HCEUSA

Health Care Ethics USA

A quarterly resource for the Catholic Health Ministry

QUARTERLY

FEATURES

The Inaugural Catholic Healthcare Ethics Innovation Forum

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Editor's note: We are pleased to present this special combined Winter/Spring 2020 edition of Health Care Ethics USA to feature a series of articles by Catholic health ethicists at the Inaugural Catholic Healthcare Ethics Innovation Forum (CHEIF) hosted by CHRISTUS Health in December 2019. In light of the scope, range and depth of the articles, we thought it would be helpful to our readers to publish the entire collection in this special combined edition. An overview of CHEIF is provided below. We will resume our normal publication of HCEUSA with the summer 2020 issue.

Great ideas are shared. After discussing the possibility of sharing ideas and best practices at a recent Theology and Ethics Colloquium presented by the Catholic Health Association in St. Louis, we realized we do not have a venue as ethicists in Catholic health care to submit innovative ideas, present them to our colleagues, and enhance them together. Our hope was to create a forum to share the good work we are all doing to embed and integrate ethics into our health ministries, to receive critical feedback from colleagues, and contribute to evolving the way Catholic health care thinks about and implements ethics.

Therefore, in December 2019, CHRISTUS Health hosted the Inaugural Catholic Healthcare Ethics Innovation Forum (CHEIF) at their system office in Irving, Texas. CHEIF's purpose was to provide an opportunity for ethicists working in Catholic health care to explore, present, and discuss innovative and novel ideas in health care ethics.

We encouraged invitees to submit abstracts on any topic related to their work in Catholic health care ethics. However, we identified four areas of focus:

1. Ethics Personnel: Competencies, Development, Self-Care, Management
2. Documentation, Tracking, and Storytelling (for institutional purposes)
3. Institutional Integration: Rounding, Leadership, Intra-Institutional Partnerships, and Ecclesial Relations
4. Assessment: Value and Quality

The presentation format at CHEIF was not traditional lecture or paper presentations, but lightning talks. Each presenter was limited to three slides and seven minutes. Presenters were grouped together by subject area, with six to seven presenters in a session, followed

by 45 minutes for a panel discussion and Q&A with the presenters from that session. This presentation style acutely focused the presenters on integration and outcomes in sharing their innovative idea. Facilitated discussion among presenters within the grouped subject area maximized collaborative dialogue on the subject area.

CHEIF featured 26 presentations on topics ranging from moral distress to ethical considerations with big data. There were 27 attendees representing 13 different organizations. The EthicsLab podcast (available at missiononline.net) recorded

onsite interviews with presenters. A post-conference survey found that 100% (13 of 13) of respondents would return if CHEIF were held again, and 92% (10 of 13) are planning to make changes to their ethics services based on attending CHEIF. Based on this success, we are currently planning to hold CHEIF again sometime later in 2020.

For those who could not attend, the Catholic Health Association offered to publish summaries of the presentations in this issue for presenters who wished to submit one. We hope you find their work helpful in improving the ethics services at your ministry. ✚

Catholic Health Ethics Internships: Lessons Learned From Five Years' Experience

Elliott Louis Bedford, Ph.D.

This presentation reviews five years' experience administering an ethics internship at Ascension St. Vincent. While the internship was originally designed for cultivating a pipeline of Catholic health care ethicists, most participants have come from medical students looking to gain experience and training in moral reasoning to aid in their clinical formation. Interns have come from academic institutions such as Saint Louis University, Indiana University, The Ohio State University, Marian University, with the majority coming from Marian University College of Osteopathic Medicine. Intern cohorts have typically included two interns working with ethics leadership over the course of a summer, though more recent experience included a larger cohort.

The internship has varied over time in terms of hours per week, compensation, and areas of focus. Experiences within the internship have focused on broad-based exposure to clinical and organizational operations within a large Catholic health system, such as ethics committee meetings, outreach meetings with local Catholic parishes, and shadowing various clinical disciplines. Interns have played an integral role in contributing to the work of the department on several projects, including developing and maintaining an ethics

SharePoint site, managing ethics consult data, cataloguing all institutional policies to aid in policy standardization, and starting new ethics integration committees.

Follow-up with interns after completion of the program is an important quality improvement component that has led to substantial changes and revisions to the program nearly every year. More recent efforts have been made to publicize and recruit for the internship as well as the Catholic health care ethics role at national events such as SEEK 2019, a gathering of 17,000 Catholic college students. In addition to the formal internship program, prospective and interested students have been encouraged to participate in the Proactive Ethics Integration program in an informal way, e.g., participating in ethics committee meetings and clinical ethics education sessions. This accessibility and awareness of the ethics internship among community and staff members have increased the number of quality referrals for the internship. Given demographic need, ethics internships are an important and easily achievable resource to help ensure a robust pipeline for quality Catholic health care ethicists and, even more so, for ethically-informed and -formed health care professionals, both clinical and non-clinical.

Our experience emphasizes that, if Catholic health care is committed to maintaining and fostering a vibrant Catholic identity and ethical culture into the future, such internships (including not only future ethicists but clinicians and administrators as well) should, and can, become more widespread across the nation. ⚕

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Ethos: A Journal of Catholic Health Culture

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In 2019, as part of its Proactive Ethics Integration program, ethics leadership at Ascension St. Vincent partnered with Marian University Department of Graphic Arts to design and produce, under the St. Vincent College of Health Professions Press, an academic journal entitled *Ethos: A Journal of Catholic Health Culture*.

Ethos starts with a simple premise: To change culture (e.g., within an organization), one must make culture (e.g., artifacts that create new possibilities and conversations as well as new limitations or impossibilities). Thus, the vision behind *Ethos* is a culture of participative, non-academic, non-expert, ethical reflection and engagement, focused more on moral growth, character development and freedom for excellence than merely the analysis of obligations and duties in clinical scenarios.

Ethos aims to foster this distinctive ethical culture within Catholic health care by presenting ethical issues and concepts in a Christian-humanistic manner, engaging the moral imagination of readers. This approach is accomplished in several distinct ways. First, through the expertise and ingenuity of the Marian University graphic arts program, the journal incorporates extensive use of aesthetic appeal and graphic design, including art and photography from featured artists who work at Ascension St. Vincent (e.g., physicians, nurses). Interactive components include a QR code to engage readers in an audio element of a related article and an ethics crossword puzzle. Second, submissions range beyond classical ethical analyses of controversial subjects and cases to include personal reflections, ethical reflections on art and music, ethics poetry, and first-person experiences and stories of character growth living out the Proactive Ethics Integration model. Third, while all submissions are peer-reviewed, contributors range from professionally trained ethicists to radiation technicians, nurses, physicians, ethics interns and others. Fourth, *Ethos* emphasizes the contributions of those participating in the Proactive Ethics Integration model, especially the Ethics Integration Committees that serve as the primary resource for local ethics services. Fifth, *Ethos* enhances its readers' ability to participate in the Proactive Ethics Integration program initiatives, such as monthly Ethics Case Calls, *Ethos* Book Club, Clinical Ethics Intensives, and the Ascension St. Vincent Ethics intranet resource site. This is especially true in the electronic version of the journal, which incorporates links to all such resources. In brief, *Ethos* represents an effort to advance an authentic and vibrantly Catholic

culture in the health ministry; it creates a forum
that demystifies ethical thought to restore it
to its appropriate purpose of helping people
in a practical and artful way to flourish as
individuals under the common good. ✣

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Conscientious Refusals in Health Care

Jason T. Eberl, Ph.D., and Christopher Ostertag

This paper includes material developed more extensively in an article by Jason T. Eberl and Christopher Ostertag entitled, "Conscience, Compromise and Complicity" Proceedings of the American Catholic Philosophical Association (92) forthcoming; and the article by Jason T. Eberl entitled, "Protecting Reasonable Conscientious Refusals in Health Care" in Theoretical Medicine and Bioethics, 40:6 (2019): 565-81.

In light of the U.S. Supreme Court's decisions legalizing abortion, the U.S. Congress passed an amendment to the 1973 Health Programs Extension Act — known as the Church Amendment — which protects the right of health care institutions, and individual health care providers employed by such institutions, that receive federal funding to refuse to offer abortion or elective sterilization procedures. Recently, debate over whether health care institutions or individual providers should have a legally-protected right to conscientiously refuse to offer legal services to patients who request them has grown exponentially due to increasing legalization of physician-assisted suicide in various countries and U.S. states, as well as greater expansion of the rights of transgender individuals who may request gender-affirming hormonal treatments or surgeries. Other cases of conscientious refusal include pharmacists who refuse to fill prescriptions for abortifacient post-coital

contraceptives. The question of whether there should be a legally-protected right to conscientiously refuse to provide specific medical services has been particularly acute for Catholic health care institutions insofar as they are governed by the U.S. Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services*, which also inform the consciences of individual Catholic health care professionals.

DEFINING "CONSCIENCE"

Definitions of "conscience" range from being some sort of moral feeling or intuition to an intellectual faculty by which one arrives at reasoned moral judgments. The former definition figures prominently in the arguments of critics of a right to conscientious refusal:

> Doctors must put patients' interests ahead of their own integrity … If this leads to feelings of guilty remorse or them dropping out of the profession, so be it. As professionals, doctors have to take responsibility for their feelings.[1]

On this understanding of the nature of conscience, the only criterion for putatively valid claims of conscientious refusal is the "sincerity" or "genuineness" of one's relevant moral feelings or beliefs. As critics rightly note, however, this can lead to a "Pandora's box of

idiosyncratic, bigoted, discriminatory medicine."[2] Contrary to the subjective emotivism of the first definition of conscience, the latter definition is rooted in *reason and communal practice*.[3] This understanding of conscience can be traced back historically to thinkers such as Thomas Aquinas. Aquinas's view of the nature and function of conscience is embedded within his overall account of *natural law*, in which he understands the human intellect to have natural faculties by which one may understand certain "first principles" of practical reasoning — i.e., reasoning about how one ought to act both generally, in terms of the overall aim of one's life or macro-level projects, and within a particular present set of circumstances.[4] It is important to emphasize that, in Aquinas's view, one is not born with their conscience fully formed as some sort of infallible moral database. Rather, one's conscience must be *cultivated* through moral education by others and one's own history of practical reasoning. Hence, depending on the quality of one's moral upbringing or how one has reasoned in past instances, one's conscience may become ill-formed. Yet, Aquinas affirms that one should adhere to the dictates of even an erring conscience insofar as not doing so would entail acting contrary to what one believes they ought to do. Conscience thus aims, if fallibly, at moral truth; however, one's rational deliberation, impacted by various social influences and internal factors in one's psychological make-up, may or may not lead to such truth. The dictates of one's conscience thus lie between knowledge — in the sense of *certainty* — and subjective feeling or intuition. An individual's conscience may err, but it is more than one's "gut feeling" of either approbation or repugnance; furthermore, it ought to be cultivated and exercised within the context of a *moral community*.[5]

THREE POSITIONS ON CONSCIENTIOUS REFUSALS IN HEALTH CARE

There are three main positions regarding whether health care professionals should have a legally-protected right to conscientiously refuse to provide specific medical services. An *absolutist* argues that such a right ought to be protected based on whatever grounds an individual practitioner or health care institution justifies their refusal. A typical rationale given to support this position is that, outside of emergency services, health care professionals have a right to define the scope of their own practice and, in some health care systems, even to refuse care to certain patients. Another supportive rationale is that an individual right to, say, reproductive autonomy is merely a *negative* right that protects one from state interference with procuring an abortion; it does not entail a *positive* claim-right on health care professionals, or society in general, to provide abortion services.

At the other end of the spectrum is the *incompatibility* thesis:

A doctor's conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient's good and the patient's informed desires. If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors. Doctors should not offer partial medical services or partially discharge their obligations to care for their patients.[6]

If one cannot conscientiously provide abortion or certain other legal services that fall under the professionally-defined scope of medicine, then one should not become a physician or select a specialty, such as radiology, that would not put one in the position of having to provide such services. The same reasoning would inform whether a religious group should sponsor a health care institution.

The currently predominant position is a *compromise* view promoted by various professional medical organizations, such as the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG). Recent opinions (1.1.7) issued by the AMA's Council on Ethical and Judicial Affairs and ACOG's Committee on Ethics both acknowledge a health care professional's liberty to conscientiously refuse to provide medical services provided that certain conditions are met, including providing "accurate and unbiased information" on all available services, even those to which the professional morally objects, referring patients to other health care professionals willing to provide such services, and providing such services in emergency situations in which no other willing professional is available.[7]

We concur with the standard requirements of the compromise view that providers should disclose all medically appropriate and legal treatment options to their patients. We also agree that providers who refuse to perform certain services should disclose that fact to their patients early on in the therapeutic relationship: a woman who desires an elective termination of her pregnancy should not be surprised when her obstetrician refuses, the same for a terminally ill patient who requests

assisted-suicide — the time of the request is not the appropriate time for a provider to initially state her refusal. This requirement should be even more stringent for Catholic and other health care institutions whose mission identity precludes offering specific services.

CONCERNS REGARDING MORAL COMPLICITY

Requiring health care providers to disclose treatment options which they refuse to perform, as well as to refer patients to other providers raises the specter of *moral complicity* — i.e., illicit cooperation with moral wrongdoing.[8] The basis for distinguishing licit from illicit cooperation rests in the *intention* of the cooperating agent and the distance between their act and another's evil act. *Formal* cooperation occurs when an agent approves of another's evil act and may be either *explicit* or *implicit*. In the former, an agent directly intends to cooperate in another's evil act for the end of the act itself. In the latter, an agent intends to cooperate in evil, not for the end of the evil act, but rather for the end of some concurrent good. Both explicit and implicit formal cooperation are illicit because it is morally wrong to intend evil, either as means to an end or as an end in itself.[9]

Material cooperation occurs when an agent is instrumental in another's evil act without approving of the act. Material cooperation can be licit, but only if sufficiently removed from the evil act; in particular, we must look at the causal chain of mediating agents between the acting agent and the commission of the evil act. If the material cooperation is *immediate*, meaning that the cooperating agent is causally proximate to another's commission of the evil act, then the cooperation is illicit. If the

material cooperation is *mediate*, meaning that the agent is causally remote from the commission of the evil act, then cooperation may be licit, provided there is a proportionate reason for the agent to cooperate in the commission of the act.

No sweeping determination of the liceity of referrals can be offered because the particular circumstances matter. We contend that a physician may refer a patient to another specialty without engaging in illicit cooperation except when a) the referred-to physician group or institution is known largely on the basis of providing the objectionable service, or b) a particular specialist is referred to on the basis of knowing they would provide the objectionable service. If, however, the physician simply provides a list of relevant specialists covered by the patient's insurance and lets the patient choose, such cooperation would be licit. In referring on the basis of knowing a particular specialist, physician group, or institution would provide the objectionable service, the physician at least implicitly shares in the patient's intention to obtain that service; in the latter case, the physician merely provides the patient with a list of specialists with no guidance on whom to choose or for what reason.

FROM TAX-LAWYERS TO PILGRIMS ON THE WAY

Bishop Anthony Fisher contends that, if we live in the world, we "will engage in cooperation from time to time — indeed sometimes it is [our] duty to do so … [to] avoid all cooperation in evil would require that we abandon almost all arenas of human activity … [and] could well constitute a sin of omission."[10] Since cooperation is unavoidable and sometimes necessary, Fisher is concerned that some

theologians might be tempted to approach questions of cooperation as "moral tax-lawyers," where the role of the "moral advisor is to help people find a way around the moral tax-law." Fisher criticizes this approach, noting that the "presumption is *against* cooperating even materially, unless there is a sufficiently strong reason to warrant proceeding." He further worries that we will become comfortable with collaborating with "the powers of this world," rather than "offering a distinctively Christian form of witness to the life of God's kingdom."

Cathleen Kaveny counters that Fisher's concept of "Prophetic Witness" does not acknowledge "specifically Christian commitments" that might lead one to cooperate with another's evildoing.[11] She hhhcontends that we must see ourselves as "Pilgrims on the Way to the New Jerusalem." Drawing on Augustine, Kaveny describes the Pilgrim on the Way as one who "respond[s] to those suffering the effects of the sin that is still in our midst." She emphasizes, "while the Prophetic Witness emphasizes the risks and dangers of cooperating with evil, the Pilgrim on the Way highlights the good that it can accomplish"; furthermore, the Pilgrim sees "this good not merely as a secular or natural good, but also as a crucial part of the evangelical mission of the Church." From an institutional standpoint, one solution to avoid illicit cooperation or scandal might be to close one's doors. Kaveny argues that the Pilgrim on the Way would reconsider such a decision: "eliminating a Catholic institutional presence could mean the loss of the crucially important insight that health care is best viewed as a corporal work of mercy rather than a commodity" and Catholic health care is essential in protecting marginalized

populations like the unborn, the terminally ill, and those with physical and intellectual disabilities.

We concur with Kaveny's insight that sometimes cooperation is warranted *because* of our specifically Christian obligations, especially in light of Catholic Social Teaching, and we are challenged to prudently draw out the implications of this insight as we continue the healing ministry of Jesus. ✢

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ENDNOTES

1. Julian Savulescu and Udo Schuklenk, "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception," *Bioethics* 31:3 (2017): 162-70, at 164.

2. Julian Savulescu, "Conscientious Objection in Medicine," *British Medical Journal* 332 (2006): 294-7, at 297.

3. See John J. Hardt, "The Conscience Debate: Resources for Rapprochement from the Problem's Perceived Source," *Theoretical Medicine and Bioethics* 29:3 (2008): 151-60.

4. For further elucidation of Aquinas's account, see his *Summa theologiae*, trans. English Dominican Fathers (New York: Benziger, 1948), Ia, q. 79, aa. 11-13; and *Quaestiones disputatae de veritate*, trans. J.V. McGlynn (Indianapolis: Hackett, 1954), qq. 16-17; Eberl and Ostertag (forthcoming).

5. Aquinas 1948, IIa-IIae, q. 33.

6. Savulescu 2006, 294.

7. See B.J. Crigger, P.W. McCormick, S.L. Brotherton, and V. Blake, "Report by the American Medical Association's Council on Ethical and Judicial Affairs on Physicians' Exercise of Conscience," *Journal of Clinical Ethics* 27:3 (2016): 219-26; ACOG Committee on Ethics, "The Limits of Conscientious Refusal in Reproductive Medicine (2007), https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine, accessed 12 October 2017.

8. A related moral concern, even if one is not complicit with another's wrongdoing, is causing *scandal*. We discuss scandal in Eberl and Ostertag (forthcoming).

9. *Catechism of the Catholic Church* (1997), http://www.vatican.va/archive/ENG0015/_INDEX.HTM, accessed 28 February 2018, nos. 1752, 1755. The *locus classicus* for the distinction between formal and material cooperation with moral evil is Alphonsus Liguori, *Theologia Moralis*, ed. L. Gaudé, 4 vols. (Rome: Ex Typographia Vaticana, 1905-1912), II.3.ii dub. 5, art. 3, no. 63. For a more contemporary formulation, see Kevin L. Flannery, *Cooperation with Evil: Thomistic Tools of Analysis* (Washington, DC: Catholic University of America Press, 2019).

10. This and subsequent quotations in this paragraph are from Anthony Fisher, "Cooperation in Evil: Understanding the Issues" in *Cooperation, Complicity, and Conscience: Problems in Healthcare, Science, Law and Public Policy*, ed. Helen Watt (London: The Linacre Center, 2005), 27-64.

11. This and subsequent quotations in this paragraph are from M. Cathleen Kaveny, "Tax Lawyers, Prophets and Pilgrims: A Response to Anthony Fisher" in Watt 2005, 65-88.

Standard System-Wide Mission and Ethics Curriculum for Medical Residents

Becket Gremmels, Ph.D.

In 2016, CHRISTUS Health's Department of Academics consolidated all the residency programs in CHRISTUS under one Designated Institutional Official (DIO) and one Graduate Medical Education Committee (GMEC). This consolidation allows for easier intra-system elective rotations, mitigates the risk of accreditation problems, improves retention of residents as physicians after graduation, and provides a more consistent experience for our medical residents. Part of this standardization included a standard, system-wide curriculum for medical residents on topics related to mission and ethics. The curriculum is only for residency programs sponsored by CHRISTUS Health. The curriculum began in June 2018 and will finish its first cycle in June 2020.

The goals of the curriculum are to: provide the information related to mission and ethics necessary to practice in CHRISTUS facilities; help residents build the skills they need to identify, analyze, resolve ethical issues in their patients' care;[1] and convey this material in a manner relevant to their clinical practice.

CURRICULUM CONTENT
In developing the curriculum we discovered there is little literature on how to best teach ethics to residents or what content to teach them.[2] Some specialty groups have specific guidance, for example the American Academy of Pediatrics has a guide on what topics to teach and teaching aides to assist faculty.[3] However, most specialties do not have such guidance. Thus, our curriculum is based on a combination of the existing literature, specialty recommendations as they exist, and our own experience of what residents should know. From these sources we developed a core set of topics that all medical residents should receive, regardless of specialty. (Table 1) The core curriculum includes a 90-minute orientation session for all first-year residents, and five 60-minute sessions each year, totaling 16.5 hours over the three-year residency. The sessions are primarily case based. Certain topics have a combination of didactic content and role play.

Table 1

Core Content for All Residency Programs	
Session	**Title/Topic**
Orientation	Intro to Mission, ERDs, SFNO Framework
1	Connecting to Purpose
2	Spiritual Care
3	Decision-Making Capacity
4	Informed Consent
5	Confidentiality
6	End-of-Life Care
7	Code Status
8	Care of the Poor and Community Benefit
9	Medically Inappropriate Treatment
10	Interacting with Pharma or Device Reps
11	Disclosing Medical Errors
12	Logical Fallacies in Medical Practice
13	Culturally Competent Care
14	Specialty-Specific Topic
15	Specialty-Specific Topic

To meet the third goal mentioned above, the sessions are tailored specifically to each program in three ways. First, each specialty receives some sessions unique to its field of medicine. (Table 2) The core curriculum includes two specialty-specific sessions, but for some specialties, we combine or eliminate sessions to make room for others. For example, the Emergency Medicine curriculum combines End-of-Life Care and Code Status into one session to make room for a session on Delivering Bad News. Second, the cases for each session are chosen specifically for each specialty. For example, while all specialties receive the same content for informed consent, cases for internal medicine are different from those in emergency medicine. Third, since our residency programs span two states, sessions discuss state-specific laws where relevant such as those regarding advance directives.

The content for each session is developed at the CHRISTUS Health System Office, either by an ethicist or another content expert for the mission sessions. Each session is delivered locally, in-person, by the local ethicist, mission leader, ethics committee chair, an ethics committee member, or a content expert (e.g., director of spiritual care for the session on spiritual care). We hold a train-the-trainer program by webinar before the first session and record it for local facilitators who cannot attend.

Table 2

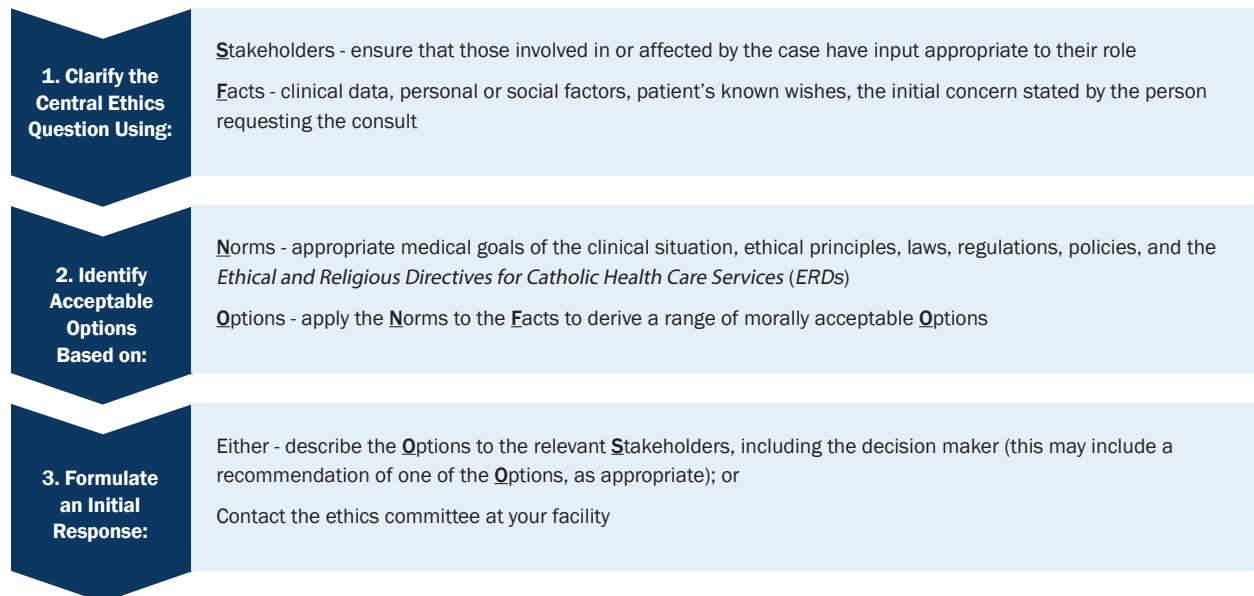| Specialized Content by Residency Program		
Specialty	**Session**	**Topic**
Internal Medicine	14	Organ Donation
	15	Ethical Issues in Palliative Care
Family Medicine	7	Combine End-of-Life Care and Code Status
	8	Beginning of Life, Applying the ERDs
	14	Physician Assisted Suicide
	15	Advance Directives
Emergency Medicine	6	Delivering Bad News
	7	Combine End-of-Life Care and Code Status
	10	Moral Distress
	14	Moral Issues in Disaster Medicine
	15	Truth Telling & Honesty
Podiatry	14	Delivering Bad News
	15	Noncompliance
Pediatrics	3	Decision-Making Capacity and Shared Decision Making
	4	Informed Consent and Informed Assent
	14	Generic Testing & Screening of Children
	15	Use of Pediatric Enhancements

MODIFIED SFNO FRAMEWORK

Since mnemonic tools are ubiquitous in medical training, we modified an existing mnemonic device to assist the residents in identifying, analyzing, and resolving ethical issues in their patient's care. (Figure 1) Jim Dubois developed the SFNO framework to assist in analyzing bioethics cases.[4]

SFNO stands for So Far, No Objections, or Stakeholders, Facts, Norms, Options. Identifying the Stakeholders (who will be significantly affected by the decision), Facts (what facts are relevant or disputed), Norms (what ethical principles, norms, or values are relevant or in conflict), and Options (what solutions are worth considering or compromising on) helps generate a starting point for moral analysis of a case.

Our Modified SFNO Framework places these four items into a three-step process; the added steps assist with the identification and resolution aspects of ethics consultation. The first step, clarify the central ethics question, narrows the focus of the discussion on the primary issue at hand. Too often, conversations and ethics consults focus on ancillary issues or get stuck down rabbit holes. The central

ethics question might change throughout the course of a case as more facts emerge. The second step identifies a range of appropriate options. Casting a wide net and eliminating unacceptable options are helpful here. It is better to reject an option for a specific reason than to leave a potentially acceptable option unnamed. The third step, formulate an initial response, works towards resolution of the ethical issue. It is broad enough to allow the resident to resolve the issue on his/her own, present options to a patient or surrogate decision maker, or seek assistance from the ethics committee. It permits the resident to make a recommendation to the decision maker or to refrain from interfering. We stress with residents to not refrain from requesting an ethics consult. It is perfectly acceptable for them to say, "I don't know" as long as they then call someone who does.

Modified SFNO Framework

1. Clarify the Central Ethics Question Using:	**S**takeholders - ensure that those involved in or affected by the case have input appropriate to their role **F**acts - clinical data, personal or social factors, patient's known wishes, the initial concern stated by the person requesting the consult
2. Identify Acceptable Options Based on:	**N**orms - appropriate medical goals of the clinical situation, ethical principles, laws, regulations, policies, and the *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*) **O**ptions - apply the **N**orms to the **F**acts to derive a range of morally acceptable **O**ptions
3. Formulate an Initial Response:	Either - describe the **O**ptions to the relevant **S**takeholders, including the decision maker (this may include a recommendation of one of the **O**ptions, as appropriate); or Contact the ethics committee at your facility

The presenters introduce the mnemonic in orientation and run through several cases with the residents. Throughout the remaining three years of the curriculum, they use the framework to analyze every ethics case discussed in the sessions. By combining the framework with the content, the curriculum prepares residents to identify, analyze, and resolve ethical issues in their own professional practice.

NEXT STEPS

We are conducting a study on the curriculum to contribute to the literature in this area. The study consists of pre- and post-surveys of the residents to evaluate their opinions on the content, length, delivery method, and self-assessed ability to identify, analyze, and resolve ethical issues in their patients' care. The study received approval from the CHRISTUS Health IRB. We plan to publish a detailed review once the study is complete. Afterwards, we anticipate expanding the curriculum to include other specialties and our pharmacy residents as well. We hope this will help others when designing ethics programs for medical residents. ✚

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ENDNOTES

1. ASBH identifies these three actions as essential features of ethics consultation. American Society for Bioethics and Humanities, *Core Competencies for Healthcare Ethics Consultation*, 2011, 2nd edition, p 3.

2. Manson, Helen. "The need for medical ethics education in family medicine training." *Fam Med* 40, no. 9 (2008): 658-64. Helft, Paul R., Rachael E. Eckles, and Laura Torbeck. "Ethics education in surgical residency programs: a review of the literature." *Journal of surgical education* 66, no. 1 (2009): 35-42.

3. Diekema, Douglas, Steven R. Leuthner, and Felipe E. Vizcarrondo. *American Academy of Pediatrics Bioethics Resident Curriculum: Case-Based Teaching Guides*. American Academy of Pediatrics. October 2017.

4. Dubois, J. "Solving ethical problems: analyzing ethics cases and justifying decisions." *Ethics in Mental Health Research* (2008): 46-57.

When to Hire a Clinical Ethicist

Becket Gremmels, Ph.D.

As evidence that clinical ethicists provide financial benefits to hospitals increases, and as the field of clinical ethics moves more towards professionalization, the number of clinical ethics positions is growing, both inside and outside of Catholic health care. While the Catholic Health Association (CHA) recommends that multi-facility systems have an ethicist at the system level and smaller systems at least have access to one, no organization or entity has yet published or discussed staffing models for ethicists.[1] While staffing models exist for nurses, social workers, hospitalists, and many other health care professions, no comparable guide exists for ethicists. This is a first attempt at a staffing guideline for clinical ethicists at the regional or facility level.[2] (Table 1) CHA describes qualifications for these positions elsewhere.[3]

Table 1

Element	Metric		
Necessary (any one of these indicates a serious need)			
Bed Count	≥ 350		
Average daily census	≥ 250		
ICU beds (excluding NICU)	≥ 50		
Trauma	Level 1		
Strongly Recommended (any one of these and at least one from the Conditional list indicate a strong need)			
Case Mix Index	> 1.7		
Specialty service line with high acuity	1. NICU - Level3 2. Burn Center	3. Pediatric Hospital 4. Fetal Surgery	5. Maternal Fetal Medicine 6. Transplant Program
Clinical Research	> 100 protocols open annually in > 3 disciplines		
Insurance	> 50% Medicare patients		
Conditional (3 or more criteria indicate a strong need, 2 or more warrant serious consideration)			
Residency program	Medical, Pharmacy, or Chaplain		
Clinic volume	$\geq$ 65,000 patient encounters per year or > 5,000 Medicare patients		
Cancer center	> 7,000 patient visits per year		
Deliveries	> 3,000 per year		
Palliative Care	Median penetration rate or higher (CPAC) • <150 beds, 343 consults per year	• 150-499 beds, 718 consults per year	• >500 beds, 1,874 consults per year
Ethics Consult Volume	$\geq$ 100 per year		
Specialty services	1. Phase 1 Clinical Trials 2. Inpatient Psychiatry 3. Neurosurgery	4. Outpatient Dialysis 5. Inpatient Rental Unit 6. LTACH	7. ACO
Region size	3 hospitals between 200 and 350 beds and $\leq$ 1-hour drive from each other		

CAPC - Center to Advance Palliative Care   ACO - Accountable Care Organization   LTACH - Long Term Acute Care Hospital

The criteria below are based slightly on evidence from the literature, but mostly from my experience as an ethicist at the local, regional, and system level as well as the experience of multiple outpatient clinical leaders.[4] This warrants four caveats: first, it is very likely some relevant criteria have been overlooked; second, it is possible some criteria below are not relevant; third, some criteria may be better placed in another category; and fourth, the numerical metrics may be too high or too low. Most importantly, this guide represents the minimum staffing levels that are appropriate; they do not address when or why a region might have more or fewer full-time equivalent (FTE) positions devoted to ethics. Thus, they cannot justifiably be used to reduce the number of ethics positions given the amount and kind of evidence currently available.

ETHICS STAFFING CRITERIA

The criteria are divided into three categories: Necessary, Recommended, and Conditional. A facility or region that meets any criterion in the Necessary category has the most serious need for a clinical ethicist. The only criterion with evidence is bed count. A foundational survey of ethics committees in U.S. hospitals found the volume of ethics consults jumps 67% at 300 beds.[5] My own experience suggests 400 beds, so the guide recommends the halfway point between them. Since bed counts are often inflated, average daily census is also included. The rest of the Necessary category is based on the high acuity and volume that come with trauma and intensive care.

The Strongly Recommended category reflects a strong need for a clinical ethicist. As this category is not as strong as the first, a facility or region must meet one of these criteria plus one

from the next. The metrics for the criteria and the specific service lines come from hospitals I believe need an ethicist based on my experience working with them. Catholic hospitals with a maternal fetal medicine physician have a particularly strong need for an ethicist due to the acuity and nature of the medical problems these physicians encounter.

Lastly, the Conditional category includes an array of other criteria to consider. Individually, these criteria likely do not warrant hiring a full-time ethicist, but a combination of any three indicates a strong need, while two indicate a need to seriously consider hiring one. Three criteria stand out in the category of outpatient services and palliative care. First, health care has moved beyond hospital-based acute care and the role of clinical ethics is increasing in outpatient care. These metrics come from experienced clinical outpatient leaders and their opinions on what constitutes a high-volume or high-acuity outpatient network. Second, while one might think palliative care reduces the need for ethics consults, in my experience the volume decreases slightly but the complexity of ethical concerns increases significantly. Third, the incidence rates of preeclampsia (1.4 in 1,000 before 28 weeks), premature rupture of membranes (4 in 1,000 around viability), and other causes of induction mean that regions with 3,000 deliveries a year could have up to 12 cases annually of potential induction of labor before viability.[6] The implications for the patients and the hospital warrant the regular discussion and availability a clinical ethicist can provide.

CRITIQUE AND FUTURE DIRECTION

As this is an initial draft guideline, some critiques are worth making to help guide future versions. First, while the guideline includes

outpatient service lines and outpatient visit volume, it is heavily focused on inpatient facilities. More criteria and nuanced metrics for outpatient services would better reflect the entire continuum of care. Second, the guidelines do not account for ethicists responsible for certain areas across a system. For example, a large system might have an ethicist responsible for home health and long-term care, all outpatient services, or clinical research. Third, the Necessary category should be expanded to include criteria that warrant two, three, or more ethicists rather than just one. Similarly, the Conditional category should include options for an FTE divided between ethics and another function, such as a mission leader or social worker who meets CHA's Qualifications for Ethicists and has protected time devoted to clinical ethics.

Clearly more input and review from other ethicists, systems, and organizations are needed before these guidelines see widespread use. Standard recommendations from an authoritative organization would assist health systems in determining where to place dedicated ethics resources and help those arguing for expanded professional ethics support in their facility or region. I hope this initial draft will be used as the basis for just such an effort. ✛

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How the 'Complex Care Team' Supports Ethics in Complex Cases

Jenny Heyl, Ph.D.

Often the call to ethics is a call of last resort. Even embedded ethicists, working proactively, get involved in cases that become unwieldy with elements well beyond the purview of ethics. Additionally, there are cases where the ethicist's recommendation is one that the physician believes might leave her legally exposed and she wants organizational support to implement the recommendation. The 'Complex Care Team' (CCT) at Mercy was developed as a result of cases with seemingly intractable and far-ranging issues and those where ethics' recommendations press for cultural change.

Some organizations might address these cases within the ethics committee. However, we believed it was important that senior leadership lead this group; ethics would be one of several important disciplines participating. Currently the co-chairs of this group are the CMO and the CNO, with members including senior leadership (both administrative and clinical), chairs of critical care and the hospitalist group, nursing leaders, care management, mission, ethics, legal, pastoral care, members of the treating health care team, and other disciplines as appropriate.

The Complex Care Team's purpose is three-fold:

- To promote procedures to proactively identify potential problems,
- To facilitate the removal of barriers to safe, effective, appropriate, and ethical care of patients, and
- To support health care team members with extremely complex medical and social issues of patients and their families.

The CCT is a standing weekly meeting and is cancelled if no cases are submitted four hours prior to the meeting time. Urgent issues are scheduled on an *ad hoc* basis. Ideally, the case is presented by the attending physician and other members from the team. The patient's primary care physician is included if possible, usually by phone. The cases range from extremely difficult discharges to behavioral issues to family (or surrogate) requests for inappropriate medical treatment at the end of life. Perhaps the greatest success of this team is the development of mechanisms to provide clear and consistent communication among the care team, patients, and their families. One example is the 'Strategy of Care' chart note, which documents the agreed upon plan of care reviewed at the CCT and then discussed with the patient (or family),

which is clearly flagged on the chart when first opened, and which informs all current and future caregivers of the agreed upon plan of care. We have found this to be successful at preventing unnecessary readmissions and supporting physicians in holding to a plan of care that has been established.

Additionally, CCT affords frontline staff the opportunity to sit at the table with senior leadership to discuss the challenges these cases present; this results in the staff feeling heard and empowered and gives senior leadership a realistic view of the daily challenges faced by the staff. The physicians also feel that the organization is behind them when a difficult plan of care needs to be implemented. ✛

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But Can It Be Measured? Designing and Operationalizing Evaluation Plans to Enhance the Quality of an Ethics Service

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A robust ethics service can provide opportunities for improved patient care, provider satisfaction, and strengthen organizational culture through identifying complex clinical dynamics that can impact length of stay, staff turnover, and, ultimately, cost. However, without appropriate evaluation plans designed in tandem with measurements and expected outcomes, we calculate numbers instead of assessing impact. Those designing and/or evaluating ethics consultation, education, and policy development underutilize logic models, often key components of solid evaluation plans. I will discuss four types of evaluation, in particular the use of logic models in evaluation planning, with special attention to application for clinical and organizational ethics.

As hospital leaders contend with competing pressures about decreasing length of stay but increasing satisfaction (for patients, staff, and physicians), measures of success vary by the discipline or interested party. In the ethics consultation literature, desirable patient outcomes take the form of decreases in non-beneficial treatments, decreased length of stay, fewer days in the intensive care unit, or decreased costs. Mark Repenshek offers three metrics to assess the value of a clinical ethics consultation service.[1] Batten argued that outcomes such as health care cost, clinical indicators in the intensive care unit, and patient satisfaction should not be used to evaluate the worth or success of a clinical ethics consultation service. He concluded that these are all outside of the ethics consultant's control and cannot be measured as ethics consultation outcomes.[2] We can see this clearly in the Andereck et al study of 384 patients in the intensive care unit, which concluded that not only were proactive ethics consultations ineffective in reducing overall length of hospital stay, ICU days, non-beneficial treatments, or hospital costs, but also such consultations were not effective in increasing perceptions of quality of care by patients or clinicians.[3] Craig and May warned that it is easy to mistake the goals of ethics consultation to

other outcomes because such outcomes are more easily measured and are closely related to the goals of ethics consultation.[4] I similarly argue that the cause-and-effect relationship between ethics recommendation and outcome remains muddied due to the transdisciplinary provision of health care, but this relationship can be tightened when clearer causal measures are utilized, such as earlier versus late ethics consultations and excess length of stay.[5]

Clinical and operational colleagues often utilize The Model of Improvement, developed by Associates in Process Improvement, to accelerate improvement ranging from decreased surgical site infections to moving resources across care sites. Three questions guide the Model for Improvement: **What are we trying to accomplish? How will we know a change is an improvement? What change can we make that will result in an improvement?**

These questions inform the PDSA (plan-do-study-act) model of quality improvement. Unlike other forms of research, where the purpose is to discover new knowledge, those who conduct quality improvement initiatives attempt to acquire data quickly and interpret data for action. For example, a quality improvement team might meet with nursing to figure out how to eliminate excess trips to the medication room (a prime opportunity for medication errors). The team might ask nurses to wear pedometers to track steps or collect log-in information from the medication room door to see how many times nurses are keying in to collect medications. Those data might be collected for 30 days and then the team gets together to evaluate the data to decide what intervention could be made to

expedite medication administration. When looking at the three questions, the team would probably say that they are trying to improve nurse efficiency or decrease medication errors. Improvement could be in the form of improved nurse satisfaction with daily work or decreased errors in medication administration. The change made could be moving the medication room to a more central location or establishing set times for medication administration. How might we consider a similar 'win' for an ethics service such as improving patient safety or patient satisfaction? Or is that even the right question ethics should be asking? If the task of ethicists in Catholic health care is to "facilitate discernment and provide guidance for making just and moral decisions when answers aren't always clear,"[6] we must articulate a set of metrics and measures of success that mirror the responsibility of an ethicist. For that, we must better understand the various forms of evaluation and the kinds of measures of success for each form.

Evaluation asks two main questions: **What do you want to know?** and **How will you know it?** To answer these questions, four interrelated aspects comprise a well-designed evaluation plan: needs or asset assessment; process evaluation; outcome evaluation; and impact evaluation. **Needs assessments** seek to answer the following questions: What are the characteristics, needs and priorities of the target population? What are potential barriers/facilitators? What is most appropriate to do? **Process evaluation** asks: How is the program implemented? Are activities delivered as intended? Is there fidelity of implementation? Are persons being reached as intended? **Outcome evaluation** targets the following:

To what extent are desired changes occurring? Are goals being met? Who is benefiting/not benefiting? What seems to work or not work? What are the unintended outcomes? Finally, **impact evaluation** asks us to consider: To what extent can changes be attributed to the program? What are the net effects? What are final consequences? Is the program worth the resources it costs?

In the *Striving for Excellence in Ethics* document from CHA,[7] these four evaluation forms can be found in the following four ethics standards: 2.c.i. client needs assessment; 2.c.iv. individual member self-evaluation; 3.d.vi. evaluation of the consultation; and 3.h.i. evaluating and assessing effectiveness of structures, processes and quality of outcomes of ethics consultation. For example, in the needs assessment, a strong evaluator would help guide a service in completing the CHA assessment tool to gauge if a standard is fully present and functional, or the degree to which the standard is an opportunity for improvement. Employing standardized tools helps us compare cohorts and provide comparisons to other institutions. Perhaps a measure of success would be that a needs assessment is completed every two years or within six months of a change in ethics leadership. A needs assessment cannot stand alone in terms of organizational and service improvement nor can arbitrary metrics like a 5% change in persons rating a standard at a '2' withstand scrutiny regarding inter-rater reliability or differential loss to follow-up. For example, if we assess the group at one period of time, but a whole different group completes the needs assessment at a future time, it is difficult to draw meaningful conclusions about improvement. A potential way to address such

concerns and to attend to the interrelated areas of evaluation is the logic model.

A logic model indicates precisely how each activity will lead to desired changes and can assist in the planning, operationalizing, and sustaining of a robust ethics service. Logic models can enhance accountability by keeping stakeholders focused on outcomes by preventing mismatches between activities and effects. These frameworks enhance relationships through a shared effort of collaboration and offer a transparent road map to a shared definition of success. Logic models help us to know what and when to measure, allow a simultaneous focus on both process measures and outcome measures, and ultimately prioritize where we will spend our limited resources. One might consider a particular limitation to a logic model to be the amount of time the process could take. Unlike the PDSA approach, which forces rapid-cycle improvement, the logic model, because it incorporates many other aspects that have their own set of barriers and constraints, may appear to delay implementation and success. However, a logic model can outlive changes in leadership, funding, or personnel because the model requires continual examination and reflection. As such, the logic model becomes a time-saving and resource-saving instrument in the design and implementation of a multifaceted ethics service.

Given that few organizations are in the position to begin an ethics service from scratch, developing an evaluation model in the midst of service delivery might seem daunting. Fortunately, implementation is a perfect time to consider adding in a logic model as it can

allow for mid-course corrections by providing an inventory of what you have and what you need to operate the program or by reducing and avoiding unintended effects.[8] In many ways, ethicists should look to evaluation, especially the logic model, as the perfect complement to how we go about our work. An ethicist does not merely find the 'right' answer or opine without thought of consequence. An ethicist helps persons to discern the good and helps to form persons who are aimed towards the good. Evaluation serves that same function; and a logic model offers a transparent roadmap of how we will move towards the good, whatever that means to the various stakeholders and their competing interests, which sounds like a pretty typical task for an ethicist. ✤

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Getting to Know You: Building an Ethics Consultation Service From the Ground Up

Claire Horner, JD, MA

A perennial difficulty in building a new ethics consultation service is trying to explain and to advertise the service to health care professionals. While health care workers in a hospital don't need a primer on the cardiology service, for example — what they do, and when they might be needed for patient care — ask any physician or nurse in a hospital with a new ethics service what ethics is and when they think it's appropriate to call a consult, and you're likely to get shrugged shoulders, a comment about "legal issues," or even an angry "we act ethically so we don't need ethics on our unit."

In our 800+ bed, adult quaternary care Catholic academic medical center, we recently reorganized and relaunched our ethics consultation service that had previously been dormant. We established a 24/7 on-call service staffed by a mix of professional and trained volunteer ethicists using an individual model, in which the consultant on call was available to come to the bedside in real time to talk to stakeholders and help resolve ethical issues. Our first, and biggest obstacle, was to let people know we existed. Our second was to dispel several myths about ethics. Among

these myths were fears that we were the "ethics police" who were only called in when a doctor had done something wrong; that calling for an ethics consult meant convening a committee to deliberate over a case, which seemed excessive for "minor" ethical issues; that ethics was merely another arm of the legal/risk management team; and that ethics deliberation was just about "what feels right" and therefore lacks any standardization or objectivity.

Faced with these challenges, we implemented two projects simultaneously to try to share the purpose and usefulness of the ethics consult service far and wide across the institution: embedding in daily multidisciplinary rounds (referred to as the "huddle") and meeting with the nursing staff on each floor to distribute a resource binder and explain the service. These approaches have taken our service from 12 consults in the year we launched to over 100 consults a year two years after reestablishing our service.

We began by visiting the medical ICU and introducing our service to the physicians and nurses with the help of an intensivist who

was involved with our ethics committee. They already had a daily multidisciplinary huddle where the attending physician met with the nurse manager, social worker, and chaplain, among other professionals, to discuss each patient in the unit and primarily discuss disposition or other social work needs. We asked to sit in on those meetings, and in time started asking questions during the meetings about identification of surrogate decision makers or if the team was having difficulty with family dynamics. We took those opportunities to explore how we might be able to help the difficult situations they faced, and our consults from that unit increased.

When the critical care service decided that such daily huddles needed to be standardized across all ICUs, the care line chief also asked that the ethics team be included given the benefit we had offered in the MICU. We expanded our attendance to all five medical and neurosurgical ICUs, and our consult numbers increased dramatically. We found that often the care teams not only were having to figure out how to navigate ethically challenging situations on their own, but also didn't know what questions they needed to be asking. Within a few weeks of rounding, these ICU teams gave us feedback that our presence and contributions to the discussion were invaluable, especially regarding questions about surrogate decision makers and various aspects of informed consent.

Our second intervention was to create a resource binder containing the most salient ethics-related information for each nursing unit and ICU. There were two components to this intervention: the binder itself, which remained on each floor and ICU for the benefit of the staff, and the short meeting with the nursing staff to give them the binder and introduce its contents.

The binder is separated into four main sections: the Ethics Consultation Service; Ethical Guidance; Important Forms; and Policies and Procedures. Our Ethics Consultation Service section describes our service and what we can offer, as well as suggested scenarios in which it may be helpful to call ethics and how to call for a consult. It also includes a magnet with our contact information for display.

Ethical Guidance begins with a one-page curated summary of the most helpful *Ethical and Religious Directives for Catholic Health Care Services*. This was an important addition, as the hospital had been affiliated with the Episcopal Church and was only recently acquired by a Catholic health system. For this reason, many of the physicians and staff were unaware of the *ERDs* or unclear about how they were relevant to patient care. This section also includes a table summarizing the statutory hierarchy for surrogate decision-making, which in Texas is different depending on whether the decision to be made is regarding routine or life-sustaining treatment. Finally, we include a table summary of advance directives, describing the purpose of various AD forms, why they are chosen, and the benefits and drawbacks of each.

The Important Forms section is one that is often referenced by staff. It contains copies of statutory advance care planning forms to help staff identify the type of document a patient has brought in: Medical Power of Attorney; Directive to Physicians; Out of Hospital DNR; and Statutory Durable Power of Attorney. Each form is annotated to point out the most important features, including

witness requirements, as well as how the staff is permitted to participate in completing the documents depending on their role on the health care team.

Finally, we included the most ethically relevant hospital Policies and Procedures, which the staff has stated is most helpful for them in their everyday practice. This includes policies on Medical Decision-Making, Advance Directives, End of Life Treatment Decisions, DNAR orders, and advance directives for Mental Health Treatment.

Rather than merely drop off the binders on each unit, I scheduled a time with each nursing director to speak with the entire nursing staff during their daily morning huddle at handoff. This allowed me to meet with as many nurses as possible during their shift change. I began by describing our service, dispelling the myths I articulated above and answering questions (or fielding concerns). I then explained the contents of the binder, drawing attention to the front cover which prominently displays our service call number. Many of the nurses during these meetings had not even heard of our service, but a few who had were able to tell stories about ethics consults they had been a part of in the past. This had the benefit of increasing our consult volume, as well as encouraging nurses to attend our educational offerings and become more involved in our ethics events. Some nurses who heard about ethics through these huddles went on to join our Ethics Committee as well.

While we are still in the building phase of our consult service, these two interventions have helped to increase awareness of the consult service throughout the hospital and address

concerns of the physicians and staff that we are unhelpful, punitive, or only involved in big, messy cases. We have built relationships with many nursing directors and physicians, which have enabled us to offer educational sessions for specific care lines and act as a resource for departments across the hospital. While each hospital's culture — and resources — vary widely from one institution to the next, we hope that by sharing some of our tools that other services may be able to use them to build their services and gain buy-in from stakeholders.

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Self-Care for Ethicists

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The first Catholic Healthcare Ethics Innovation Forum (CHEIF), held on December 16-17, 2019, provided an opportunity for those in Catholic health care to explore, present, and discuss innovative and novel ideas in health care ethics. The "lightning-round" format allowed participants to share the work they are doing to embed and integrate ethics into their health systems, to receive critical feedback from colleagues, and contribute to evolving the way Catholic health care thinks about and implements bioethics. The goal was to develop a forum where participants can present innovative ideas and enhance them together.

One of the key focus areas of the forum was on the competencies, development, management and self-care of those involved in the work of ethics, from the bedside to the boardroom. Caregivers (and I include ethicists within this term) are often very good at taking care of others, but neglect taking care of themselves. However, unless caregivers (including ethicists) are able to practice self-care, they run the risk of compassion fatigue, decreased work satisfaction, and burnout.[1] As Egan, et al state, "The stance that HCPs [Health Care Professionals] adopt of 'you before me' should not be 'you instead of me.'"[2] Yet, this is often the case. Mills, Wand and Fraser define self-care as "a proactive, holistic, and personalized approach to the promotion of health and well-being through a variety of strategies, in both personal and professional settings, to enhance capacity for compassionate care of patients and their families."[3] What follows is an outline of some of the self-care practices, resources and tools which might be of use to those within the field of ethics and ethics leadership in caring for themselves, as they seek to care for others, both professionally and personally.

THE ROLE OF THE CLINICAL ETHICIST: CHALLENGE AND REWARD

The nature of clinical ethics work requires that the ethicist be called into some of the most difficult conversations in health care. She or he must enter into situations with often complex medical, interpersonal, social and cultural dynamics, sometimes with little institutional or collegial support, and without the benefit of a consistent interprofessional team. A growing trend towards a more "proactive" model of ethics where ethical dimensions of care are addressed further upstream as part of the obligation to care for the whole person means that sometimes ethical concerns can be addressed *before* there is a conflict or before interpersonal dynamics become so strained, and that the ethicist is viewed as a valued member of an interdisciplinary care team. However, this is still not the prevailing norm. As such, many ethicists find themselves being called into an ethical conflict much too late, when tensions are already high, as well as the stakes (such as end-of-life cases), and the lines have already been drawn between the patient and the care team, or the patient and family, or between members of the care team. The ethicist must step into these settings, listen to often heart-

wrenching stories from patients and families and moral distress of care providers, and then try to work with both to chart a path forward which respects the goals, values and beliefs of all involved, but most especially the patient. If one were to describe the job of clinical ethicist to prospective candidates in this manner, who would apply?

Yet, within such a vocation also lies the opportunity for meaning, purpose, fulfillment, collegiality and job satisfaction, as well as the opportunity for significant "compassion satisfaction" (CS).[4] One of the keys to preventing compassion fatigue and promoting compassion satisfaction lies in balancing caring for ourselves so that we can care for others. We must keep our spiritual, emotional and physical "buckets" full so that we can then draw from the wellspring of our reserves to help and care for others.

BUILDING A SELF-CARE "TOOLBOX" FOR ETHICISTS

When I decided to prepare a presentation for the CHEIF conference on this topic, it was not because of any expertise on this topic on my part. It was because I sensed a great need, both personally and professionally, for such a resource; to invite further conversation, and to raise awareness of this need. It may also stem, perhaps to the most significant degree, from my experience as the primary caregiver for my first wife, who struggled valiantly with chronic illness for twelve years, and passed away from cancer. In part, these lessons stem from failings on my part to utilize such resources, and the subtle (or not so subtle) reminders from her, even in the midst of tremendous existential suffering, that I needed to take care of myself or I could not hope to take care of her.

What follows stems originally from a presentation I gave to a group of case managers and social workers at St. Francis Medical Center in Hartford, Conn., on the occasion of their annual "appreciation day." I realized, as a clinical ethicist and vice president of mission at the time, that I failed to take my own advice; my spiritual toolbox was almost empty. I have modified and adapted it to apply more fully to the role of the ethicist, although I hope others within the health care field and otherwise also find some of these ideas meaningful.

"Self-Care Toolkit"

A Flashlight: A flashlight is used to guide the way when it is dark. It shines a light on places that are hidden, and on perhaps places where we'd rather not go. For the ethicist, a flashlight is a trusted mentor. Someone working within the field whose experience and wisdom we can rely on to guide us, especially when our path seems dark and uncertain. Someone we look up to, and who inspires us in the role we have chosen.

A Critical Friend: This term may seem contradictory at first but, upon reflection, I'm sure many of us can name a person in our lives who cares enough about us to be compassionately honest; someone who knows what we are capable of, and who holds us to account when we fall short of our true potential. A critical friend does not just agree with us to avoid conflict or because it is easier. They check our blind spots, challenge our assumptions and call us out when we either get to full of ourselves or wallow in self-pity. A "critical friend" can be either personal or professional, or both. The key to this relationship is trust.

A Warm Blanket: The image that immediately

comes to mind for me with this reference is the Peanuts character, Linus, who always carries a blanket with him. In one Peanuts episode, he lends his blanket to Charlie Brown, who is in a national spelling contest. However, Linus becomes so lost and traumatized without his blanket that he has to travel to the spelling bee to get it back. Charlie Brown's dog, Snoopy, is always trying to steal Linus' blanket. In one of my favorite cartoons, Snoopy is actually wrapped in Linus' blanket, and Linus is holding on to Snoopy' s ear instead. Both are snuggled on a beanbag chair. To me, this is how a warm blanket feels. When we feel lost and traumatized, our warm blanket is our safe place. It is a person (or pet), place or activity where we feel wrapped in warmth, love, and safety. When we are enfolded in our warm blanket, we don't have to explain ourselves, or talk about what is bothering us (although we can if we need to), or do anything in particular except just "be."

A Pressure Release Valve: When the stress of balancing work and life, of a particularly bad day or a challenging encounter builds up within us, we need to find a pressure release valve. The image that comes to mind here is that of a pressure cooker. If the pressure cooker did not have a valve to release steam, it would explode. It is the same with us. We either find a positive valve to release pressure, or we explode at our colleagues, our loved ones, or the patients and families entrusted to our care. This pressure release could be a reflective exercise such as prayer or journaling, or meditation. It could be physical exercise such as running, walking the dog, or weightlifting, or a combination of reflection and physical exercise like yoga. Sometimes, when we don't find a positive pressure release valve, we turn to a negative one like alcohol or drugs. These are not authentic

pressure release valves, but only serve in the long run to increase the pressure inside of us and decrease our ability to deal with it effectively. It is important, even in the midst of a busy workday, to integrate even a minute or two of pressure release. These might include a few minutes of deep breathing exercises, or keeping a prayer next to my computer so that, rather than getting frustrated as I wait for it to start up, I use this time as a moment of intentional reflection (one of my personal favorites). When I am on a conference call or webinar, I use exercise bands and a standing desk to stretch and move around, or a mini pedal-bike attached to my chair so I can pedal during webinars. Whatever strategies you employ, the important thing is to find a positive pressure release valve, so that we don't take our frustrations out in negative ways.

Duct Tape: As the legend goes, duct tape can fix almost anything (except maybe ducts). It is a very versatile product, and an essential element in our self-care toolbox. What is the one tactic, approach, or resource that you utilize in your professional life that almost always works, either to clarify a concept, de-escalate a situation, provide perspective, or help others become invested in what you are saying or doing? What one thing or practice can you turn to that almost always works? This is your spiritual duct tape that holds life and work together. Of course, if we watch any gangster or crime shows, we know that duct tape is also often used as a gag. It is placed over people's mouths so they can't talk. Sometimes, we may need to use our metaphorical duct tape (not real duct tape) to remember to listen more than we talk. This is how we learn the patient or family member's values, hopes, fears and concerns, or those of the care team. Sometimes as the ethicist, we are

quick to jump in to solve the problem, when what we really need to do is listen. Sometimes when we provide space for silence, problems solve themselves.

WD-40: Much like duct tape, WD-40 is purported to be the cure-all for many things. If the wheel squeaks, add some WD-40. If the door is jammed, add some WD-40. The blue and yellow can has magical properties. When we are confronted with the "squeaky wheel" family member who, although having no legal or ethical right to do so, demands treatments or interventions clearly at odds with the patient's values and the standard of care, or threatens to sue us at every turn, the proper tool is not duct tape, but WD-40. What do we use to grease the wheel and get things moving again? What is our spiritual WD-40 to open doors that have been closed to us, or that have become stuck? Often, it is seeking to approach difficult situations with compassion and empathy. Is the "squeaky wheel" family member feeling scared, or guilty, or angry, or all three? Seeking to understand first rather than to react is often the best "WD-40" we can use.

A Balancing Scale: It has become somewhat normal parlance to avoid the term "work/ life balance" in favor of the term "work/life integration." This is due in part to the fact that there are times when the nature of the work we do as ethicists requires that we sprint for a while before we can rest; the intense care team or family meeting, the impending publication deadline, the quarterly report that is due, or the continuous cycles of ethics committee meetings, consults, policies needing review, church relations work, travel and community engagement, all seem to clamor for our immediate attention. This may mean

that we work extremely hard (sprint) for a defined amount of time. The question is, how do we integrate life within the mix? How do we avoid sprinting all the time? This is work/life integration. The reason I still posit a balancing scale as an essential tool in our self-care toolbox is because the image takes into account the "weight" of the work we do. Some aspects of our work carry heavier weight or meaning than do others, and some weigh more heavily on us. When we evaluate both our "energy grid" and our vocation, we need to honestly weigh those things that give us meaning and purpose, and those things which pull us away from our meaning and purpose. We cannot avoid all of the latter, just as much as we cannot only do the things that fit into the former category. We need to balance both of these things, and also rely on our "flashlight" and our "critical friend" as well as our family and those closest to us to tell us when we are off-balance.

Ritual: The last tool in our self-care toolbox is ritual. Although I could not find a way to cleverly (at least in my own mind) connect ritual to a tool in a toolbox, ritual may be more about *how* we use these tools. I do think it is an essential aspect of self-care. Rituals can help anchor our day, connect us to community, mark the passage of time, and honor significant moments. They can be elaborate or simple. Elizabeth Gilbert writes, "This is what rituals are for. We do spiritual ceremonies as human beings in order to create a safe resting place for our most complicated feelings of joy or trauma, so that we don't have to haul those feelings around with us forever, weighing us down. We all need such places of ritual safekeeping."[5] This is, in part, the sense in which I view rituals as an essential tool for our spiritual tool-box. They help us process the feelings of grief, loss, joy

and hope that are part of both our vocation and of the human condition. They can be more formal such as weddings or funerals, blessings and prayer services, employee recognition celebrations or values recognition awards, or quite simple like prayer before meetings or meals, or touching the picture of our spouse, children or pet before we begin our day. Rituals mark life's moments and life's passage. Here are a few suggestions of rituals I have encountered in my life and work. I also invite you to reflect upon those that you have experienced.

- When "foaming in" to a patient's room, set distractions aside and focus on this unique patient, with all the gifts and challenges she or he may present. Breathe deeply and be entirely present to the face of the Other before you.
- When you change out of your scrubs, lab coat or business attire into your "leisure wear," try to focus on shedding the negative energy of the day and clothing yourself with positive energy. If you can't do this, consider the pressure-release valve suggestions above.
- If you have a long commute home, do something that relaxes you (but not too much if you are driving!) or reinvigorates you. This might be quiet time for reflection, listening to music, audiobooks, or podcasts, or reading a good book (if you are on a train or bus or plane, etc.)
- Find a way to acknowledge, memorialize and honor loss, but don't be paralyzed by it. If you are, seek out support. I had a former student who became an occupational therapist. As such, she developed strong relationships with some of her clients. I remember her

calling me in tears one day because she had her first patient die, and she didn't know how to process it. I suggested that she write his initials in her prayer book or journal, and go back to it as often as needed until she felt she had honored his passing. This ritual worked for her. I encourage you to find your own ways to ritualize loss; to honor it, but to still move forward to do the essential work of healing. Institutionally, we need to find ways to support care teams in doing the same. How do we create space and rituals that promote healing?

Not all of the tools in this spiritual toolbox may be applicable or helpful to every reader. I encourage and invite the reader to reflect upon what essential tools are in their spiritual toolbox, and whether or not they are helpful. I also invite us, as an ethics community, to continue to share our tools and resources with one another in support of the vocation to which we have been called.

A WORD FOR THOSE ETHICISTS IN THE BOARDROOM NOT THE BEDSIDE

Many of us who were trained as clinical or bedside ethicists and have since moved to system-level or leadership/administrative roles within ethics experience the void that comes from no longer (at least primarily) interacting with patients, families, and caregivers on a daily basis. Personally, this has proven to be both a blessing and a trial. The day-to-day work with patients, families and care providers is, in my opinion, where the "real work" of ethics resides. It is when we look into the eyes of a dying patient, or a struggling family member or a concerned physician or nurse and can provide some comfort, solace or direction to them

through our shared learnings, listening and expertise that we find meaning and purpose. It is also when we can become the most exhausted, frustrated, fragile and jaded. These experiences can both lift us up and drag us down. It is the work that many of us were trained to do, and why we got into the field of ethics in the first place. It is where our sense of vocation, meaning and purpose lies. Yet, for some of us, this is no longer the world in which we live. We have moved from the bedside to the boardroom and from the critical care unit to the corporate office. Where do we find meaning and purpose, and what keeps our spiritual "bucket" full?

I started out my professional career as a high school teacher. My first love has always been the classroom and the interaction with students, especially those that others had written off or declared "unteachable." Yet, after several years of teaching, I became a high school principal. I spent most of my time outside the classroom, hiring and mentoring teachers, meeting with parents, attending school board meetings, or revising curricula. I still managed to teach one class per semester, but the dynamics and focus of my job had changed. That which gave me the greatest fulfillment, joy, sense of purpose and stress (teaching students) was no longer my primary focus. I grieved the loss of this part of my life and my vocation, and struggled to find meaning in my role as a leader and administrator. As a teacher, I built relationships with and directly impacted over 100 students each day. As a principal, I worked with, supported and mentored (or they mentored me) over 100 teachers. They, in turn, were better equipped to teach, support and inspire their students. While my impact might not be as deep with individual students, my reach and ability to effect change for the good was much broader.

As leaders in ethics, we have the opportunity to effect broad and systematic change within the field of ethics. We can find meaning and purpose in the development of new approaches and frameworks in ethics which move ethics further upstream and closer to the persons being served, and which support and empower others (especially caregivers) to identify and address the ethical dimensions of care in the work that they do and the care they provide every day. While we may not be at the bedside, we support those who are, and our breadth and reach can extend much further. We may not be at the forefront of patient care, and people may not even know the role we play in supporting those who are. In many ways, we are called to embody the type of leader Lao Tzu brings to mind when he writes, "a leader is best when people barely know he exists, when his work is done, his aim fulfilled, they will say: we did it ourselves." As system leaders in ethics, we may find ourselves fulfilling the roles of mentor and critical friend outlined above. This, along with recognizing the opportunity we have to effect lasting and meaningful change in the field of Catholic health care ethics, can help keep our spiritual bucket full.

FINAL THOUGHTS

Although this work has focused on self-care for ethicists and ethics leaders, I would be remiss if I did not comment briefly on the tremendous need for self-care and support of our direct care providers, including physicians, nurses, social workers and chaplains. There is significant evidence of moral distress, compassion fatigue, and burnout amongst those most responsible for caring for our patients. It is my hope that some of these strategies may be of help to

them in easing moral distress and compassion fatigue, and in promoting moral resiliency and compassion satisfaction, and that the role of ethics and of the clinical ethicist can also prove to be a valuable "tool" in their self-care toolbox. ⊹

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ENDNOTES

1. The term "compassion fatigue" (CF), is sometimes used to describe burnout among nurses, which defines a state of chronic worry and tension produced by the effect of the continuing impact of caregiving, which is related to secondary vicarious traumatic stress disorder. CF has been described as a negative effect in the professional caused by working with traumatized people, resulting in an inability to provide compassionate care. See Charles Figley, *Treating Compassion Fatigue* (New York: Brunner-Routledge, 2002), and Carla Joinson, "Coping with Compassion Fatigue," *Nursing* 22.11 (April 1992): 116-120.

2. Helen Egan et al., "'You Before Me': A Qualitative Study of Health Care Professionals and Students Understanding and Experiences of Compassion in the Workplace, Self-compassion, Self-care and Health Behaviours," *Health Professions Education* 5 (2019): 225-236.

3. Jason Mills, Timothy Wand and Jennifer Fraser, "Exploring the Meaning and Practice of Selfcare Among Palliative Care Nurses and Doctors: A Qualitative Study," *BMC Palliative Care* 17:63 (2018): 1-12.

4. Compassion satisfaction (CS) is defined as the ability to receive gratification from caregiving. Stamm describes CS as the degree of joy resulting from the clinical experience of helping others. See Beth Stamm, "Helping the Helpers: Compassion Satisfaction and Compassion Fatigue in Self-care, Management, and Policy," in Kirkwood AD, Stamm BH, eds., *Resources for Community Suicide Prevention [CD]* (Meridian and Pocatello, ID: Idaho State University, 2012).

5. Elizabeth Gilbert, *Eat, Pray, Love* (New York: Riverhead Books, 2007).

Bylaws for Clinical Ethics Consultation at the Providence Center for Health Care Ethics

Nicholas J. Kockler, Ph.D., MS, HEC-C

At Providence in Oregon, our ethicists accompany caregivers, patients, and their families as they wrestle with complex and value-laden issues that often impact life and death decisions. Rooted in the notion of clinical ethics as professional practice, our ethics consultation service is staffed by professionally trained ethicists.[1] While best practices, standards, and competencies required to do the work of health care ethics are emerging and professionalizing at large, we found it incumbent to make a statement to our institution and our colleagues about our accountability to excellence as professionals.[2] At present, the Bylaws for Clinical Ethics Consultation is being vetted by and socialized with institutional partners. These bylaws are predicated on a number of pertinent presuppositions on the work of health care ethics in Catholic ministries, and they establish the formative documents of the service, guidelines and practice commitments of professional practitioners (ethicists), and acknowledge the intra-institutional accountabilities of ethicists and an ethics consult service.

WHY BYLAWS?

While there is no binding set of standards or practices for ethicists as professionals, in the setting of emerging standards (cf. *Striving for Excellence in Ethics* and the American Society for Bioethics and Humanities [ASBH] *Core Competencies for Health Care Ethics Consultation*) and the employment of multiple ethicists, we desired a way to inform the practice of clinical ethics consultation in a reliable, consistent, and professional manner. Therefore, we drew upon the analogy of the professional staff bylaws operative in our institution. Whereas many health care organizations articulate clinical ethics consultation policies that establish norms of conducting a consult, we did not believe that was the appropriate institutional mechanism. By comparison, policies do not dictate the practice of medicine or nursing as professional practices; so too we believe the same should apply to clinical ethics.

PRESUPPOSITIONS

Five major presuppositions shape the impetus and form of the bylaws:

1. Ethics consultation is a professional practice performed by ethicists.
2. Clinical ethics *praxis* is aimed at supporting and empowering the principal moral agents in patient care situations, not supplanting them. Therefore, there are implications for how to organize and to integrate ethicists qua professionals with *fiduciary responsibilities*.
3. The ASBH guidelines and competencies are compatible within the Catholic health care context.
4. An operating policy does not and should not define ethics consultation. Such policies ought not undermine the professional autonomy of ethicists. (Therefore, in our context, our ethics consultation policy defines *how to request* a consult and *what one can expect* in the consultation.)
5. Such bylaws (vetted, socialized, and endorsed appropriately) demonstrate *transparent self-regulation* of a profession.

In our context, we envision the integration of clinical ethics along the lines of primary, secondary, and tertiary integration. Primary ethics occurs directly in the sacred provider-patient encounter (or directly between caregiver and patient/decision-maker). The exercise of primary ethics by a caregiver is predicated on the possession of sufficient proficiency of the ethical components of correlative professional competencies.[3] Secondary ethics happens when those directly involved in the care of a patient need additional support to address basic questions or policy clarifications. We use the term *ethics liaison* to describe this role, but most often it is a member of the ethics committee. In smaller ministries (e.g., critical

access hospitals), these caregivers may also be part of the care team. Finally, tertiary ethics is the availability and performance of a professional consultation service by specialists with expertise in the field (aka, ethicists or attending ethicists in our context).

FUNCTIONS AND PURPOSES

As currently written, our bylaws state four functions:

i. To characterize the practice of clinical ethics consultation by a professionally trained ethicist;
ii. To establish the role and function of an "attending ethicist" in providing clinical ethics consultation;
iii. To outline the operations of the Ethics Consultation Service as they pertain to clinical ethics consultation; and
iv. To clarify the expectations of the attending ethicist in performing clinical ethics consultation.

More broadly, the seven purposes of the bylaws are as follows:

1. To describe the major dimensions and features of clinical ethics consultation and its assessment as operationalized by our Center;
2. To set forth the general expectations of the professional practice of clinical ethics consultation on the Ethics Consultation Service as operated by our Center;
3. To be accountable for emerging professional norms in clinical ethics and to stakeholders or relevant interested parties whether internal or external to the organization;

4. To support the dimensions of a culture of high reliability and patient safety as they apply to the practice of clinical ethics consultation;

5. To strive toward excellence in all aspects of clinical ethics consultation;

6. To maintain lateral accountabilities with local institutional entities (e.g., leadership, ethics committees, professional staff, etc.); and

7. To be engaged in continuous quality improvement and self-care.

CONTENT OUTLINE

The bylaws are divided into two broad sections: articles and appendices. Articles contain the theological, philosophical, and professional standards, norms, and guidelines of clinical ethics consultation. Appendices contain the reference documentation and communication resources in operationalizing the Ethics Consultation Service in general and clinical ethics consultation in particular. In general, we do not anticipate or intend for the articles to change much over time (though we do expect some iterative revisions, especially as the bylaws are reviewed by others). Yet, we do expect that the appendices will change more rapidly in response to the changing health care environment and organizational contexts within which we practice.

While a summary of each article is outside the scope of this paper, the following eleven articles constitute the bylaws, narrowly speaking.

i. Preamble
ii. Purposes of the Bylaws
iii. Definitions
iv. A Natural History of Ethical Issues in Health Care

v. Health Care Ethics Praxis
vi. The Nature of Clinical Ethics Cases
vii. Personnel & Functional Roles
viii. Consultation Guidelines
ix. Functional Products: Interventions and Outcomes
x. Professional Practice Quality Improvement
xi. References

At present (February 2020), the appendices to these bylaws include the following items:

A. General Operating Policy: Clinical Ethics Consultation (regional policy)

B. Clinical Ethics Consultation Process (conceptual map of the process of clinical ethics consultation)

C. Message for Clinical Ethics Consultation Orders in Oregon (states in scope, out of scope, business hours, etc.)

D. Clinical Ethics Support: C.A.S.E.S. Approach (for circumstances when an ethicist is not available or not necessary: a function of secondary ethics integration)

E. Providence Model for Health Decision-Making in Clinical Settings (a visual disclosure model to assist with exploration and explanation of ethical thinking)

F. Clinical Ethics Case SBAR Form (a tool for caregivers to use to organize relevant case information)

G. Clinical Ethics Triage Screening Tool (to help determine whether to escalate an issue to the attending ethicist)

H. Perinatal Ethics Team Letter (to communicate resources for high-risk obstetric cases, neonatal cases, and other

maternal-fetal medicine issues)

I. Clinical Ethics Consultation | Clinical Ethics Alert (a one-pager on consultation; a communication tool for caregivers)

J. Ethics Liaison | Clinical Ethics Alert (a one-pager on the role of ethics liaisons, who are embedded resources who may be able to provide clinical ethics support when an ethicist is not available)

K. Evaluation Framework for Clinical Ethics Consultation (the conceptual framework for the summative and formative metrics of the consultation service)

ITERATIVE DESIGN AND EVOLUTION

Over time, we anticipate revisions to the current iteration of our bylaws. On the one hand, institutional parties will have additional insights and feedback to integrate into the document. Moreover, our ongoing formation and ministry as ethicists will bring new perspectives to the vocation of ethics that in turn will shape the document. On the other hand, external forces such as Church teaching, developments in the ethics literature, and research and other scholarship in the field will mold the content as well. Overall, while the bylaws are a testament to our commitment to the professional practice of clinical ethics consultation, like other professions, we seek to be faithful to our fiduciary responsibilities and core commitments as we adapt and respond to the signs of the times. ✛

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ENDNOTES

1. Nicholas Kockler and Kevin Dirksen, "Integrating Ethics Services in a Catholic Health System in Oregon," *National Catholic Bioethics Quarterly* 18(1) (Spring 2018): 113-134.

2. The first iteration of our bylaws was co-authored by N. Kockler and Kevin M. Dirksen, M.Div., M.Sc., HEC-C.

3. John Tuohey and Nicholas Kockler, "Ethics Education Enhances Skills of Doctors in Training," 93(3) (Spring 2012): 29-37.

A Three-Pronged Approach to Ecclesial Relations for Catholic Health Care Facilities

John F. Morris, Ph.D.

The *Code of Canon Law*, the Second Vatican Council, and the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)* from the United States Conference of Catholic Bishops all affirm the pastoral responsibility of the local bishop for all Catholic health care ministries within his diocese.[1] And while the importance of the need for mutual cooperation between a Catholic medical facility and the local bishop is officially acknowledged, in practice the relationship between the two is often tenuous, strained, or practically non-existent. After all, diocesan bishops are not experts in health care and medical treatments. Plus, many Catholic medical facilities either hire ethicists or work within systems that provide ethics consultation to ensure fidelity to the ERDs and Catholic moral teaching. Given this two-fold reality, maintaining a pro-forma relationship with the bishop would appear adequate. Indeed, in the past while serving on the ethics committee for a Catholic hospital, it seemed to me that hospital administrators only spoke with the diocesan bishop's office when there were major ethical problems that had occurred. And while such major issues did not arise often, when they did, such discussions

were almost always "after the fact" and were more concerned with damage control than building the "mutual cooperation" mentioned before.

Can Catholic health care do better than this? Further, rather than being an added burden or nuisance, would not a more integrated relationship between Catholic medical facilities and the local diocese strengthen Catholic health care ministry as a whole?

I believe the answer to both questions is a definitive yes, and can be illustrated by the current situation in the relationship between the Diocese of Kansas City-St. Joseph and our two Catholic hospitals, St. Joseph Medical Center and St. Mary's Medical Center. Both hospitals have a long history in the Kansas City area. The Sisters of St. Joseph of Carondelet came to our city in the late 1800s to establish schools for the growing population. But they soon realized that there was also a need for better health care services in the region, especially for the city's poor. They eventually established St. Joseph Hospital in 1874. The Sisters of St. Mary were invited to Kansas City

to take over the operation of the city's German Hospital. After much local encouragement they opened their own hospital, St. Mary's, in 1909. The two orders of Sisters officially merged their hospital operations in 1997 and formed Carondelet Health, which was eventually bought by Ascension Health in 2002. Thus, our hospitals have more than a century of health care ministry to the people of Kansas City. However, in 2012 Ascension began seeking a buyer for the two facilities. In 2015 they were sold to Prime Healthcare, Inc., a for-profit company based in California.[2]

The sale to a for-profit company caused great concern among Catholics in the Kansas City area, who feared that the legacy of the two orders of Sisters was about to come to an end. But the representatives of Prime Healthcare, Inc., recognized the value of the historic missions of the two hospitals, and as part of the sale entered into a formal covenant agreement with the Diocese of Kansas City-St. Joseph, which we refer to as the Catholic Traditions Agreement. The most important aspect of the agreement is that Prime affirmed they would maintain the Catholic identity of the hospitals and abide by the ERDs in all of their operations. But what has become an even more interesting outcome of the Catholic Traditions Agreement has been the method that was set up to verify that the hospitals are operating as Catholic facilities. It was especially important for the diocese to ensure that if the hospitals were going to retain their names, continue the legacy of their founding Sisters, and be recognized as Catholic facilities, there would need to be a clear and ongoing method of assessing their fidelity to the covenant

agreement. In short, a merely adequate ecclesial relationship between the diocese and the hospitals would not suffice. The method that was created involves a three-pronged approach centered on the establishment of a new Office of Catholic Health Care within the diocese to oversee the Catholic identity of the hospitals, and serve as the primary liaison between the facilities and the bishop's office.

Here are the basics of this three-pronged approach. First, as a visible sign of their Catholic identity, the hospitals agreed to maintain a Director for Mission Integration. The director is hired by the hospitals, but the bishop has the right to approve of their candidate, who must be a Catholic in good standing with the Church with training and experience in Catholic health care ministry. As a "director," this person participates in senior-level administrative meetings and has a seat on the governing board of each hospital. The director also has access to the surgical logs and reviews them daily to ensure what procedures are being performed every day in each facility. Finally, the director covers an anonymous "hotline" that has been established for both staff and patients to report concerns affecting our Catholic identity. In effect, the Director of Mission Integration is an "inside person" overseeing the Catholic culture of the facilities, while working closely with the Director of Catholic Health Care for the diocese who represents the second prong of this approach.

The Office of Catholic Health Care was established as a condition of the sale and is funded by the hospitals. The rationale is that Catholic health care represents a unique and

important niche within the American health care market, providing a strategic marketing advantage and brand recognition as it were for any owners. And so, an investment by the hospitals towards maintaining their Catholic identity was warranted. However, in our approach, the director of this office is hired by the diocese and serves as part of the Chancery staff. The director must be a Catholic in good standing with the Church, and have expertise in Catholic moral teaching, health care ethics, and the ERDs. The Director of Catholic Health Care serves as the primary liaison between the Director of Mission Integration within the hospitals and the diocese, and has regular meetings with both sides. The director also sits on the ethics committee for the hospitals, as well as the governing board as a representative of the bishop. And although the Director of Catholic Health Care works with the Director of Mission Integration, there is also direct two-way communication with the CEOs, CMOs, and CNOs of both hospitals that creates the spirit of mutual cooperation that lies at the heart of ecclesial relations with Catholic health care facilities. In effect, the Director of Catholic Health Care is an "outside person" working with the hospitals and providing an objective perspective and helpful input regarding their Catholic identity.

The third and final prong of this approach is the Vicar General – Vicar for Clergy of the diocese. Since the Director of Catholic Health Care works at the Chancery, there is direct and open communication with the Vicar General, who in turn keeps the bishop informed of all matters related to the Catholic identity of the hospitals. The Vicar General also sits on the ethics committee for the hospitals, and so is directly

involved in discussions of Catholic identity in those meetings with hospital personnel as well. The Director for Catholic Health Care also meets regularly with the Vicar General and the bishop. In effect, the Vicar General is the "inside person" for the diocese with direct access to the bishop. With this approach, the Director of Mission Integration in the hospitals, the Director of Catholic Health Care for the diocese, and the Vicar General representing the bishop, have direct, open, and continual communication. And given that the Director of Catholic Health Care operates with both the hospitals and the bishop's office, the lines of communication are seamless. This has allowed us to be proactive regarding areas of concern for the hospitals' Catholic identity, preventing many potential problems from ever arising. And in those few cases in which issues have arisen retroactively, the lines of communication allow us to address such matters in a timely fashion and avoid scandal. In sum, this three-pronged approach offers a truly integrated method of ecclesial relations that benefits the facilities through the direct and active support of the diocese for our local Catholic hospitals, while also benefiting the diocese by keeping the bishop continuously informed of their activities and providing open means of communication from his office to hospital administrators. This mutual understanding and support have strengthened the Catholic health care ministry in Kansas City, preserving and promoting the legacy of our founding Sisters. ✢

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ENDNOTES

1. For a summary of the relevant Codes, teachings of Vatican II, and the ERDs, see John J. Coughlin, "Catholic Health Care and the Diocesan Bishop," 40 *Cath. Law*. 85 (2000-2001). Available at: https://scholarship. law.nd.edu/law_faculty_scholarship/69, and Barbara Anne Cusack, JCD, "The Role of the Diocesan Bishop in Relation to Catholic Health Care," *Health Progress,* July-August 2006, pp.64-65.

2. Historical information provided by Marty Denzer, "St. Joseph's and St. Mary's Are Catholic Hospitals in Action," *The Catholic Key*, 9/11/2015, available online at: https://catholickey.org/2015/09/11/st-josephs-and-st-marys-are-catholic-hospitals-in-action/.

Ethics Documentation in the EMR: Exploring the 'Why' Behind Standardized Templates

Mark Repenshek, Ph.D., and Leslie Kuhnel, D.Be., HEC-C

As early as 1998, the American Society for Bioethics and the Humanities (ASBH), in *Core Competencies for Health Care Ethics Consultation*, makes the recommendation that ethics consultation should be documented in the patient's record or some other permanent record. Over 20 years later, it is not uncommon to find health care institutions that struggle to determine whether and to what extent such documentation should occur. In response to this need, the authors compared clinical ethics consultation (CEC) templates from two different institutions for consideration in various phases of development: design and implementation, and utilization.

RATIONALE FOR STANDARDIZATION IN DOCUMENTATION

ASBH's *Core Competencies for Health Care Ethics Consultation* and the Catholic Health Association's *Striving for Excellence in Ethics* represent two significant resources within the field that inform the standards by which CEC is performed. The latter resource offers the following under the heading "Consultation & Advisement 3.d.":

Guidelines for Ethics Consultation. The ethics consultation service operates according to established committee guidelines regarding documentation processes and standards.[1]

The former resource offers the following in its 1998 edition:

Documentation. Ethics consultations should be documented either in the patient record, or in some other permanent record. The results of consultations ethically requiring patient involvement should be communicated to patients. All consultation services should have a policy specifying the degree and type of documentation required for consults. Such documentation promotes accountability, optimizes communication, and facilitates quality improvement.[2]

ASBH reinforced this standard again in the 2011 revision of the Core Competencies document, stating:

Documentation. All case consultations in which the patient's participation is ethically relevant or that will have a material impact on the patient's care should be documented in the patient's medical record, except in rare circumstances … Standard forms or standardized electronic data entry are useful for ensuring that all important components of ethics consultations are consistently and thoroughly summarized in the patient's medical record.[3]

While the 2011 ASBH standards include both the normative claim regarding documentation in general, as well as offering suggested fields for consideration when creating a standardized documentation format, they do not fully explore "why" such documentation should be considered. From our perspective, the "why" can be found in how standardized documentation in the EMR is of benefit in the following three areas:

Education
- Clarifies the essential elements of a quality ethics consultation chart note for those reading the note
- Informs the ethics committee members and health care ethics consultants about the standards for clinical ethics consultation documentation

Communication
- Anchors documentation of ethics consultation across care settings within and beyond the patient's current hospitalization or medical encounter
- Highlights the critical recommendations from a clinical ethics consultation in the patient's EMR as a matter of transparency, consistency and efficiency

Quality
- Reduces the potential for unnecessary variability in approaches to documentation
- Provides data capture mechanisms for continuous quality improvement initiatives

EMR CEC TEMPLATES
Design and Implementation Phase
In the CHI Health – Midwest Division of CommonSpirit Health, a multi-site health care system employing a consultant model for ethics consultation, various opportunities for realizing the benefits of standardized template development prompted efforts to move towards standardization. While variability across individual consultants was minimal because of the limited number of people documenting consultations, designing and implementing a standardized template promised to be beneficial in that it could provide consistency across consultation events, as well as consistency in those instances where ethics consultations were documented by someone other than the primary consultant. Implementation of standardized templates held the possibility of creating efficiencies by providing a documentation framework that prompted for key elements within the consultation note, and of providing a communication shell that could be easily and more quickly completed. Finally, integration of the standardized documentation would allow for providers

and other health care team members to become familiar with the content, purpose and substance of ethics consultations, allowing them to quickly locate the various elements of the consultation note, such as the resulting recommendations, the ethical analysis, or even the follow-up contact information.

To this end, our system developed a consultation documentation template for use within the EPIC platform. Designed around the already-familiar SBAR (Situation-Background- Analysis/assessment-Recommendation) format used within other interdisciplinary communication, this template includes elements that provide background information, such as who requested the consultation and how, the modality of the consultation, who all was involved, the ethical analysis, and the resulting recommendations. Efficiencies are gained by utilizing pre-population functions of the EMR for such things as name, age, demographics, admissions/length of stay (LOS) data and other key elements of the consultation note. Recommendations are clearly highlighted with bold font, and contact information is incorporated automatically to make follow-up communication easier should other team members want to connect back to the consultant. The standardized template also includes information about what topics of ethics consideration have been addressed within the consultation itself, with the latest iteration of the template incorporating the Armstrong Clinical Ethics Consultation Coding System 2013©.*

The standardized documentation template developed at CHI Health continues to be refined based on feedback from stakeholders and benchmarking with similar organizations. Opportunities for expansion of its use across CommonSpirit Health are being explored as well, as are opportunities or adaptation into other EMR platforms.

One current positive outcome of the development and implementation of this standardized documentation template is the satisfaction of those using and referring to it. Benefits have already been realized in terms of the time efficiencies gained from the prompts regarding what to include. In addition, the various standardized elements help tell the story of the consultation in a way that brings as much clarity as possible to the often gray areas of ethics consultation, and that "speaks the language" of the EMR practices of other health care professionals.

Utilization Phase

In roles with both Ascension and with Hospital Sisters Health System (HSHS), design, implementation, and utilization of a CEC template for the EMR were relatively similar. In the case of this work within Ascension in 2015, unique challenges presented themselves with regard to the size and scale of such an initiative across seven EMR platforms. Within HSHS, the scope of the work was significantly reduced to a single platform.

Importantly, for the purposes of utilization, fields for documentation emerged that were consistent across both systems. These fields include:

- Requested Assistance
- Discipline Requesting
- Ethical Question, Inquiry or Concern Stated by Person Requesting Consult
- Patient Pertinent Clinical Information

- Disciplines Engaged in Ethics Consultation
- Applicable Ethics Policy Categories
- Patient's Preference(s)
- Reason for Ethics Consultation
- Category for Ethics Consultation
- Summary of Ethical Analysis

Once the documentation was finalized, standardized date and time stamp to the record was integrated.

It was important for EMR documentation to reflect the standardized methodology for case review. In this way, each category within the EMR template reinforced the essential elements of high-quality CEC. In both systems, the framework of Assess, Analyze, Act was used and served as the headers for the above fields.[4] In nearly all fields open narrative was significantly limited in favor of drop-down menus. This served a number of purposes, most importantly, to minimize unnecessary and risk-associated variance in the patient's medical record while creating opportunities for continuing quality improvement initiatives in CEC.

CONCLUSION

Two efforts at developing, implementing and utilizing a standardized documentation template are illustrated within the examples presented here. Though work in this area continues, already the benefits in terms of education, communication and quality have been realized.

Several long-term opportunities remain, including evaluating if standardized templates demonstrate increased efficiency and consistency over time, and how they are perceived by non-consultants reading the information contained within the consultation notes. There are also opportunities to see how such templates can provide for increased data collection and quality analysis over time. Finally, there are cross-organizational opportunities for sharing templates and developing standards that are agreed upon and adopted across the field, for internal and external benchmarking, and for the development of common recommendation phrases that can further educate colleagues about the reasons for various recommendations in a way that reflects professional standards. Ultimately, the goal is for the story of the ethics consultation to be told within the medical record in a way that demonstrates quality, consistency and reflects the professional standards of the field. ✛

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Socially Responsible Investment Guidelines

Mark Repenshek, Ph.D.; Christopher Ostertag; and John Paul Slosar, Ph.D.

Ascension's Ethics Department provides values-based ethical guidance to asset managers for Ascension and its affiliated entities. As a faith-based and non-profit entity, Ascension has a fundamental commitment to invest its assets in a socially responsible way. To this end, the Ethics Department of Ascension has developed a Socially Responsible Investment (SRI) Philosophy and Guidelines (the "Guidelines") with the intention of ensuring that the assets of Ascension and its affiliated entities are invested appropriately. The goal of this piece is to provide a brief summary of key elements of these Guidelines relevant to evaluating entities from an environmental stewardship perspective.

BRIEF SUMMARY OF AN
SRI PHILOSOPHY

Ascension is committed to exercising stewardship of financial resources through investments that are consistent with Ascension's mission, vision and values which includes refraining from investing in companies when that investment would entail implicitly condoning and/or directly contributing to activities that are understood within Catholic teaching to be morally wrong. Because Ascension understands that health care is first and foremost a basic human right, any investments in health care delivery organizations will be evaluated on the basis of whether their policies and practices are

consistent with that belief. Moreover, Ascension seeks to avoid investments in companies whose policies and practices contribute to the violation of human rights, whose policies and practices are directed specifically to opposing the moral teachings of the Catholic Church, whose policies and practices are consistently found to be discriminatory, or whose working conditions are exploitive. Ascension's SRI Guidelines are drawn out of the Catholic moral tradition and provide some specific guidance for investment and asset management. In addition to ensuring that its investments are not contrary to the principles of Catholic social thought, Ascension also makes investments that seek to further a social responsibility mission by focusing on investments that focus on environmental stewardship or are designed to improve access to certain social goods and services that are deemed basic human rights but may not be available (or are available only on a limited or inadequate basis) to the poor and vulnerable, such as health and health care, clean water, food and nutrition, financial services, and adequate and affordable housing and education.

SRI GUIDELINES:
ENVIRONMENTAL SCREEN

Recently, Ascension's investment manager requested the assistance of Ascension's Ethics Department to interpret and implement an environmental screen both of companies

currently in its investment portfolios and of companies in which Ascension may invest in the future. The SRI Guidelines provide the basis for the environmental screen, but, when tasked with screening hundreds of companies, we believe it is important to establish a standardized process to ensure the consistent application of the SRI Guidelines. For the environmental screen (as well as additional screens pursuant to the SRI Guidelines), we use a variety of tools and resources that provide company profiles as the basis for our review. Based on established factors and metrics, companies are scored and placed into one of four categories: very severe, severe, moderate, and minor. Because of the rigor of the research on each company, we can create a set of parameters specific to the categories themselves that are designed to assist in the evaluation process. For example, we can establish the principle that companies with "minor" environmental concerns need not be restricted from investment. Likewise, we can establish the principle that companies in the very severe category be automatically restricted from investment. For companies in the other two categories, we can then provide review with additionally developed guidance to address the following questions: (1) is the company's response to real or alleged environmental concerns substantive, consistent, and ongoing relative to the severity of the assessment category?; (2) has the company been consistently cited for violating environmental protection regulations?; and (3) does the company have policies and practices that contribute to the violation of human rights or are exploitative or discriminatory? With these considerations in mind, the Ethics Department of Ascension offered a reasoned evaluation as to whether restricting these companies from

investment is consistent with Ascension's SRI Philosophy and Guidelines.

The SRI Guidelines are both a useful tool for screening potential investments and an illustration of the mission, vision, and values of Ascension in action. Just as important as the Guidelines themselves is the process of developing and implementing such Guidelines, for this prayerful and reflective process challenges us to explore creative ways in which we might continue the healing ministry of Jesus in our ever-changing world. ✛

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Integrating Mission and Values Into Everyday Decision-Making for Leadership Teams

Emily Trancik, Ph.D.

Leaders in Catholic health care often express their commitment to make decisions consistent with the organization's mission and values. At times, they indicate a need for guidance, especially when questions regarding balancing stewardship and care for the poor and vulnerable arise. For the biggest of decisions, those which have a significant impact on our patient population or our associates, or those which have big financial and cultural repercussions, Ascension developed an Organizational Ethics Discernment Process (OEDP). While an OEDP is an opportunity for integrating mission, values, and ethical principles into decision-making, the full process is time and labor intensive. It typically involves weeks of preparation, a full-day meeting with many leaders, and the creation of a comprehensive report describing the decision made and process to get there. These full discernments are critical for making mission-oriented decisions on a large scale, but they can only be used for decisions having the most significant impact on associates and the patients we serve.

Every day, however, leadership teams are making decisions that affect how we live our mission, even if they involve a smaller set of stakeholders and don't justify mobilizing the significant resources of an OEDP. Nonetheless, a commitment to mission means that every decision at every level should be compatible with the values of the organization. In what follows, I will share a Values-Based Decision-Making Guide that can be used for systematic integration of mission, values, principles of Catholic Social Teaching, and aspects of spiritual discernment into day-to-day conversations in the boardroom.

This tool was developed when a local leadership team realized the need to have a systematic way of addressing values in every decision they make. The leadership team asked for guidance from ethics because they were feeling the tension between the need to make hard decisions for the sake of stewardship of resources, and a commitment to care for the poor and vulnerable. The result of the collaboration was the Values-Based Decision-Making Guide, a series of eight questions intended to help leadership teams enter into an ethical decision-making process. This tool is based on the more extensive OEDP, distilling

what is normally a long conversation into succinct questions for consideration. The whole conversation is designed to take between 30 minutes to one hour. While having an ethicist present to facilitate is helpful, the tool is designed to not require ethics expertise present.

An overview of the Values-Based Decision-Making Guide follows:

Values-Based Decision-Making Guide Reflection

Level setting and information gathering

1. Why is the decision difficult?
2. Do we have all the information we need to make this decision now?
3. Do we have input from the stakeholders who will be affected by the decision?

Integrating values and principles

1. How does this decision connect to service of the poor and vulnerable?
2. What creative alternative solutions have been explored?
3. What values and principles underlie the decision?

Follow up and implementation

1. How does the team feel about the decision being made?
2. What is the best way to implement the decision, being sensitive to all stakeholders?

Before engaging in this process, it is particularly important to reflect in preparation for the conversation ahead and to pray for a spirit of discernment. The tool itself begins with acknowledging the ethics dilemma by asking why the decision is difficult. The team may be experiencing ambiguity about the ethically optimal course of action. If a decision has already been made, it may result in difficult consequences for some stakeholders and there may be concerns about how to implement that decision. The team will likely be thinking about the tension between competing goods, and it should be stated. Second, as in any decision-making process, participants should stop to consider if there is any essential information still needed. Stakeholders who are not present should be given the opportunity to provide input. When a leadership team is making a decision on behalf of a unit or a service line or a center, to practice subsidiarity they should make sure to have that representation.

Only then can conversation shift to how the decision aligns with the organization's values and principles. Participants are encouraged to discuss the challenge to care for the poor and vulnerable and the role of good stewardship of resources. They are asked to consider if they have given enough time to exploring creative options, as creativity is one of Ascension's values often exercised during ethics conversations. The printed version of Values-Based Decision-Making features text boxes, which highlight definitions of preferential option for the poor, creativity and stewardship, to keep those concepts on their minds as the discussion occurs.

The conversation ends with a distilled version of a "Testing the Spirit" exercise, wherein participants are asked to place how they feel about the decision on a continuum of desolation to consolation. They could consider

how confident they are that the decision being made is the right one. If there is desolation, they are encouraged to discuss what might need to change to feel more confident in the decision. Finally, they consider the best way to follow through and implement, being sensitive to the needs of stakeholders affected.

Before recommending that it be used regularly or introducing the tool to other teams, it was piloted with the leadership team as a part of a retrospective review of a recent decision. They reexamined their original decision-making process through this framework, looking to identify how their conversation or decision would have been different if they had a systematic way to address the ethical dimensions of the decision and integrate values. A few key changes were identified. First, they invited leadership from the unit affected by the decision to be present for the retrospective conversation. Those stakeholders greatly appreciated having been included. Second, they noted an increase in discussion on the impact on poor and vulnerable persons, which had not been as emphasized previously. As importantly, they were able to highlight what went well in the initial conversation. The team had exercised great creativity in finding a solution for a population of patients who were affected by the decision, and their implementation and communication plan was strong.

It is important to note the cautions and limitations of use of a tool like this. First, before introducing a tool like this, a facilitator should ensure that participants understand that using this tool does not constitute a "discernment," a term that should be reserved only for when the full Organizational Ethics Discernment Process is implemented. This tool is intended

to increase the consideration for values into the decisions that are being made every day, and is not an alternative to a full discernment, nor is it intended to replace ethics consultation. Second, one reason why this tool worked so well was because a few key leaders on the team had been through a formation program. They were able to explain concepts and principles to leaders newer to Catholic health care. Openness to use of a tool like this, as well as its success, is dependent on the leaders' willingness to spend time exploring how ethical decisions are made, which comes from good formation. While a Values-Based Decision-Making tool can't replace the transformation of hearts and minds that comes through formation, the process does have formative elements. Later feedback from individuals from this leadership team indicated that the retrospective conversation used was an exceptionally transformative experience for them personally.

Ideally, after practicing the process several times, leaders would not need to go through it step-by-step and will have internalized the concept behind values-based decision-making into their normal processes. Ultimately, it is less important to be referencing a tool and answering eight questions than it is to have integrated mission and values into hearts and minds, and this tool can be used as a step along that journey to growth. ✛

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Legal Lens

AI 'OUTPERFORMS' DOCTORS DIAGNOSING BREAST CANCER

A study in the journal, *Nature*, suggests that artificial intelligence is more accurate than doctors in diagnosing breast cancer from mammograms. A study was conducted by researchers from Google Health and Imperial College London, who designed and trained a computer model on X-ray images from nearly 29,000 women. In reading mammograms, the algorithm outperformed six radiologists. The study indicated that the AI model used was just as effective as the current double-reading system used by the National Health Service radiologists. Moreover, it outperformed tremendously at cancer-identification in comparison to a single doctor. According to Professor Ara Darzi, report co-author and director of the Cancer Research UK (CRUK) Imperial Centre, "This went far beyond my expectations. It will have a significant impact on improving the quality of reporting, and also free up radiologists to do even more important things." Although very promising, for now these results were just part of a research study.

Fergus Walsh, BBC News, Jan. 2, 2020
https://www.bbc.com/news/health-50857759

IN THE DEMOCRATIC DEBATES ON HEALTHCARE: HOW MODERATE IS THE "PUBLIC OPTION"?

The single-payer health plans, also called "Medicare for All," proposed by Senators Bernie Sanders and Elizabeth Warren have been criticized as being "too disruptive" to the health insurance market. This criticism is not unwarranted: the implementation of a single-payer system would effectively eliminate the private insurance market and require tens of millions of Americans to give up health insurance that they may like. This is why candidates like Joe Biden and Pete Buttigieg have put a "public option" in their health care proposals, which would preserve the current private market and give people the option to choose government insurance. However, although a public option may be less disruptive than a single-payer system, if this public option is inexpensive and attractive, the notion that this will preserve the choice of private insurance may become a fallacy. Based on the market, though, it seems these public option plans would look similar to existing insurance, as the price of coverage would be high and the covered doctors and hospitals would be limited. In order for these plans to be successful they would need to have lower prices and demonstrate their value to

customers by offering special services. The plans could do so if they explicitly linked to Medicare — then requiring providers that accept Medicare patients to also accept public-option patients — which would allow these plans to have negotiating power in setting lower prices and covering more doctors and hospitals. But because Medicare is able to pay doctors and hospitals lower prices than private insurance there may be backlash in the form of some doctors no longer accepting Medicare patients. Ultimately a public option plan would not directly affect private insurers, but because it would affect consumers and the rules of the market, it could influence any insurance company's business decisions.

Margot Sanger-Katz, *The New York Times*, Dec. 3, 2019
https://www.nytimes.com/2019/12/03/upshot/public-option-medicare-for-all.html

MORE WORK REQUIREMENTS — THIS TIME FOR ACCESS TO FOOD STAMPS

The Trump administration has proposed three rules targeting the Supplemental Nutrition Program, known as SNAP — a program that feeds more than 36 million people. The first of these proposed rules will limit a state's ability to exempt work-eligible adults from having to maintain steady employment in order to receive SNAP benefits. Under the current rules, work-eligible adults between the ages of 18 and 49, without any dependents can only receive three months of SNAP benefits in a three-year period if they do not meet the 20-hour work requirement. But waivers have been allowed to be granted in states with high unemployment rates or a lack of sufficient jobs. The new proposed rule only allows states to issue waivers if the applicable city or county has an unemployment rate of 6% or higher, and the

waivers must be supported by the governor and will expire after one year. In the same way that Section 1155 waivers have claimed they will move people "from welfare to work" these rules are claiming the same, but it is predicted that this will disproportionately affect minorities and people with seasonal or part-time jobs. The Department of Agriculture estimates that over five years, this change would cut benefits to around 688,000 SNAP recipients, but it would save the administration $5.5 billion. The other two proposals also involve limiting eligibility, such that the Urban Institute estimated the three proposals would affect approximately 2.2 million households and 3.7 million individual beneficiaries. Denying basic food and nutrition to Americans who face the highest barriers to employment and economic stability will only worsen food insecurity in America and cause serious harm to individuals, communities, and the nation.

Juliet Linderman, *The Associated Press*, Dec. 4, 2019
https://apnews.com/46cda2574cbad2a31d52c33d07d7c77d

A WOULD-BE BIG $AVER FOR MEDICARE: DRUG PRICE NEGOTIATION

On Dec. 12, 2019, the House passed legislation to empower the federal government to negotiate prices with pharmaceutical manufacturers and ultimately lower the rising cost of prescription drugs. The bill also included provisions to create new vision, dental and hearing benefits, while also capping out-of-pocket drug costs for Medicare beneficiaries at $2,000. The central provision of the measure enables the Department of Health and Human Services to negotiate the price of up to 250 commonly used drugs — including insulin — and would also require pharmaceutical manufacturers to

offer the agreed-upon price to private insurers. Manufacturers would also be required to pay rebates to Medicare if the prices of their drugs increase faster than inflation. President Trump has stated he will veto the bill despite curbing the cost of prescription drugs being a central theme in his 2020 reelection campaign and the attractiveness of this priority among both voters and politicians across either side of the isle. Alongside President Trump, pharmaceutical companies and drug manufacturers are also strongly opposed to the bill. A less contentious bill has been proposed in the Senate, which would also cap out-of-pocket expenses and require the rebates paid to Medicare but does not include any negotiating power. Other bills that have drawn more bipartisan support tack on the requirement of price transparency from both pharmaceutical and insurance companies. Critics of the House bill warn that this would open the door to a government takeover of the prescription drug market and essentially force pharmaceutical companies to eliminate research and development, which would deprive the public of lifesaving treatments. Based on estimates by the Congressional Budget Office, over the next decade this House bill could result in approximately 20 fewer drugs created but also would save taxpayers $5 billion. It remains to be seen if the pockets of special interest backers or American citizens will be prioritized.

Sheryl Gay Stolberg, *The New York Times*, Dec. 12, 2019
https://www.nytimes.com/2019/12/12/us/politics/house-prescription-drug-prices.html

BILL OF THE MONTH: FOR HER HEAD COLD, INSURER COUGHED UP $25,865

Forty-year old Alexa Kasdan's week-long sore throat led her to go see a doctor. She went to her primary physician at Manhattan Specialty Care just off Park Avenue South. When the bill came, although insured by Blue Cross and Blue Shield through employment insurance, Ms. Kasdan's bill totaled $28,395.50 for an out-of-network throat swab. Her insurer presented her a check for $25,865.24. There are many reasons this lab work could cost so much. According to Dr. Ranit Mishori, professor of family medicine at the Georgetown University School of Medicine, the lab tests ordered were entirely unnecessary. She said, "There are about 250 viruses that cause the symptoms for the common cold, and even if you did know that there was virus A versus virus B, it would make no difference because there's no treatment anyway." Another reason could account for the high cost — using an out-of-network lab for analysis. And, yet another cause for the shocking price could have been a connection between the lab and Alexa Kasdan's doctor. Richelle Marting, a lawyer specializing in medical billing, indicated that this is a common problem for insurance companies and practices like this eventually drive up premiums for all plan participants. Investigations of this case are currently underway.

Richard Harris, NPR News, *Kaiser Health News*, Dec. 23, 2019
https://khn.org/news/medical-bill-of-the-month-head-cold-throat-swab-dna-tests-insurer-coughed-up-25k/

AS VAPING-RELATED DEATHS RISE, ARE REGULATORS DOING ENOUGH?

On Jan. 2, 2020, the Trump administration announced a ban on popular e-cigarette flavors, including fruit and mint, while allowing only menthol and tobacco flavors to remain on the market. Department of Health and Human Services secretary Alex Azar stated this approach was a "smart, targeted policy that protects our

kids without creating unnecessary disruption [in the market.]" This ban has been met with immediate criticism from public health advocates claiming it does not do enough to protect teens and limit access to e-cigarette products. This flavor ban also does not apply to all e-cigarette liquids, only to those used in disposable pods; e-cigarette liquids that are used in 'open tank' e-cigarettes, often sold at vape shops are not subject to this ban. Defenses of the exemptions to the ban claim that a complete ban would lead to an underground market for illegal vaping products and job losses. Whereas critics, such as Gary Reedy, chief executive of the American Cancer Society, claim this ban to be "a hollowed-out policy that will allow the tobacco industry to continue to attract kids to a lifetime of nicotine addiction." This ban has no impact on the company Juul because they had already pulled these flavors amid criticism linked to surges in teenage use, but now their competitors will be forced to do the same. The flavors that remain are claimed to be unpopular among teenagers, but public health advocates claim they will just simply switch to menthol. The policy will go into effect in early February of this year. Whether it has any effect on documented lung injuries and the percentage of teen-users will be observed.

Chris Kirkham, *Reuters*, Jan. 2, 2020
https://www.reuters.com/article/us-usa-vaping/trump-administration-restricts-some-e-cigarette-flavors-idUSKBN1Z11B7

THE DAMAGE OF VACCINE MISINFORMATION

An analysis of vaccination trends in Denmark shows just how detrimental vaccine misinformation can be. Due to wrongful information about the human papillomarviruspapillomavirus (HPV) spreading across Danish media outlets, thousands of young females did not receive the vaccine. The study was conducted by researchers at the University of North Carolina at Chapel Hill, who looked at four different time periods to study HPV vaccination rates in Denmark. Researchers found that after the scare induced by the misinformation, there was a 50 percent drop in vaccinations, causing approximately 26,000 Danish females to be left unvaccinated. According to study author Peter R. Hanses, professor of economics at UNC, "Denmark is a good case study to see how a country deals with vaccine misinformation. By using anecdotal stories, media can create a false equivalence between outrageous claims and scientific facts." This study is essential, as HPV vaccinations are safe and can prevent up to 90 percent of cervical cancers."

Kayla McKiski, *U.S. News & World Report*, Jan. 23, 2020
https://www.usnews.com/news/health-news/articles/2020-01-23/the-damage-of-vaccine-misinformation

Literature Review:
Cultivating a Lens of Mutual Learning Among Contraception and NFP Literature

Kirsten Antonacci Dempsey, MA

A LENS OF MUTUAL LEARNING

As new literature arises on controversial topics in Catholic health care like contraception and natural family planning (NFP), it is helpful to use a particular lens to elucidate positive takeaways from different viewpoints. Julie Rubio provides such a lens in her 2005 article, "Beyond the Liberal-Conservative Divide on Contraception: The Wisdom of Practitioners of Natural Family Planning and Artificial Birth Control," where she examines *Humanae Vitae* alongside the experiences and arguments of advocates on both sides to search for common grounds.[1] By promoting an understanding of reasons why each side uses their respective methods, Rubio establishes a lens of mutual learning from which to evaluate the methods themselves. Rubio's hope "is that bringing the distinctive experiential wisdom of both groups into relief and exploring the common ground that both sides share will make room both for respectful agreement and mutual correction."[2] This approach seems capable of bridging divides and fostering fruitful conversations. This is especially valuable in Catholic health care given the moral commitments to abide by the *Ethical and Religious Directives* amid diverse religious, political, and social views among the employees

who work for, and patients who receive care at, Catholic institutions. This lens of mutual learning can aid ethicists, clinicians, and others in Catholic health care to meaningfully engage with new research arising in both the contraceptive and NFP literature. Using Rubio's approach, I will examine two recent works from these literature circles and suggest how each can learn from the other.

RECENT NFP LITERATURE

Unseld, Matthias, Elisabeth Rötzer, Roman Weigl, Eva K. Masel, and Michael D. Manhart. 2017. "Use of Natural Family Planning (NFP) and Its Effects on Couple Relationships and Sexual Satisfaction: A Multi-Country Survey of NFP Users from US and Europe." *Frontiers in Public Health* 5 (42). doi:10.3389/fpubh.2017.00042.

Unseld, Rötzer, Masel, and Manhart (2017) conducted a multi-country survey to examine effects of NFP on couple's relationships and sexual satisfaction. Two online questionnaires were created, for women and men respectively, translated from German to English, Polish, Italian, Czech, and Slovak, and then distributed to all current email addresses of two major NFP organizations in the US (Couple to Couple League, CCL) and Europe (Institut für Natürliche Empfängnisregelung, INER), which teach the symptom-thermal method (involves

cervical mucus observation combined with temperature). A total of 2,560 respondents completed the questionnaire between February and April 2015, with 32.4% U.S. respondents and 43.7% European respondents, 77% female and 23% male. Most were married (89%), well-educated (73% hold a university degree), and described their financial status as "good" (46%) or "very good" (19%). Average NFP use was 8.5 years (+/- 8 years), and 80% of the 95% who reported using NFP use sympto-thermal method. Users learned their method from a trained NFP counselor (74%) and/or by reading an NFP book (54%).

The authors surveyed four effects of NFP on relationship dynamics: gaining knowledge of one's body, developing one's relationship, valuing partner's interest in NFP, and explaining sexuality to children. Ninety-five percent of women and 55% of men said using NFP has improved knowledge of one's body. Among first year users, 92% (n = 297) affirmed this. Majorities of men (74%) and women (65%) stated NFP use improved their relationship and the authors found that education level did not impact this improvement. Regarding partner involvement in NFP, 94% of women and 96% of men felt their partner's interest is either "very important" or "important." For respondents with children, over 80% of respondents indicated the knowledge gained by using NFP helped them explain sexuality to their children.

The survey then examined five effects of NFP on sex life: speaking about sexuality in one's relationship, enjoying sex life, improving knowledge and understanding of sexuality, frequency of sex, and satisfaction rates with frequency. Most women (69%) and men

(72%) pronounced that NFP enhanced their ability to discuss sexuality with their partner. Over 80% of respondents stated NFP improved their knowledge and understanding of sexuality, again without education level impacting responses. Of respondents in a relationship, approximately 62% of all respondents said NFP improved their sex life overall. Regarding frequency, men and women responded similarly, with almost half indicating they have sex four or more times per month. Seventy-five percent of women and 73% of men said they were "satisfied" or "very satisfied" with their frequency of sex.

This survey provides valuable insights on the experience of NFP users. The authors' results reflect former studies, like VandeVusse (2003), Fehring (2016), and Oddens (1999). However, their work expands on earlier studies because they have a larger and geographically diverse respondent size of over 2,500 individuals from seven different countries, thus enhancing generalizability across countries and cultures. Their study is limited, as the authors acknowledge, by the respondents' profile reflecting generally married, well-educated, and financially secure individuals, which may limit generalizability to non-married, less well-educated, and/or less financially stable individuals.

RECENT CONTRACEPTION LITERATURE

Bitzer, Johannes, Victor Marin, and Josefina Lira. 2017. "Contraceptive counselling and care: a personalized interactive approach." *The European Journal of Contraception & Reproductive Health Care* 22 (6): 418-423.

Bitzer, Marin, and Lira (2017) discuss studies on deficiencies in contraceptive counseling and care (CCC) and respond with an approach to CCC that improves shared decision-making by tailoring contraception to each individual. Examining European and global studies, the authors organize gaps and deficiencies into four issues. First, healthcare providers (HCPs) seldom listen to patient concerns and lack patient-centered communication skills. For instance, HCPs generally guide discussions about contraception with little room for patients to express their opinions. Second, HCPs often lack time to take sexual and reproductive health histories, given that consultations are frequently reported to be around five minutes. Third, HCPs lack knowledge and training about methods and guidelines for use and safe prescribing. Studies reveal that patients often receive outdated, erroneous information about method characteristics, risks, and benefits, which the authors suggest may result from insufficient education on contraception in obstetrics and gynecology residency programs. Fourth, HCPs commonly dominate clinical interactions and do not meaningfully involve users in decision-making, with method selection largely depending on provider preference. These issues impact selection of methods appropriate to a patient's biopsychosocial (BPS) profile, goals, and values, which can then affect adherence.[3]

In response to the above weaknesses, the authors seek to develop a holistic approach to CCC by utilizing literature standards and the concept of interactive shared decision-making. They identify three elements of good CCC: 1) building a trustful relationship, 2) informing, educating, and empowering women/couples regarding their sexual and reproductive

health, and 3) helping women/couples to choose or change a method to best fit their needs, values, and BPS profile. The authors clearly and thoughtfully describe behavioral characteristics and practices that build trust with patients, like active listening and inviting questions. To the second element, their goal is for the woman/couple to know and understand how each method works, and what its efficacy, risks, benefits, and side effects are such that the patient becomes expert on the method and the method becomes 'her/their own.'

Regarding method selection, the authors outline a five-step approach for counselors to use: 1) Listen to patients' needs, priorities, and values, and exclude methods that do not meet them, 2) Assess patients' BPS profiles and exclude methods based on medical and psychological criteria, 3) Look for possible benefits of remaining methods, 4) Show the benefit/risk ratio of available methods and foster shared decision-making, and 5) Accompany the woman through follow-up visits and proactive discussions to ensure safe, effective use. Ultimately, the three elements correspond with literature revealing positive impacts from patient-centered care, relationship-building, and shared decision-making. The authors' straightforward approach to address current counseling deficiencies contributes to the ongoing research for more personalized, holistic approaches to family planning counseling.[4]

MUTUAL LEARNING
To encourage mutual learning among these articles, Rubio's approach involves first examining common grounds. One point is a common interest in counseling strategies that involve shared decision-making between HCP

and patients. Bitzer et al. work toward this by outlining a new approach for counseling. Unseld et al. see this reflected in satisfaction of users with NFP methods and positive reports on relational and sexual questions. Another point is the common interest in promoting knowledge and understanding of one's method. Bitzer et al. encourage this through their interactive, personalized approach to counseling to find a method best suited to a patient's needs, values, and BPS profile. Unseld et al. find NFP users experiencing an improved understanding of their sexuality, their bodies, and satisfaction with their method, suggesting that NFP counselors are utilizing a shared, personalized approach to counseling.

Having examined some common grounds, each side can proceed to learn from the other. The contraception literature on holistic counseling strategies is more abundant than the NFP literature, which is only mentioned briefly in articles describing NFP methods. NFP literature could expand research in this area. Conversely, Unseld et al.'s article reveals affirmations of NFP methods' positive impact on some of the very deficiencies identified in CCC literature. For instance, if NFP users report improvements on relationship and sexual factors, then NFP counselors are likely listening and responding to patient needs, priorities, and values that affect these factors. If NFP users are more knowledgeable about their bodies and sexuality, and feel better equipped to discuss sexuality with their partner and explain it to their children, then NFP counselors are likely informing, educating, and empowering women/couples regarding their sexual and reproductive health. Concerning method selection, NFP counselors are typically trained in one method so their strategies to respond to women/couples'

goals and values is to educate them how to use their method toward their needs or goals, such as avoiding or achieving pregnancy. NFP counselors and physicians could take Bitzer et al.'s advice to improve education on other NFP methods to enable more suitable method selection among NFP methods based on the needs, priorities, and values of each patient.

Further research among both literature circles could work to incorporate the positive takeaways from each side. Employing a lens of mutual learning can encourage this research and foster fruitful conversation among these different views. Such mutual learning can aid HCPs and counselors in improving the clinical encounter and working with patients to better understand and meet their reproductive needs, goals, values, and BPS profiles. ✛

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ENDNOTES

1. Julie Hanlon Rubio, "Beyond the Liberal/Conservative Divide on Contraception: The Wisdom of Practitioners of Natural Family Planning and Artificial Birth Control," *Horizons* 32, no. 02 (2005): 271, accessed November 4, 2016, doi:10.1017/s0360966900002553

2. Rubio, "Beyond the Liberal/Conservative Divide on Contraception," 291.

3. A BPS profile is the collection of biomedical, psychological, social, and other factors (i.e. relational and sexual) that affect a patient's healthcare decision-making.

4. I recognize there are theological and practical challenges with referring to contraceptive counseling and family planning counseling interchangeably, but it is not in this article's scope to address them.
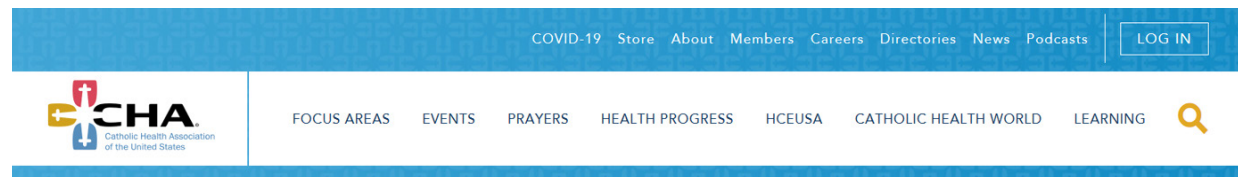
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CHA has created a webpage with information, prayers and resources from our members and other reliable sources related to COVID-19, available at www.chausa.org/coronavirus.

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Catholic health care is on the front lines responding to the coronavirus outbreak in the United States. During this time, we pray for all those affected by the virus. Below is a sampling of statements, information and resources from our members and other reliable sources related to COVID-19. **For the latest notices, waivers and regulations see the** CMS and HHS **websites.**

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• April 16 - Palliative Care and COVID-19: Implications for Clinical Practice (Part 3)

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For the latest COVID-19 notices, waivers and regulations see the CMS website.

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