in 1–5 years and only 30 percent remaining in 16–30 years present

a gaping hole. I have long admired ethicists in the retiring cohort. Some I consider mentors. Thus, this survey comes with a sense of impending loss. The survey does not uncover the hopes and possible contributions of these retiring ethicists. Many retirees are most impactful in their field once freed from the limits of organizational structures. I urge these ethicists to respond boldly to the fertile opportunities before them. They are poised to respond well to another need noted in the survey, namely, adding to the academic literature. Further, those retiring could become valuable mentors for younger ethicists, both those working and those in graduate programs.

Second, the data reflect a shift in educational backgrounds on two fronts. One is the movement from theological to more philosophical ethics. The second is the shift from a doctorate to a master's degree as essential preparation. Only 30 percent viewed a Ph.D. as essential. I wonder whether pragmatism and utility are finding their way into the profession. Increasingly, I am convinced that Catholic health care ethicists, along with mission leaders, function as missionaries in a foreign land. We cannot presume a flourishing Catholic culture in our institutions. Modernity profoundly shapes the landscape of health care. *Gaudium et Spes* noted the increasing scientific spirit in the world influenced by math, technology, and economics (GS, §§5, 63). Clinical ethics alone cannot adequately confront these cultural currents. The rigors of a doctoral program expose students to a breath and depth of reading.

A good program and competent directors will make students contend with the themes, blessings, and challenges of the enlightenment. Such critical thinking is necessary to change cultures and to effect systemic change, particularly if it aims to sufficiently cohere with the Catholic tradition.

Third, matters of cooperation and analyzing business partnerships have occupied much of ethicists' time. The somewhat esoteric theological Principle of Cooperation has received much attention in the past two decades particularly by theologians in Catholic health care (yet barely taught in graduate programs). Cooperation is not going away. If anything, highly complex arrangements will increase. This, combined with my previous point on education, concern me. These realities call for the deepest, richest aspects of the Catholic theological tradition. Theologians uniquely possess a depth and expertise with regard to the tradition. They think within the tradition, not about the tradition. Fewer theologically informed perspectives may stymie our ability to adequately address the emerging complexities.

As Catholics, the paschal mystery forms us to believe time and again in the promise of new and abundant life. While concerns hover over these data, I am reassured by the work of the CHA to address this reality. I find strength in the work and writings that our senior ethicists have performed. Finally, I am reassured by seminal efforts to cultivate young scholars and ethicists. Though small in size, I have

encountered enthusiasm and commitment from younger colleagues. This offers fertile ground for the Spirit to bring forth new life.

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The 2014 CHA follow up survey on ethicists in Catholic health care provides interesting and specific detail about who we are and what we do. The results are not surprising. They suggest that we are older, well educated, not diverse, and we have a vast amount of responsibility, both organizational and clinical.

One thing this snapshot of Catholic ethicists is lacking is detail concerning our gender make up. While it is noted that the field is predominately male with men making up 62 percent of the profession (and thus 38 percent female), no other gender specific information is discussed.²

Due to considerable discussion recently about “the gender pay gap” in the mainstream media, many questions arise that could be answered by the survey results. Is “the gender pay gap” something that exists for Catholic ethicists? What are female ethicists earning on average? More precisely, how much are female ethicists in the same role as their male counterparts earning?

Similarly, what is the gender make up of leadership roles of Catholic ethicists?

From the survey, we see that the titles ethicists hold vary greatly, so much so that a large number of people answered “Other.” It makes it quite unclear as to whether our titles match our roles. Yet within the health care leadership structure, title and role are rarely uniform from system to system. Nor can we expect our roles as ethicists to be uniform in the way a nurse’s job is generally from hospital to hospital, operating room to operating room, or ICU to ICU. Yet, regardless of specific title, there are clearly senior leadership roles, especially within regional and national systems. More than likely, these senior leadership roles are represented in the survey by the titles of VP and Senior VP. It would be interesting to know for instance, of the 15 percent who are VP or Senior VP titles, what percentage are females?

If we want to attract the next generation to this vocation, we need to demonstrate that there is no great disparity in compensation and/or leadership roles between genders. As this generation of leaders in ethics begins to build a succession plan and mentor the next generation of leaders, it is important that we see more females begin to take on leadership roles.

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With nearly 40 percent of currently working ethicists over age 60, and only

31.4 percent having a succession plan, there is a clear area of concern for the future. A hopeful sign is the ever-increasing number of graduate students in ethics programs attending conferences. The disadvantage is that some of those students lack experience in health care delivery. Fellowships and similar opportunities can give them some practical experience in ethics case consultation, and in recent years there are many, many more opportunities for formal training in that area.

A different model that can deliver effective system ethicists is to develop the skills and provide formal education to an employee with experience in health care who shows interest and potential in the ethics discipline. This approach, while it requires time and foresight for succession planning, can produce a well-rounded system ethicist with the credibility to be immediately effective. Another approach is to develop local ethics champions. They work a bit like physician extenders/mid-level providers. In our system they are members or chairs of facility ethics committees from a range of disciplines who have developed their skills through additional education and practice. They are known within their institutions as ethics issue resource persons, and can handle many common issues without the involvement of the system ethicist. This model has allowed for a sound ethics service across a 15-hospital system with only one full-time ethicist.

Regarding the “status” of ethicists within the organization, I would tend not to

make too many assumptions. Title is less important in some organizations than in others. In my large regional system, before we became part of Ascension Health, there were only a few system-level VPs. Informal conversation with mission and ethics leaders in other organizations suggests that the VPs in many places earn less than the system directors with comparable positions and scope of responsibility in our organization. As was rightly pointed out, not sitting on the senior leadership team should not necessarily be construed as lacking influence. Ethicists can and do make themselves relevant by being in close relationship with the Senior Mission VP. Those with a robust ethics practice probably find that they have neither the time nor the interest in being a regular member of the system’s senior leadership group, but welcome the opportunity to be involved in organizational issues when called upon.

I was surprised to note that there was no mention of skills in conflict resolution, consensus building, or team leadership listed among the top required competencies, though perhaps those skills are understood to be included in the general term “communication skills.” While the theological underpinnings are essential to understand, without the ability to work collegially with others in solving the day-to-day dilemmas that face every health care system, facility, and department it would seem nearly impossible to be an effective force.

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My initial inclination was to respond to the 2014 CHA follow up survey on *Ethicists in Catholic Healthcare* focusing on the issue of diversity. It is clear from both the 2008 initial survey as well as from the follow up, the field remains quite racially and ethnically homogenous. However, I believe Dr. Angove, et al., offer an excellent examination of this issue and potential implications in a previous issue of *Healthcare Ethics USA* v. 22, no. 4 (Fall 2014). Instead, I wish to focus on a shift that occurred in the survey results from 2008 to 2014 in the area of “Roles and Responsibilities” for Catholic health care ethicists.

Dr. Hamel notes that in the 2014 survey “the most significant difference [in ethicists’ roles and responsibilities] is that in the 2008 survey, working with ethics committees ranked second, whereas in the most recent survey, it came in much lower.” Although this may raise some interesting concerns in relationship to a number of other areas within the 2014 survey, I would like to suggest an alternative hypothesis. One optimistic explanation for this change in role and responsibility of the ethicist may be that the survey came out at a time where health

care institutions/systems were just beginning to better understand the implications of population health. The tectonic shift in focus from the episodic care of individuals with acute health needs to the health of entire populations rightly impacts the way we think about the traditional roles and responsibilities of ethics consultation and ethics committees—a traditionally acute care focused consultation structure.

I believe it is of significant relevance to this idea that when ethicists were surveyed in 2014 as to “how ethics might contribute most to their organization in the next 3-5 years,” that “providing new ways of offering ethics services in new models of care” emerged. Along with the next most frequently mentioned area of organizational impact, that is, “nurturing a strong ethics culture and ongoing ethics education to empower various individuals and groups (including medical residents and nurses),” it may be that the more traditional role of educating the ethics committees within the institution is no longer seen as the most effective way to disseminate ethics knowledge and resources throughout the organization—even when considering clinical ethics resources at the bedside. To be clear, I am not suggesting that this work is unimportant or nonessential (in fact, I believe quite the contrary). What I am suggesting though is that population health has pushed ethicists to re-think traditional models of organizational education and integration beyond their own influence on a particularly acute care focused committee structure. This insight

is affirmed in the survey itself, wherein ethicists' view their own contribution to the ministry in the next 3-5 years, by "... finding ways to integrate ethics across the continuum of care and re-thinking our ethical frameworks in light of the shift in emphasis beyond the acute care setting."

I am further encouraged by the findings in the 2014 survey that suggest that "what experience future ethicists will need in order to be effective in the ministry,...most frequently cited [were] clinical experience and previous work in a health care setting." The timeliness of this insight is only highlighted in the survey where it indicates "familiarity with the fundamentals of business and strategy, operations, and how to interface with senior leaders" as a critical experience platform from which future ethicists should launch their career development. At a time where health systems themselves are creating new organizational structures to address the needs of caring for populations across the continuum of care, the operational experience of being embedded within this changing environment is invaluable.

Yet, amidst all the changed responsibilities noted in the shift from the 2008 survey to the 2014 survey, I am concerned that time is not afforded the re-thinking of ethics integration seen as so critical over the next 3-5 years. In other words, it seems from the survey that although role responsibilities are shifting for ethicists, those responsibilities comprise "...church relations, executive formation, analysis of new affiliations and partnerships, mission

due diligence, organizational ethics issues, etc." In the flurry of mergers and acquisitions, can we as a field find time to rethink our work? Amidst the compendium of new demands, will we find time to creatively integrate ethics into new delivery systems that will require new structures for ethics consultation and education? Will we be able to create the vision that ethics committee structures need to develop in order to bring ethics consultation proactively to the clinical team, patients, families *and community*? I believe the juxtaposition of survey results from 2008 and 2014 requires we find this time. The survey itself called out from the membership of our profession a desire to rethink our work and our traditional structures of institutional influence.

The need to create this time for creatively rethinking our work is even more critical in light of the demographics of our profession. It is my hope that we utilize the wisdom of the near 30 percent of our field that plans to exit the profession within five years—many of whom have witnessed multiple tectonic shifts in health care delivery over their careers—to creatively rethink ethics structures with the shift to population health. In this way, I believe we can achieve a proactive and embedded organizational structure for ethics that moves us toward the care of populations while maintaining a foothold in the traditional acute care setting guided by the very wisdom within our field.