The Future Shape of Ethics: Are We Prepared for What's Coming?

Editor's Note:

Almost every discussion of health care ethics I have been involved in eventually gets around to the changing or evolving nature of the discipline. Not everyone agrees on what ethics will look like in ten or twenty years, but everyone agrees that it is going to change. Electronic medical records, virtual care, system mergers, the rapidly evolving role of the mission leader, changing patterns in reimbursement and emerging issues (e.g., genomics and transgender medicine) will force us to examine what ethics includes, as well as specific practices. Health Care Ethics USA invited two ethicists, Alan Sanders from Trinity Health and Becket Gremmels from CHRISTUS Health, to reflect on what they see as the future of the ethics function. Alan explores Trinity's "expanding vision" of ethics; Becket highlights several factors that are changing the way ethics committees work.
We invite other systems to share their observations about what Catholic health care will require of ethicists in the future.
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When Catholic Health East and legacy-Trinity consolidated in 2013, the sponsors developed a mission and vision for the new Trinity Health. As a result, our mission today is to be a compassionate and transforming healing presence within our communities, and our vision is to be the most trusted health partner for life. This mission and vision are based on Trinity Health's founding story of the Good Samaritan. Prophetically, this story was modified in the 1990s by the late theologian and ethicist Jack Glaser to reflect changes occurring in the U.S. health care marketplace system in the era of managed care, changes that many say are similar to changes occurring today.

Glaser's modification of the story is simple, but it reflects the much more complex ethical questions that confront health care systems in our rapidly changing and challenging times.[1] In the modified version, rather than encountering one wounded traveler on the side of the road, the Samaritan encounters a number of wounded and realizes there are likely many more beyond his immediate sight. With his limited resources, he now faces a population of people needing help, prompting difficult ethical questions related to resource allocation, among others. This reminds the reader of the challenges health care systems face today, at a time when we are called upon to address population health and adjust to value-based payment models – models that reward health systems for measurable outcomes in improving health in place of the older fee-for-service model.

In response to this new environment, mission and ethics at Trinity Health has adopted a three-realms-of-ethics model to serve as an ethical framework for our organization. The realms are clinical ethics, organizational ethics, and social ethics. These three realms are not new to Catholic health care, especially in the context of the Catholic moral tradition, but they have not previously served as an overarching ethical framework for those who work in ethics in Catholic health care organizations.[2]

Ask anyone in Catholic health care what the word "ethics" suggests to them, and you will likely get answers ranging from choices related to clinical treatments (typically what is prohibited by the ERDs), to matters of compliance and law, to whether the organization is governed by principles of justice in the way it treats its colleagues. Generally speaking, most people do not think beyond the organization itself, to how ethics might impact the health of the population at large. Therefore, we have begun to educate and form all colleagues in mission and ethics around this expanded ethical framework, represented in the draft ethics icon below.

The draft icon depicts the three realms of ethics as concentric circles with Trinity Health's vision to become the most trusted partner at its center. The words "discernment" and "reflection" run throughout all three realms, and are rooted in Trinity Health's mission, vision, and values. The goal is that these three realms of ethics are seen as responsibilities for the entire ministry and its colleagues, not just the work of mission and ethics or other specific departments or, least of all, exclusively the work of ethics committees. However, each realm does have particular responsibilities that are evolving and emerging.

Clinical ethics is the realm with which most people are familiar. It is the realm of clinical ethics consultation or facilitation (e.g., end-of-life and beginning-of-life), and a host of policies and educational services guided by the ERDs. Over the years, the role of clinical ethics committees has evolved away from providing clinical ethics consults to supporting a trained team of individuals to facilitate and document those conversations. Consistent across many Catholic systems,

clinical ethics committees continue to provide a retrospective review of cases, quality improvement of the ethics consult process, policy development, and education.

> The realm of organizational ethics has gained increasing attention over the years through the work of theologians and ethicists in Catholic health care.[3] Organizational ethics includes mission discernment, the name for Trinity Health's values-based decision-making model; assessment of partnerships, especially with other-than-Catholic partners; and close working relationships with human resources and other departments in the organization to help ensure that the ministry's decisions, practices, and policies promote and align with the Catholic moral tradition. However, members of clinical ethics committees are not equipped to address most matters of organizational ethics because their training tends to be focused exclusively in clinical bioethics, and representation on the committees often does not include those involved in organizational ethics decisions.[4]

Least defined in Catholic health care is the realm of social ethics, although this realm has a long-standing history in the Catholic moral tradition through the principles of social justice and the common good. In the draft ethics icon and related ethical models, the realm of social ethics surrounds clinical ethics and organizational ethics because the social realm is the largest and has more influence on them than they are able to have on it.[5] At its broadest reach, social ethics is the entire society and its culture.

Here, however, a distinction needs to be made regarding the voice or witness of the global Catholic Church in society, and the role of Catholic health care, a distinction that has been addressed by both Pope Benedict XVI and Pope Francis. Pope Benedict XVI offers some principles for social ethics related to Catholic health care in his encyclical *Deus Caritas Est* (*God is Love*), particularly where he states that the Church's charitable activity (including that of health care organizations) should not become just another form of social assistance. Further, he cautions that it must be independent of parties and ideologies, and should not be used as a means of engaging in proselytism. Rather, the Church's charitable activity is to be accomplished and distinguished by dedicating itself to others with heartfelt concern, enabling others to experience the richness of their human dignity.[6]

Pope Francis further emphasizes these obligations by comparing the Church to a field hospital that seeks and heals society's wounded.[7] He makes a similar point in his apostolic exhortation *Evangelii Gaudium* (*Joy of the Gospel*), where he says the Church's pastoral ministry cannot be obsessed with the transmission of a disjointed multitude of doctrines to be imposed insistently, but rather, should strive to bring out and develop facets of the inexhaustible riches of the Gospel that meet the needs of those who are suffering in the moment.[8]

While the voice and witness of the Catholic Church and Catholic health care are distinct, they are not mutually exclusive when viewed in the light of value-based payments and the need to address the multiple needs of communities under the umbrella of population health. The goal of population health is not to just treat illness, but also to encourage wellness and reward health systems for achieving that goal. "Wellness" is a very broad category, one that juggles both scientific and political agendas, and includes

the physical, mental, social, and spiritual aspects of human beings. As examples, the clinical classification of gender dysphoria, and the related, but often conflated, social issues of gender identity, as well as genomics, are small drops in a sea of changes in front of us challenging conceptions of human health and the role of medicine.

What is clearly in the realm of social ethics for Catholic health care are issues of social justice (e.g., human trafficking), socially-responsible investing, the work of foundations, advocacy, and current work in population and public health aimed at promoting healthy behaviors. Catholic health care organizations are already struggling with questions about social priorities amid competing interests and limited resources. Other pressing concerns include balancing obligations to further the common good of communities, while respecting both the autonomy of individuals who live within them and the individual discretion of providers, as well as providing models for encouraging healthy lifestyles such as diet and exercise.[9]

All of this is to say that in mission and ethics at Trinity Health we know that the work of ethics is expanding, and we are just beginning to outline what all of this means practically. First, Trinity Health is drafting what it considers "essential work in ethics" for mission leaders and ethicists in these three realms, guided by Catholic social principles and the *Ethical and Religious Directives for Catholic Health Care Services*. Second, we are forming a system-wide ethics council and regional ethics councils to drive this work, including outlining responsibilities of mission leaders and ethicists in assessing the effectiveness of the activities. Third, we will continue training and process improvement for our clinical ethics facilitation teams, including quality improvement in ethics consult documentation and tracking. And finally, all of this work must be applied across the continuum of care as well as integrated with Leading Catholic Identity (LCI) and Promoting Catholic identity (PCI), Trinity Health's formation and assessment programs respectively.

We in mission and ethics at Trinity Health know we have a lot of work ahead of us and, like many other Catholic health care systems, will be relying on the expertise and reflection of Catholic theologians and ethicists to help us navigate these swirling waters. The point is that we can no longer fixate on matters of clinical bioethics but have an obligation to create systems and structures that also support organizational ethics and social ethics. While clinical ethics remains vital to patient care and safety, an exclusive focus on questions concerning clinical treatments will cause ethicists and those serving in ethics structures, such as ethics committees, to miss this bigger picture. The three realms are not mutually exclusive, and when each realm is given its due attention and expertise, we provide a more robust ethical framework for addressing the increasing complexity of ethical challenges that confront us.

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[1] Jack Glaser, *Three Realms of Ethics: Individual, Institutional, Societal – Theoretical Model and Case Studies* (Kansas City, Missouri: Sheed and Ward, 1994).

[2] Frank Morrissey, "Implications of Canon Law for Catholic Health Care Leaders and Organizations," (presentation at the Catholic Health Association (CHA) Sponsor Formation Program for Catholic Health Care, Itasca, IL, March 6, 2016).

[3] Philip Boyle et al., *Organizational Ethics in Health Care: Principles, Cases, and Practical Solutions* (San Francisco, California: Jossey-Bass, 2001). See also Editors, "Shedding Light on Organizational Ethics: Five Ethicists Help Define and Contextualize an Elusive Topic," *Health Progress*, 87, no. 6 (Nov.-Dec.2006): 28-33.

[4] Alan Sanders, "Organizational Ethics in Catholic Health Care: Sustaining a Commitment to Mission and Core Values," *Health Progress*, 94, no. 3 (May-June, 2013): 72-77.

[5] Jack Glaser, "Phase II of Bioethics: The Turn to the Social Nature of Individuals," *Bioethics Forum*, 11, 3, Fall, 1995: 12-22. See also Luciano Floridi, *The Ethics of Information* (Oxford, United Kingdom: Oxford University Press, 2011), 282-283.

[6] Benedict VXI, *Deus Caritas Est* [Encyclical On Christian Love], Vatican Website, December 25, 2005, Part II, 31-32, accessed January 8, 2018, http://w2.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est.html

[7] Anthony Spadaro, "A Big Heart Open to God: An Interview with Pope Francis," *America Magazine*, 209, no. 8 (Sept. 19, 2013), accessed January 8, 2018, https://www.americamagazine.org/faith/2013/09/30/big-heart-open-god-interview-pope-francis

[8] Francis, *Evangelii Gaudium* [Joy of the Gospel, Apostolic Exhortation on the Proclamation of the Gospel in Today's World], Vatican Website, November 24, 2013, Chapter 1, 34-40, accessed January 8, 2018, http://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html

[9] Michael Rozier, "Structures of Virtue as a Framework for Public Health Ethics," *Public Health Ethics* 9, Issue 1, (April 2016): 37-45.

FROM THE FIELD

The Evolution of Ethics Committees at CHRISTUS Health

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Health care today is a rapidly changing environment. Not only are we being asked to do more with less, we are asked to have it finished yesterday even though we were only told about it today. As soon as the goalposts are reached, they are moved farther downfield. Ethics committees are no exception as their work is in flux. Many are taking a hard look in the mirror and asking how we improve what we do and if how we do that work still meets the need we serve. In my work, I have seen this discussion focus on four main areas, and I expect that ethics committees will continue (or begin) to focus on them in the years to come.

First, data. Data has driven clinical decisions for decades but nowadays it drives organizational decisions as well. Without evidence to show that an action will likely have the desired impact, many leaders and administrators will not support an initiative. While some might lament this change (I have heard a few people say, "Jesus didn't have a scorecard"), the push for data-driven decisions is an attempt to be good stewards of our resources. Stewardship is not so much about saving money as it is about doing the most with what we have. Without evidence brought by data, how else can one evaluate competing choices that all have the potential to fulfill our mission? The same is true for the goals of an ethics committee.

For ethics committees, data primarily involves tracking clinical and organizational ethics consults. For example, elements like the patient's age, race, gender, insurance status, length-of-stay (LOS), diagnoses or diagnosis related groups (DRGs), discipline of consult requester, unit where the consult occurred, inpatient or outpatient, reason(s) for the consult as stated by the requester, reason(s) as discerned by the ethics consultant, etc. A few articles have reported data from ethics consults in Catholic hospitals, many more in secular hospitals[1] Many ethicists and ethics committees track data yet have not reported it in the literature. I encourage all my colleagues working in

ethics to publish the data they track. Baseline comparisons are available for most other fields in health care, and establishing such for ethics would benefit all of us, especially those who have historically lacked resources.

By reviewing data on its consults, an ethics committee (or ethicist) can strategically target its education efforts or process improvement work in the Next Generation model.[2] For example, if there are six consults over two months on the same unit about family members wanting to override a patient's living will, it would behoove the ethics committee to provide a lunch and learn or other educational event on this topic to that unit. Without data, many of these learnings and consequent efforts would be hard to come by.

Second, value. Many ethics committees and ethicists are using this data to show the value of what they bring to the hospital, especially the value of clinical ethics consults.[3] Here, value means the benefit that an ethics consult brings to the organization. To be meaningful, the value of consults needs to be expressed quantifiably and in a way that the organization typically analyzes operational benefit. This typically involves metrics like LOS, 30-day readmissions, use of non-beneficial treatment at the end of life, voluntary turnover of front-line staff, patient satisfaction, employee satisfaction, contribution margin (also called realization rate), etc. If an organization uses other operational measures, an ethics committee should use those as well.

A sharp distinction must be drawn between the quality of an ethics consult and its value to the organization. This raises legitimate concerns that using such metrics could pigeonhole ethics committees into a cost-reduction mechanism. Improving such metrics should not be the goal of an ethics consult; we do not exist to reduce length of stay, but to help those making clinical decisions do so in an ethical manner. Moreover, value does not necessarily mean quality. A good ethics consult might involve a recommendation to extend length of stay. This may benefit the patient, but not the organization. Conversely, a bad ethics consult might involve a recommendation that increases employee satisfaction. For example, an ethics consultant might recommend prohibiting an angry family member from visiting the patient (which would make staff happier as they do not have to interact with an enraged person) yet not follow the proper process of due diligence or meeting with the family member alone to hear their side.

The fields of palliative care and hospice have both successfully shown their value based on the financial implications that come from their services while maintaining their direct purpose of focusing on patient comfort and reviewing the quality of services based on their metrics. The Center to Advance Palliative Care (CAPC) has such a database for palliative care consults. If palliative care and hospice have done this for decades, why not ethics? I believe that a primary reason why palliative care and hospice typically have more support and resources than ethics committees and ethicists is because we have not taken steps to quantify our value in a manner that is meaningful to hospital administrators. By refusing to provide resources to a project that cannot show its value, administrators are only being good stewards of the organization's resources. It is a delicate task to show this in a manner that does not relegate ethics committees to a cost-reduction tool, but we do not get a pass because we are doing good work. If we are

to be taken seriously as a clinical service, then we must act like one.

Third, quality. Here, I do not mean clinical quality indicators but ethics quality, or the facets of an ethics committee that make it a good ethics committee. For years, the literature in Catholic bioethics has lamented the lack of clarity around quality but not much has changed.[4] In 2011, we received a valuable tool in *Striving for Excellence in Ethics* published by the Catholic Health Association.[5] It is a great resource for assessing the quality of a committee's structure and work. Unfortunately, it is not clear how widely it is used or how many ministries expect their ethics committees to adhere to its recommendations. More importantly, there has not been much critical feedback on the tool in the literature despite a request from CHA for such a field test and calls from others for such standards in Catholic health care.[6] If we want to improve the quality of the work of our committees as a field, we must take constructive criticism seriously and ask ourselves "*What does good ethics look like?"* Such a task is outside the scope of this article, but I will make one point here.

Striving for Excellence in Ethics sets good, reasonable standards for ethics committees (especially regarding their structure, function, education efforts, policy work, integration, etc.,) but the document is rather vague regarding specific quality elements for ethics consultation, especially the process of consultation itself. For example, it states that the ethics committee has guidelines for its ethics consultation service regarding the methodology for consultation, documentation, scope and authority of the service, evaluation, etc. Yet it does not describe in any detail what these should look like. In my experience, having worked with dozens of ethics committees, such details are vital to assessing the true quality of an ethics consultation service. In that regard, resources like ASBH's *Core Competencies for Ethics Consultation* or *Assessing Clinical Ethics Skills* (ACES) from Loyola, are more helpful insofar as they have specific, measurable, detailed expectations for the consultation process.[7] Tailoring these and similar tools to Catholic health care would go far in helping ethics committees and ethics consultation services review the quality of their work. Outside of the work of Kockler and Dirksen, there has not been much from Catholic health care on this topic.[8]

Fourth, standardization. As health systems continue to grow they are increasingly standardizing processes at the system level. What was once decided locally and performed differently in every region is often becoming the same throughout the whole health system to increase efficiency and quality. This is true for many fields, and ethics is no different. For example, in July 2017, CHRISTUS Health's Ethics Council (a system level group that consists of regional mission leaders and ethics committee chairs, and ethics leaders from the system office) finalized our internal Standards for Ethics Committees. It outlines expectations for our committees' functions, structure, scope, processes, etc. Other systems are doing similar work.[9] Such standardization helps fill in the (intentional) gaps in documents like *Striving for Excellence in Ethics* and helps ensure the quality of the work done on the ground. Others are attempting to standardize the field itself, across systems, in part through quality efforts like those described above.

Two challenges for any standardization effort are: (1) to strike a balance between system-wide standardization and appropriate local flexibility; and (2) to standardize in a manner

that respects the principle of subsidiarity. To the first point, it makes little sense to standardize the method of requesting ethics consults (calling the operator, using a pager, calling personal cell phones, etc.) across a system the size of CHRISTUS Health, but it is quite reasonable to standardize the method of documenting ethics consults in the patient's chart across our multiple electronic medical record (EMR) platforms. Such appropriate standardization also facilitates the collection and comparison of data, which in turn helps an ethics committee prove its value. To the second point, our approach at CHRISTUS has been develop standardized processes within the Ethics Council. With this process, the regional leaders develop the expectations to which they themselves will be held.

As ethics committees in Catholic health care continue to evolve, discussions about that evolution often focus on data, value, quality, and standardization. Each area bleeds over into the other three, and pursuing each one aids pursuit of the others. I encourage anyone working in Catholic health care ethics to contribute to the literature on these topics. Tell your story or critique and improve the work of others. Without our collective efforts, the continuing journey of ethics committees in Catholic health care could founder on the shoals of the broader changes in health care occurring today.

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[1] Mark Repenshek, "An empirically-driven ethics consultation service," *Health Care Ethics USA* 17, no. 1 (2009); Liza-Marie Johnson et al., "Ethics consultation in pediatrics: long-term experience from a pediatric oncology center," *The American Journal of Bioethics* 15, no. 5 (2015); Keith M Swetz et al., "Report of 255 clinical ethics consultations and review of the literature" (paper presented at the Mayo Clinic Proceedings, 2007).

[2] Janis Rueping and Daniel O Dugan, "A Next-Generation Ethics Program in Progress: Lessons from Experience," *Hec Forum* 12, no. 1 (2000).

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Additional Resources

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