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FEATURES

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SAINT LOUIS UNIVERSITY

The Third Annual Catholic Healthcare Innovation in Ethics Forum

Mark Repenshek, Ph.D.
Becket Gremmels, Ph.D.

The third annual Catholic Healthcare Innovation in Ethics Forum (CHIEF) was hosted by Ascension and CommonSpirit Health in September 2021. Rather than a hybrid of in-person and virtual due to the COVID-10 pandemic, CHIEF was again held completely virtual. The planning committee, made up of ethicists from Ascension, CommonSpirit Health, Providence Health & Services, OSF HealthCare, Mercy Health System, and SSM Health, affirmed the goals of CHIEF: to provide a venue for ethicists working in Catholic health care to present innovative ideas or projects, receive critical feedback, and contribute to evolving the way Catholic health care thinks about and implements ethics.[1]

As in years past, we solicited talks on specific focal areas. This year the planning committee selected:

- Ethics Outside the Hospital
- Ethics and Data Science
- High Reliability in Clinical Ethics

The majority of the conference time over the two days remained as lightning talks. Each presenter was limited to seven minutes and three slides (plus a title slide). Presenters were grouped by subject area, and each group was followed by a 45-minute panel discussion and Q&A with the presenters from that session. Over the two days, there were 24 presentations from 20 ethicists on topics ranging from "Recalibrating Clinical Ethics Toward Justice" to "Benchmarking and Variance Analysis in Clinical Ethics Consultation."

In addition, the conference planning committee decided to create two breakout sessions that intentionally would not follow the lightning talk format. For each session, we invited subject matter experts for a 15-20 minute presentation followed by engaged dialogue on a tangible work product. This format allowed us to do a "deeper dive" on two areas. The first was "Ethics and Data Science: The Experience at the VA" offered by Dr. Ken Berkowitz, Acting Special Advisor, National Center for Ethics in Health Care, US Department of Veteran Affairs and the second was "Striving for Excellence in Ethics 3.0" offered by Dr. Nate Hibner, Director, Ethics, The Catholic Health Association.

As with the CHIEF 2020, the planning committee approached the virtual format with the desire to optimize the virtual format rather than simply look at it as a substitute to an in-person gathering. To that end, this year's conference utilized a Virtual Conference Platform. The Virtual Conference Platform

allowed for participants to network during conference "brain breaks" or request to meet with other participants in a variety of virtual meeting rooms to discuss session content further.

We were once again blessed this year with a keynote presentation from a leader in the field, Carol Taylor, PhD, MSN, RN. Dr. Taylor preserved the tradition of CHIEF keynote presentations offering more of a retreat-like engagement, hers being "Reflection on a Lifetime of Grace: Emerging Challenges." Throughout the keynote, Dr. Taylor allowed for moments of reflection on the themes of Vulnerability, Empathy and Health Equity, as well as contribution from conference participants which she then seamlessly wove into her talk with reflective responses.

Evaluation data indicate that CHIEF 2021 was again a success. With 79 participants, CHIEF continues to increase attendance each year. Over 93% of participants thought the event had a "high" or "higher quality" when compared to other professional events attended. Nearly 77% of survey respondents indicated that they would "likely" or "very likely" make changes to the ethics services at their respective organizations as a result of attending CHIEF. Such changes include but are not limited to implementing training in bioethics for clinical staff, designing indicators and measurement tools that allow for improvement in the clinical environment, and striving for a better incorporation of charity — being an instrument of grace during challenging and complex interdisciplinary ethics conversations. The CHIEF Planning Committee is still working to find the right balance and use of the "brain break" sessions as indicated by survey data on suggestions for improvement. Finally, it appears from these data that regardless of whether we proceed in-person or virtual, CHIEF will continue to be well received as over 50% of survey respondents said "CHIEF was great no matter the format."

We remain grateful to The Catholic Health Association for their offer to publish summaries of presentations in *Health Care Ethics USA* for presenters who wished to submit. We look forward to CHIEF 2022 again this fall, preserving its well-received format. ✣

ENDNOTE

1. You can find more information about CHIEF and the agenda here: www.missiononline.net/chief-2021-09151621/#

Data Entry and Analytics: One Year With Ascension's Ethics Integration Database

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In April of 2020, amidst a flurry of activity related to COVID-19 across all of healthcare, a small cohort of ethicists within Ascension decided to embark on a redesign of the "Ethics Tracker" database. At the outset of this project there was agreement that the redesign needed to be guided by end-user input, that the database would be structured in such a way that the ethics department of Ascension could make decisions guided by the data captured, and that data visualization would help Mission Integration as a whole "tell our story." These goals, guided by a Usability Testing Process and Redesign in collaboration with expertise from the Ascension Studio team, helped the Ethics Center of Expertise (CoE) avoid some of the pitfalls of past database design and bring to scale a data entry and visualization system called Ethics Integration Database (EID).

USABILITY TESTING

In the early phases of the redesign process, we connected with the User Experience (UX) team at Ascension Studio to learn about ways we might improve the ethics database for end-users. After discussing how and by whom our database is used, the UX design team recommended we do usability testing as part of our redesign process. Usability testing allows us to gain insight into the end-user's experience of the database and to incorporate this feedback into the redesign process itself, thereby allowing end-users to be an integral part of the redesign process. Our engagement of the usability testing process consisted of the creation of a usability test plan, usability testing, and the incorporation of usability testing feedback into the redesign process.

A usability test plan is essential to help ensure consistency across the usability testing process. In this test plan, we first identified the testing subjects. We were able to include users from all roles who would be entering data into our database, users from different markets as well as the system office, and users with varied experience entering this kind of data. Our test plan also included a script for usability testing to ensure consistency across each testing session, as well as a template for recording feedback from the user during testing. Finally, our test plan included three case scenarios which would serve as the basis for a testing subject to enter a record into the database.

Each usability testing session included a facilitator, a note-taker, and the testing subject. Given the location of our testing subjects and the presence of a global pandemic, we utilized a virtual format for our testing sessions. Using

the script from the test plan, the facilitator would first provide a high-level overview of usability testing and our ethics database. Next, the facilitator would ask the testing subject to share their screen. The facilitator would read through the first case scenario and then ask the testing subject to enter this record into the database. Importantly, we asked the testing subject to "talk aloud" throughout the testing session, so we could know what the testing subject was thinking as s/he was entering the data for the scenario. The note-taker would try to capture everything that was said by the testing subject throughout the testing session and would generally capture how the testing subject was recording the case scenario in the database. We would provide very minimal guidance for the testing subject while entering the case. After completing the first case scenario, we would do the same for the second and third cases. Our ethics database is accessible by desktop and mobile platforms, so we made sure every testing subject used both desktop and mobile platforms — and we changed up the order of their use to avoid order bias.

Finally, after completing all of our usability testing sessions, we compiled all the notes from the testing sessions and looked for themes. Surprisingly, we discovered strong themes after only a few testing sessions. We discussed the results of the usability testing in a redesign group meeting and were able to make changes to the database that were driven by the end-users.

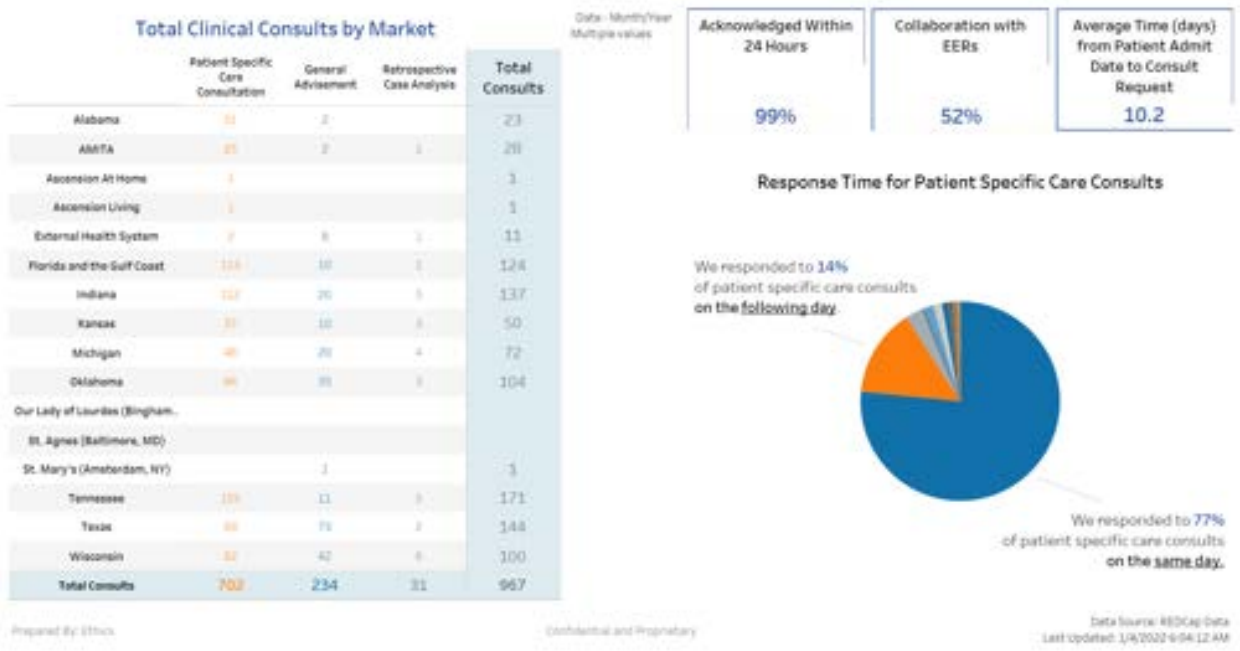
DATA ENTRY AND VISUALIZATION

The timing of the redesign of our database was somewhat serendipitous as we were able to take advantage of two platforms that Ascension began to formally support through internal infrastructure — REDCap and Tableau. REDCap was created at Vanderbilt University in 2004 in response to the growing need for a secure data collection tool that met HIPAA compliance standards. That development led to the REDCap consortium in 2006 which began as a group of non-profit organizations interested in expanding the functionality of REDCap through collaboration.[1] Relative to the design of EID, use of REDCap allowed the Ethics CoE to take advantage of well over a decade of database design with the additional benefit of internal experts to design a structure that would yield high usability.

Tableau is a visual analytics platform. Tableau was founded in 2003 as part of a computer science project at Stanford that desired to make data analysis more visually appealing and more easily interpreted by the general population.[2] Mission Integration has begun work to communicate its "empirical narrative" in the same way all other clinical and operational entities have done. Relative to the "empirical narrative" of EID data entered into REDCap, use of Tableau allows the Ethics CoE to provide data visualizations regarding all domains of ethics service.

Use of these two platforms greatly increased the appeal of data entry, as those inputting records could visualize models, tables, etc., directly related to the data entered. This was an important first step in redesign as the insights gained from usability testing were able to be implemented in the redesign of EID. This redesign has also enabled the creation of a significant number of dashboards (n > 30 at this time) within Tableau for data visualization and communication throughout the healthcare

TABLE ONE



ministry. For example, Table 1 is a dashboard illustrating our data for FY 21 related to Clinical Consultation.

Ascension's data analytics visualization tool provides the ability to see the volume of clinical consultation across Ascension broken down by Ministry Markets and by sub-type (i.e., Ascension Clinical Ethics Taxonomy) of clinical consult as well as several other "key performance indicators". Specifically, the key performance indicators shown on the right side of Table One include the number of clinical consults acknowledged within 24 hours of request; percentage of clinical consults entailing some sort of collaboration with at least one Embedded Ethics Resource (EER — members of our Ethics Integration Committees trained in certain types of clinical ethics consultation); and average time from "patient admit date to consult request."

These data allow us to better understand the demand for different types of clinical ethics consultations (e.g., patient specific care consults versus general advisements and retrospective case analyses). The other metrics related to response time, collaboration with Embedded Ethics Resource and "average time (days) from patient admit to consult request" are indicative of whether Ascension's clinical ethics consultation service delivery model is working in moving consult requests upstream and allow us to identify opportunities for continuous quality improvement.

In addition, the Ethics CoE shares an Organizational Ethics Overview, Ecclesial Relations Overview and an Education Overview Tableau dashboard with the entire organization through the Ascension Analytics Hub. Internal to the Ethics CoE, a variety of additional dashboards allow us to "drill down" on specific

areas for further inquiry and data analysis. By its very nature, this work will be ongoing as we continuously explore new questions based on our current and future data set. Nonetheless, a single data repository for analytics has been incredibly beneficial to improve both the quality of the work we do and inform decision-making for the Ethics CoE across the entire organization.

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ENDNOTES

1. For more information on REDCap, see: https://projectredcap.org/. Accessed on December 31, 2021.
2. For more information on Tableau, see: https://www.tableau.com/. Accessed on December 31, 2021.

Revising Repenshek's Minimum Standard Set of Data

Becket Gremmels, Ph.D.

Establishing a minimum standard set (MSS) of data to collect is key for Catholic health care as Clinical Ethics Consultation (CEC) Services and Ethics Committees increasingly base their work and strategy on consultation data. An MSS that is widely agreed-upon and implemented would allow Catholic healthcare to: (1) compare data between hospitals, ethics consultants, Ethics Committees, and health systems; (2) develop standard methods of calculating the return on investment (ROI) for clinical ethics consults, similar to palliative care;[1] and (3) create a baseline for quality assessments of individual consults and CEC services.

Mark Repenshek has outlined a minimum standard set (MSS) of data that Ethics Committees should include in a database on clinical ethics consultation (CEC).[2] He lists nine data points as "the bare essentials for starting a CEC database" (see Table 1). Repenshek emphasizes that "an MSS is truly that — the minimum set necessary." CEC Services and Ethics Committees can and should add other data points that they see as relevant, but should at least include capture these elements. He describes his MSS elements in detail elsewhere and makes the case for why they should be included. To clarify, the Patient Encounter Number is the identification number unique to the hospitalization in question, and Location means what kind of unit the patient is in such as ICU, oncology, emergency department, ambulatory, etc.

However, several other fields appear necessary to achieve the goals of an MSS for CEC in Catholic health care (see Table 1). Each of these fields has unique benefits for assessing a CEC service. For example, the patient's discharge date allows for a calculation of the patient's total length of stay (LOS) which is required for many ROI metrics.[3]

A few fields can provide a quick snapshot of the patient's clinical situation, specifically the patient's discharge disposition, primary diagnostic related group (DRG) or ambulatory payment classification (APC), and type of decision maker.[4] This in turn provides context for the ethical issues in the case. For example, a patient discharged to hospice with renal failure and a medical power of attorney typically presents different kinds of ethical issues and requires different actions than a patient discharged home with substance abuse who is unrepresented. Including the APC, and visit date in addition to admission date, ensures the MSS does not focus exclusively on inpatients. These fields do not provide a complete picture of the clinical situation, and other additions may improve the expanded focus to non-acute settings, but they are enough for a minimum standard set of data.

Other fields describe the consult itself. The names of the ethics consultant(s) involved,

the actions they took in the consult, the type of consult, and the secondary reason for the consult provide a brief glimpse as to what the consult was about and what occurred. The names of the consultant(s) and actions taken allow for quality assessment of individuals and teams. Stratifying consults by type permits cursory analysis of the consult's complexity, depending on how the categories are defined. Finally, adding a second reason for the consult gives more detailed insight into the ethical issues involved. Comparing actions in the consult, consult type, and the reasons for the consult between health systems would require standard terms, classifications, and definitions for these fields. While some examples exist, there are no standards as of yet.[5] However, even a standard within a system would be more informative than none at all. Again, this does not give a full picture of what occurred but it is a minimum.

Lastly, the number of licensed beds in the hospital and number of ICU beds are required to calculate the Consult to Bed Ratio (CBR) and Consult to ICU Bed Ratio (CiBR).[6] These recently developed metrics to assess the volume of consults in a hospital. Case Mix Index provides insight into the acuity and complexity of the patients in the hospital. These three fields are static and do not change for each patient, which reduces the time needed to input the data.

TABLE 1

Revised Minimum Standard Set of Data*			
1. Medical Record Number	6. CEC Request Date	**11. Patient Discharge Disposition**	**16. CEC Type**
2. Patient Encounter Number	7. CEC Consult Date	**12. Primary DRG \ APC**	**17. Secondary Reason for CEC**
3. Patient Admission \ **Visit** Date	8. CEC Time Commitment	**13. Type of Decision Maker**	**18. Licensed Beds in the Hospital**
4. Discipline Requesting	9. Primary Reason for CEC	**14. Ethics Consultants Involved**	**19. Licensed ICU Beds**
5. Location	**10. Patient Discharge Date**	**15. Actions Taken by Ethics Consultants**	**20. Hospital Case Mix Index**

*Elements 1 through 9 are Repenshek's proposed MSS. The revised MSS proposed here includes his and adds those in bold.

A significant obstacle to collecting data in these fields is the time needed for data entry. Most ethics consults are still performed by volunteers, i.e. physicians or employees who have other full time jobs. An additional request could push them to stop volunteering to do ethics work, or they may simply not enter any data at all. Of the 20 data points proposed here, nine (eleven if the EMR documentation already captures type of decision maker and ethics consultants) are able to be automatically pulled in a report from the EMR or a data repository. Only the eleven (possibly nine) specific to the ethics consult, such as CEC Request Date or the reasons for the consult, need to be documented by the consultant. However, it is likely that many of these fields are already included in the consultant's EMR documentation and again can be pulled automatically. Automating the process of data collection improves the volume of data collected and likely the quality of data as well. The patient encounter number can serve as a flag to easily identify the patients in question.

The revised MSS proposed here increases the ability for continuous quality improvement related to CEC, enhances comparisons of CEC work between ethics consultants and Ethics Committees, and improves analysis of relationships between the kind of work done in a consult and the consult's outcomes. A commitment to implementing this MSS, or a similar one if agreed upon, would benefit all Catholic hospitals and could change the field of clinical ethics in Catholic health care.

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ENDNOTES

1. For an example, see the Hospital Impact Calculator by the Center to Advance Palliative Care (CAPC). www.capc.org/impact-calculator
2. Mark Repenshek, "Creating a Clinical Ethics Consultation Database." *In* Catholic Health Care Ethics: A Manual for Practitioners. *National Catholic Bioethics Center*, 3rd edition, 2020, p 6.39-6.46.
3. Homan, Mary E. "Factors associated with the timing and patient outcomes of clinical ethics consultation in a Catholic health care system." *The National Catholic Bioethics Quarterly* 18, no. 1 (2018): 71-92. Repenshek, Mark. "Examining Quality and Value in Ethics Consultation Services." The National Catholic Bioethics Quarterly 18, no. 1 (2018): 59-68.
4. An alternative to primary DRG worth considering is the Major Diagnostic Category (MDC) which has fewer, more generic categories. However, this presentation at CHIEF 2021 mentioned primary DRG.
5. For consultation types, see Kenney, Matthew R. "A System Approach to Proactive Ethics Integration." *The National Catholic Bioethics Quarterly* 18, no. 1 (2018): 99. American Society for Bioethics and Humanities, Core Competencies for Health Care Ethics Consultation, 2011, 2nd edition, 10-11. For reasons for consultation, see Armstrong Clinical Ethics Coding System, 2013.
6. Glover, Avery C., Thomas V. Cunningham, Evelina W. Sterling, and Jason Lesandrini."How much volume should healthcare ethics consult services have." *The Journal of Clinical Ethics* 31, no. 2 (2020): 2-16. Feldman, Sharon L., Sundus H. Rias, Joshua S. Crites, Jane Jankowski, and Paul J. Ford. "Answering the Call for Standardized Reporting of Clinical Ethics Consultation Data." *The Journal of Clinical Ethics* 31, no. 2 (2020): 173-177.

What Bioethics Grad Students Want in Catholic Health Internships

Jaime Konerman-Sease, Ph.D.(c)

Cultivating a pipeline remains a popular topic in the world of Catholic health care ethics since CHA identified the need for a pipeline for new ethicists as part of Project Legacy. *HCEUSA* has previously published examinations on developing and running an internship program[1] as well as attempts to create shared terminology, expectations, and structures for a pipeline.[2] This survey contributes to the project of building an ethics pipeline by examining what graduate students in bioethics want in Catholic health internships. Exploring the desires and interests of potential interns is an important step to creating successful internships as positive internship experiences are likely to lead to a broader candidate pool for positions in Catholic health care ethics.

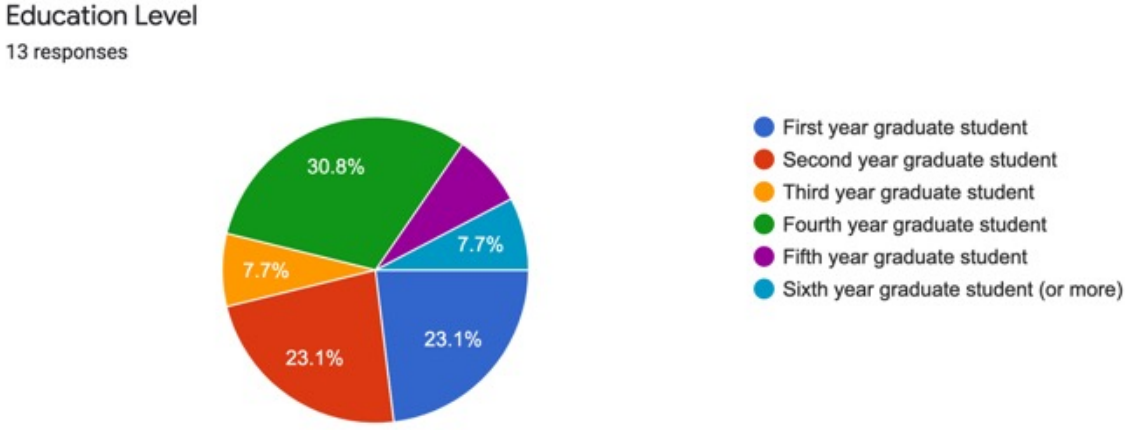
METHOD

In the summer of 2021, a brief 24 question survey was sent by email to graduate students in Bioethics programs from a variety of programs. Questions focused on interest in participation in different aspects of clinical ethics including ethics committees, consultation, chart notes, case discussions, and clinician education. Answers were gathered via google form and no identifying information was collected.

RESULTS

Characteristics of Respondents

Thirteen students responded. Three first-year graduate students, three second-years, one third year responded, four fourth years, one fifth year and one sixth year. Eight have never completed an internship in Catholic healthcare, three were current interns, and two were former interns.



EXPERIENCES VALUED BY FORMER AND CURRENT INTERNS

Former interns valued the opportunities to learn about and participate in the daily activities of clinical ethics in Catholic health care on the local consultation level as well as any systems-level projects. Former interns wished they could have learned more about healthcare systems such as the economics and finances of healthcare, they also wished for an opportunity to lead an ethics consult and learn more about navigating ethics committees. Current interns appreciated experiencing the practical day to day operations of Catholic Healthcare and connecting with leaders in the field.

EXPERIENCE

Consultation Experience

A majority of students have observed an ethics consult (84.6%). Two have observed no ethics consults (15.4%), almost half have observed one to five ethics consults (46.2), the remaining 38.5% have observed five or more ethics consults. Ten students were confident that they would like more experience observing ethics consults (76.9%), two were tentatively interested in more observation (15.4%) and one was not interested in observing more consults (7.7%).

Overall students had less experience participating in ethics consults than observing. Five students had participated in no ethics consults (38.5%) while 3 had participated in 1 – 5 (23.1%) and five students had participated in five or more consults (38.5%). An overwhelming majority were interested in participating in more ethics consults (12, 92.3%) while one student was not.

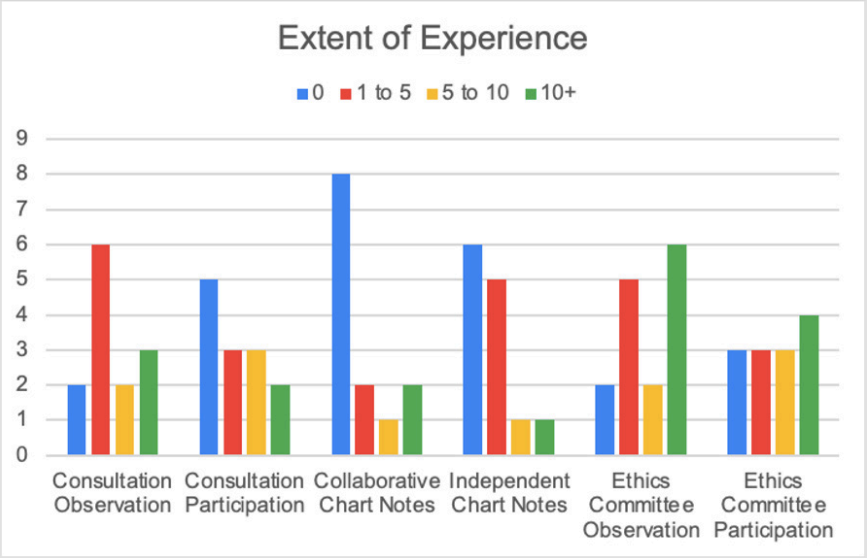


Chart Note Experience

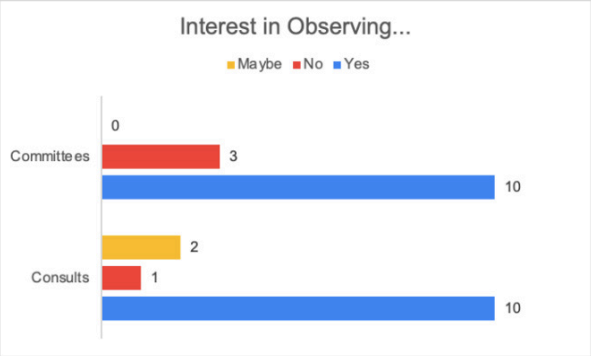
Six students had never independently written a chart note for an ethics consult (46.2%) while five had written 1-5 chart notes (38.5%). Two students have written over 5 chart notes independently (15.4%). Eight students have never written a chart note in collaboration with another ethicist (61.5%), while two students have collaborated on 1-5 chart notes (15.4%) and three students have collaborated on five or more chart notes (23.1%). Ten of students responding want more experience writing chart notes.

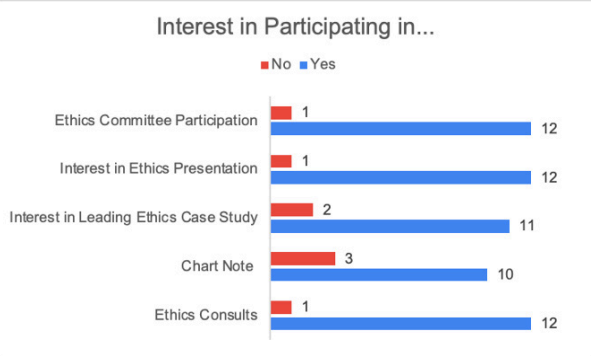
Ethics Committee Experience

Overall, students had the most previous experience with ethics committees. Almost half of respondents (6) have observed 10 or more ethics committee meetings. Over half of the students have participated in five or more committee meetings (53.9%). Students were overall interested in both observing more ethics committee meetings (76.9%) as well as participating (92.3%).

Leading Ethics Education Sessions

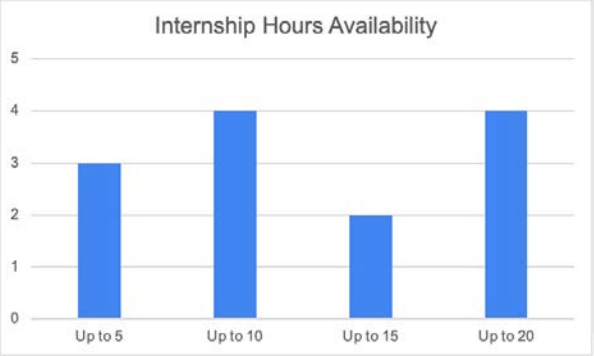
About half of the students have not led an ethics case study (53.8%), while two have led one case study and four have led more than one. 11 students were interested in leading a case study as part of their internship (84.6%). When asked if they have presented on ethics topics to clinicians outside of an academic conference setting, 10 students responded yes (76.9%) and 3 responded no (23.1%). Almost all students were interested in presenting on ethics topics to clinicians in an internship (92.3%).





Internship Type

The number of hours a week students were available for an internship varied. Two were available for up to five hours, four were available for up to 10 hours, two were available for up to 15 hours, and four were available for up to 20 hours. Available hours did not correspond with what year students were in their graduate studies.



Students were mixed on internship payment type. Seven would participate in unpaid internships, six would participate in internships for course credit, eight would participate in an internship which pays minimum hourly wage for hourly work, and all 13 would participate in an internship with a stipend comparable to a graduate assistantship at their university.

Other Experience

When asked what other experiences students would like to gain from an internship with a Catholic Healthcare System, most students mentioned aspects of organizational ethics, church relations, and professional development. Students were interested in gaining mentors in the field as well as working with patients, families, community groups, and chaplains. When it comes to clinical ethics experience, most students were interested in gaining more consultation experience (46.2%), three wanted more experience working with ethics committees (23.1%), two wanted more experience education clinicians on ethics issues (15.4%) and two wanted more experience in organizational ethics (15.4%).

DISCUSSION

This survey was notably focused towards clinical ethics questions to reflect that the intention of internships is to prepare students for entry level positions which overall require clinical ethics experience. Responses show that many students were interested in more clinical ethics experience, however the opportunity to gain experience in organizational ethics was also appreciated. Participation was more appealing than solely observation experience, however most students were interested in both. Those who had significant experience still wanted more experience observing and participating in all activities of Catholic healthcare ethics.

Students who responded "no" to interest in particular observation or participation experience were likely to have significant experience (10 or more times) in that particular option. No student had significant experience in all of the clinical ethics options and no student answered "no" to all or even a majority of the options in this survey.

Student experience in clinical ethics is varied among the graduate students who participated in this survey. Due to the small sample size, it is difficult to generalize this data to the wider population of bioethics graduate students. However, this data can be helpful in creating internship experiences and reveals that students likely will come to an internship with a diverse set of experiences and interests. Therefore, each internship should be tailored to the particular intern in order to offer a meaningful learning experience.

In the interest of diversifying the field of Catholic health care ethics, it's important to start with internships as the pipeline into the field. Payment is an important thing to consider. Research from other fields including law, STEM, and business show that students from higher socio-economic backgrounds

are more able to intern without pay.[3] Unpaid internships are likely to select for the type of people already have resources and can do unpaid work. We must consider this when building internships with the hope to diversify the future candidate pool of ethicists in Catholic health.

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ENDNOTES

1. Bedford, "Catholic Health Ethics Internships: Lessons Learned From Five Years' Experience."
2. Gremmels, "A Proposed Pipeline for Ethicists."
3. Burke and Carton, "The Pedagogical, Legal, and Ethical Implications of Unpaid Internships"; Fournier et al., "Unpaid Work and Access to Science Professions."

Annual Pastoral Visit for Building Catholic Identity

John F. Morris, Ph.D.

The two Catholic hospitals in Kansas City, Missouri, operate under a unique relationship with the Diocese of Kansas City – St. Joseph. As discussed in a previous HCEUSA article, St. Joseph Medical Center and St. Mary's Medical Center were bought by Prime Healthcare, Inc., a for-profit company based in California.[1] Recognizing the importance of the legacy of the hospital's founding Sisters, Prime entered into a formal covenant agreement with the diocese referred to as the Catholic Traditions Agreement to maintain the historic mission and Catholic identity of the facilities. However, with all of the changes involved in the sale of the hospitals, as well as the transition from "not-for-profit" to "for-profit" status, making it clear within the community that the hospitals are still Catholic has been a challenge — even staff have been confused about the situation at times. And so, the Office of Catholic Health Care (of which I am the current Director) was mutually established to serve as a direct liaison between the diocese and the hospitals. My office has then collaborated on a number of different educational offerings and events aimed at supporting and promoting the ongoing mission of the hospitals as Catholic health care ministries. One of the most important of these events is the Annual Pastoral Visit by Bishop Johnston to each of the hospitals.

THE FIRST "PASTORAL VISIT"

The first Pastoral Visit emerged, quite simply, out of a desire to show that the facilities were indeed still Catholic by having the bishop visit them in person. This was also in keeping with his pastoral responsibility for all Catholic health care ministries within his diocese.[2] As the USCCB has noted "The bishop has the responsibility and right to exercise his authority over all apostolates in his diocese, including that of health care, in accordance with the Code of Canon Law, c. 678, and any other universal or particular law that may be enacted."[3] From the beginning of the relationship between the facilities and the diocese, there was a strong desire to maintain close relationships between hospital leadership and the bishop in order to respect his role and authority over these important Catholic entities in our area. One important way a bishop carries out this pastoral responsibility in his diocese is through the Pastoral Visit. As explained in Canon 396.1: "A bishop is obliged to visit the diocese annually either in whole or in part, so that he visits the entire diocese at least every five years either personally or, if he has been legitimately impeded, through the coadjutor bishop, an auxiliary, vicar general, episcopal vicar, or another presbyter."[4] And so, while our Catholic Traditions Agreement spells out several ways the relationship between the diocese and the hospitals is to be carried out

and supported, it was recognized that having the bishop make a Pastoral Visit to bless the facilities and engage with the staff would be a concrete way to manifest the continued Catholic identity of the hospitals.
It took some time for all of this to be arranged, but two years after the sale to Prime was officially completed Bishop Johnston made his first Pastoral Visit. He spent the morning at one facility, touring a unit, visiting with both patients and practitioners there, before holding a prayer service followed by an open forum for other staff. He then spent the afternoon at the other facility doing the same. The visit was very successful and was deeply appreciated by both Catholic and non-Catholic staff. The event was also reported in the diocesan paper and through our social media pages. The overwhelming feedback from those who were able to attend was basically, "When can the bishop come visit again?"

ESTABLISHING THE PASTORAL VISIT AS AN ANNUAL EVENT

In addition to respecting and promoting the bishop's pastoral responsibility over the hospitals, there had been a desire to establish a long-term, consistent event to celebrate, if you will, the Catholic identity of our hospitals and their relationship with the diocese. And while the Office of Catholic Health Care is in regular contact with the hospitals as directed by our covenant agreement, much of that work is behind the scenes with hospital leadership. Plus, the bishop is the focal point for Catholic identity in the diocese. So, even though Bishop Johnston's initial visit was viewed as a single event, we quickly saw the value of establishing it as an Annual Pastoral Visit. We have now made it a priority to schedule the Annual Visit early each year to get it on the bishop's schedule. The event is also well-publicized early in the Fall so that staff can arrange to join us, and recorded for those who are not able to join in person. Our local Catholic media also covers the story to continue to let members of our parishes know that the hospitals are carrying on the historic missions of their founding Sisters.

The importance of this Annual Pastoral Visit was manifested rather strongly last Fall during the midst of the COVID-19 pandemic because the visit had to be canceled due to the restrictions put in place across the country for hospital visitations. And while the staff completely understood the need for this, many expressed their disappointment to the two CEOs that the bishop would not be visiting. As a result, the CEOs asked if Bishop Johnston would make a video for staff that could be posted internally, as a small way to make up for the lack of a personal visit. Bishop Johnston was able to compose a beautiful message of gratitude and blessing for our hospital workers. This video was also very well received, with both CEOs getting appreciative feedback from the staff — once again, both Catholic and non-Catholic employees expressed how much they appreciated that the bishop took the time to let them know he and the people of the diocese were praying for all of our local, front-line health care workers. In our annual meeting between the bishop and the hospital leadership they made a point of sharing this feedback with him, and how much his direct, personal interaction with the hospitals has meant.

THE ONGOING VALUE OF THE ANNUAL PASTORAL VISIT

Needless to say, the Annual Pastoral Visit has become an important and visible sign of the Catholic identity of St. Joseph Medical Center and St. Mary's Medical Center for our staff and patients. And since the event is publicized, the bishop's visit also promotes our identity within the metropolitan area served by our hospitals. But more importantly, this Annual Pastoral Visit has fostered a much deeper relationship between the hospitals, their staff, and the diocese through the personal touch of Bishop Johnston. He has embraced these visits, and his messages are truly pastoral — speaking to the hearts and souls of our health care workers.

As everyone involved with health care knows, this Summer was especially challenging with the rise of the Delta variant. Just when most of the country had been able to get their COVID-19 vaccines, and we were all starting to breathe a sigh of relief that the pandemic was coming to an end, Delta swept across the country leading once more to full ERs, high numbers of COVID positive cases, and sadly, more deaths. In August, our CEOs contacted my Office of Catholic Health Care to ask if the bishop would make another video for staff. Once again, Bishop Johnston was able to compose a new message of encouragement, hope, and gratitude. The video was especially meaningful given that we are in one of the areas where the Delta variant was particularly prominent. Fortunately, the Delta variant did subside in our area by early Fall, and Bishop Johnston was able to return in person for the Annual Pastoral Visit at the end of October. The turnout this year was once again very strong and both hospitals, and it was clear that the bishop's presence was a blessing for all those who attended.

It is also important to recognize that hosting an annual event like this takes time, planning, and money and that working with staff to arrange schedules so as many who desire to attend are able is a challenge, which shows their commitment of hospital leadership in supporting the Annual Pastoral Visit. Yet, I am not sure that myself or the bishop would have thought when we were arranging the first visit, or even when we decided to establish this as an annual event, that the hospital staff would have been so disappointed at his absence last year, or that the CEOs would have ever considered asking him to make a video encouraging their employees this Summer during the height of the Delta variant rise. For me, these are all clear signs that here in Kansas City our two Catholic hospitals and the diocese are embracing the "covenant" aspect of our Catholic Traditions Agreement.

CONCLUSION

In close, I offer for your consideration the idea of hosting an Annual Pastoral Visit with your local bishop. I know it is not uncommon for Catholic hospitals to have the bishop come to the facility for a special event — the dedication of a new prayer space, the blessing of a new unit, or perhaps on special occasions and anniversaries. However, a Pastoral Visit is different. An invitation to the bishop acknowledges his pastoral responsibility for the hospital and helps foster a better relationship between the hospital and the diocese. Further, as we have learned from our experience here

in Kansas City, a public visit like this can be a powerful sign for employees and the local community of the Catholic identity of the hospital — especially if this can be established as a regular event. But most of all, an Annual Pastoral Visit provides an opportunity for a more personal relationship with your bishop. All of these aspects will enrich the ministry of Catholic health care.

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End-of-Life Sacramental Care During COVID-19: The Importance of Clear Communication

John F. Morris, Ph.D.

As everyone reading this knows, the COVID-19 pandemic has affected many different aspects of health care. One area that has been especially impacted is end-of-life care due to the risk of exposure and possible transmission of the virus during patient interactions. One sad outcome of this that we have all become familiar with is the strict visitation limits put in place by hospitals across the country for COVID positive patients, which in many cases meant family members were unable to be present with a loved-one throughout their illness — even when the patient was dying. These visitation limits also made the provision of end-of-life sacraments a challenge for Catholics who desired them due to the close interaction of priests ministering these to infected patients.

REMINDER OF THE FUNDAMENTALS FOR THE SACRAMENT OF THE ANOINTING OF THE SICK

Catholic medical facilities adapted quickly, following previously established protocols for the provision of end-of-life sacraments under emergency circumstances as during a pandemic. For example, in March of 2020 the Catholic Health Association posted a document, "Reminder of the Fundamentals for the Sacrament of the Anointing of the Sick," which explained that while Canon Law indicates anointings are to be done by the priest with his hand, exceptions are allowed for a grave reason such as when there is risk of infection, and they are able to use an instrument such as a cotton ball or swab instead which can be safely discarded afterwards. Indeed, referencing the New Commentary on the Code of Canon Law, the CHA "Reminder" specifically noted that ministers to the sick are allowed to take the same precautions against potential infection as medical professionals. Other accommodations that are allowed include the use of a sterile container of oil that is separate from the normal stock of oil a priest would use for the sacrament and disposal prayer sheets that can be discarded of with other biohazardous material. There are also allowances for providing the "Rite for Emergency" when death is imminent.[1]

OPPORTUNITY FOR OUTREACH AND EDUCATION

But while Catholic hospitals and dioceses quickly implemented such protocols or formed specially trained teams of priest chaplains to meet the needs of patients requesting these

sacraments, most non-Catholic hospitals did not.[2] Instead, stories began to emerge that clergy were being denied admittance to COVID positive patients, and in some cases even denied access to non-positive patients because they were roomed on floors deemed as "COVID units" during the worst of the outbreak. And while several of these cases were eventually settled by the Office for Civil Rights (OCR) at the U.S Department of Health and Human Services as incidents of religious discrimination, the more important issue was that many members of the faithful were not able to receive end-of-life sacraments at the time of their death.[3]

Early in the pandemic, my Office of Catholic Health Care for the Diocese of Kansas City-St. Joseph was contacted by a local health care ethics consortium to record an interview for the city's medical community about Catholic perspectives on end-of-life care, and specifically our beliefs related to sacramental care of the dying. Several of the area's non-Catholic hospitals had encountered families outraged that their loved ones had been denied these sacraments before they died, and members of their Spiritual Care Departments were contacting the ethics group to see if they knew what the problem was with these Catholic families. It was noted that other religious denominations recognized the threat of contagion and spreading COVID-19 and accepted (albeit reluctantly) that they could not be with patients in their rooms, but the Catholic families did not always accept this reality. The diocese had also received a few calls from members of the faithful who did not understand why their parish priests were being refused admittance to local hospitals to visit and anoint dying family members (even a few clergy called in this regard). We further discovered — much to our surprise — that in our two, area Catholic facilities patients were not allowed to receive these sacraments when the priest chaplains were unavailable, and parish priests were being denied pastoral visits, because many of our non-Catholic staff had similar views to those noted above and concluded these sacraments simply could not be provided by outside clergy due to the risks posed by COVID-19. The request for an interview with this local ethics consortium then provided a much-needed opportunity for outreach and education regarding these important matters for the Catholic faithful.

In arranging the interview with the ethics group, as well as through investigating the situation in our Catholic hospitals, it was soon discovered that most non-Catholic chaplains and medical professionals did not fully understand the Catholic view of sacraments, nor appreciate the specifics of how these rites must be conducted for them to be considered valid. For example, people I spoke with did not understand that the end-of-life sacraments can only be performed by a priest who must be physically present with the patient — after all, all religions who believe in prayer know that prayer can work at a distance, so some chaplains and hospital personnel had wondered why the priest could not simply do the sacrament from a waiting room where there would be no fear of infection, or even simply pray for the dying person in their Church. In addition, the concrete, visible signs of the sacrament were not understood, such as the oil that is used for the anointing. Another dimension that was overlooked by many non-Catholics was the real meaning of a sacrament such as "anointing of the sick" for a patient who was not simply sick, but who was

clearly dying. Our belief in "spiritual healing" and the opportunity that can be provided for reconciliation with God before death through these rites were not fully appreciated by members of different faiths.

And so, in the interview which was conducted in May of 2020 I was able to clarify the Catholic perspective on sacramentality, emphasize the importance of these rites for faithful Catholics desirous of them when facing the threat of death, and the allowances that can be made to the rite for its safe provision or in emergent situations. The diocese also provided instructional documents from the USCCB and CHA that clarified all of these points to be shared with hospital chaplains and health care professionals, and to provide a better context for understanding the requests of patients and families for these sacraments. My Office was also able to provide specific education for our two Catholic hospitals through their Ethics Committee about the importance of these sacraments, and the need to make every accommodation possible for their provision when requested. We also worked with our Catholic hospitals to train several priests on how to conduct the rites safely and properly don PPE, who have then been serving as resources for our local hospitals. We also made sure to communicate all of this to the priests of the diocese, so that they understood the concerns of the local hospitals, as well as how to arrange for one of the priests who had been trained to visit sick or dying parishioners in facilities with visiting restrictions and COVID-19 protocols. The goal was to find a balance between respecting the necessary protocols in pace and the faith beliefs of Catholics.

THE NEED FOR ONGOING EDUCATION FOR BOTH CATHOLICS AND NON-CATHOLICS

Since May of 2020, there have still been reports of incidents in our area in which the provision of Catholic end-of-life sacraments were not allowed. In some cases, the reason for not allowing the sacramental visit still stemmed from a lack of understanding of the importance of such rites in the lives of Catholics, or a lack of understanding of the manner in which the sacrament can be safely provided — and so, ongoing education remains a priority.

However, other situations genuinely seemed to be ones in which the sacrament could not be safely provided or a priest with the proper safety training was not available. But it is important to recognize that there are many instances in which Catholics who would desire the end-of-life sacraments are unable to receive them — such as when death is sudden or unexpected. The Church, in her wisdom, accounts for these cases, but we recognized that education was needed for laity on the Church's perspective regarding the death of the faithful who do not receive the end-of-life sacraments. While every effort should be made to provide these rites for Catholics who are dying, the United States Conference of Catholic Bishops and groups such as the CHA provide guidance that when this is not possible a priest, "can provide the patient the prayer of the Church, prayers for a dying person, the prayer of Apostolic Pardon, and the assurance of the Plenary Indulgence granted the person with COVID-19."[4] Many families who were distraught to find out that their loved ones died without the benefit of the end-of-life sacraments were greatly relieved and spiritually uplifted to learn about the Apostolic

Pardon and the Plenary Indulgence, as well as being reminded of the value of their own prayers, united with those of the Church, for all of the dead.[5] These key elements of our faith are especially important to recall as we continue to struggle through this pandemic.

CONCLUSION

The impact of COVID-19 on end-of-life sacramental care highlighted the importance of good communication with non-Catholic members of our hospital staffs, reminding us that while many non-Catholics have joined us in this health care ministry, that does not mean they understand all of the intricacies of the sacramental life of the Church. In retrospect this idea is obvious, but in the midst of everything that the pandemic has thrown at the world it is clearly something that was easily overlooked — though not intentionally — and needed to be addressed.

But the invitation by the local ethics consortium to address end-of-life sacramental care for Catholics also highlighted the importance of communicating these important values and beliefs to other health care providers for the good of all the faithful in our diocese. Once again, it is obvious that Catholics in our area go to non-Catholic hospitals, and yet they were being impacted as well by the lack of these sacraments. The Office of Catholic Health Care and the Spiritual Care Departments of our two Catholic hospitals were able to work together to provide educational information about end-of-life sacramental care in the Catholic Tradition for these other hospitals.

This experience serves as an important reminder that Catholic Ethicists can use our knowledge and skill to enrich not only the facilities we work for, but we can also have a positive impact on the communities where we are located when we remember to look beyond the walls of our own hospitals. ✠

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Reframing FABM as a Subset of the Continuum of Fertility Awareness (CoFA)

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INTRODUCTION

Many Catholic healthcare systems have programs offering Fertility Awareness Based Methods (FABMs) to patients who wish to become pregnant or limit the frequency/number of pregnancies. FABM services like these accomplish dual purposes: they allow Catholic healthcare organizations to confront certain operational realities of patients' reproductive healthcare needs while also faithfully implementing ERDs 43, 44, 52, and 53. In reviewing strategies within our own ministries, however, we noticed that FABMs are targeted *only* toward women who are working to achieve or avoid pregnancy, despite the potential for benefit beyond this context. Pregnancy-specific approaches to fertility awareness, while satisfactory from a Catholic moral perspective, miss critical opportunities to support younger and older women, include men as stakeholders, and improve resources for patients who have traditionally had challenges in accessing primary care. We wondered if compliance with the ERDs has created a false sense of security, leading the ethics community to neglect a further examination of fertility awareness services as a whole — who is offering it, to whom, and under which circumstances.

CURRENT STATE

FABMs are currently offered in the context of pregnancy alone and isolated from the broader matrix of healthcare services. This creates a perception that fertility awareness is only useful to achieve or avoid pregnancy, when the advantages of fertility awareness actually begin before puberty and stretch beyond menopause. In reality, pregnancy-centered approaches miss chances to educate patients about the "Fifth Vital Sign" and how one's menstrual cycle provides insight into overall wellbeing.[1] Isolated fertility awareness also pushes men out of a space that could benefit them. When fertility awareness programs leave out these other areas of benefit, they may succeed in satisfying the ERDs but fall short of promoting human flourishing. When the audience for fertility awareness is focused only on women during child-bearing years, Catholic healthcare systems are unable to live our mission to its fullest or contribute to improving universal health inequities across care settings. So while offering FABMs within the silo of pregnancy is not necessarily contrary to the ERDs, it may not be the best way to honor them either.

Even when services are appropriately pregnancy-focused, implicit biases may create inequities in who is offered education around the use of FABMs. US culture tends to promote child-bearing in "normative mothers"

but to discourage parenthood altogether for "non-normative" women.[2]

CHARACTERISTICS OF "NORMATIVE" VS "NON-NORMATIVE" WOMEN

Normative Mothers are women who meet *all* of the following criteria:	**A non-normative mother may have *any* of the following qualities:**
Married	Unmarried
Able-bodied	Impaired in any way
Heterosexual	Anything other than heterosexual
White	Anything other than white
Native-English speaking	Any language other than English
Middle- or Upper-Class	Financially Marginalized
Mid 20s	Any other age
Intend to have small families	Intend to have large families
Cisgender	Non-cisgender
Prenatal Care/ Healthcare access/ Insurance	
Pretty/thin	

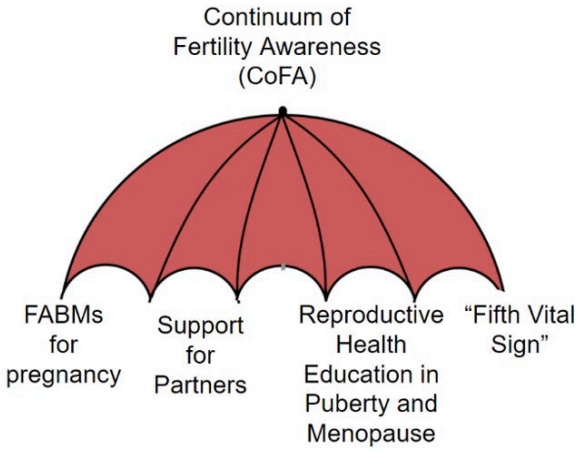
While social clues may sometimes lead to important information about the patient's health or risk factors, a patient's background or preferences should not be used solely to determine whether the patient is a good candidate for FABMs or not. Guidance about how to intentionally conceive a child should not be reserved for normative mothers when non-normative mothers are frequently presumed to be unsuitable for FABM and nudged towards pregnancy avoidance. The societal bias between these two groups has created significant gaps in access to fertility awareness services. Multiple demographics have been left out entirely, including women who do not look like normative mothers, most (if not all) men, and individuals facing barriers around primary care access. By restricting access to fertility awareness in this way, even unintentionally, everyone who stands to benefit from a broader structure of education is left out, further challenging our ability to promote the true flourishing of our patients.

A more comprehensive framework is needed. To address this, we have developed the concept of a Continuum of Fertility Awareness, a field which includes the many ways fertility awareness can serve a patient through the stages of life.

CoFA

In order to provide the best outcomes and opportunities for our patients, we need to zoom out from FABMs that are only offered as a way to achieve or avoid pregnancy. To that end, we have developed the idea of a Continuum of Fertility Awareness (CoFA), an umbrella term for the multi-faceted field that includes, *but is not limited to*, methods of family planning. It extends far beyond the short window in a person's life when pregnancy is the main concern. CoFA considers FABM services as only one part of a holistic, life-spanning approach to reproductive healthcare and develops from there to include the research, educational opportunities, and benefits to be gained by tracking the menstrual cycle from the beginning of puberty to the completion of menopause. Henceforth, we will use CoFA in

referring to this field of work and FABMs when describing specific fertility awareness-based methods used for family planning practices.



In addition to broadening the life stages in which fertility awareness is applicable, framing CoFA as a *field* of healthcare changes the focus of delivery from only those women who are seen as "good candidates" for FABM to all patients. But doing so exposes a new question: whether fertility awareness services are being offered to the right groups of people in the right ways or if they are being offered too selectively. And in those spaces where inequities and opportunities exist, CoFA programming may bring solutions that provide more benefit to a greater number of people.

SPECIFIC OPPORTUNITIES FOR IMPROVEMENT

We have identified a few spaces that would be well-served by expanding FABM services into CoFA programs.

Opportunity #1: Support for Partners

Essential conversations about fertility, menstruation, and menopause tend to take place within one of two relationships: between mothers[3] and daughters as the elder helps to guide her child through 'female problems,' or between women and their healthcare providers as the patient navigates gynecological changes. Men are often excluded from such conversations, perhaps because societal stereotypes (Al Bundy and Homer Simpson, among many) depict them as either not interested in or not responsible enough to share in reproductive decisions.[4] Not only do outdated gender roles place disproportionate burdens on women to be the sole educators, monitors, and gatekeepers of fertility, the stereotypes diminish the thoughtfulness with which many, if not most, men approach their partners and daughters — in short, failing to honor their human dignity. We were inspired by the men we know, who professed to us an interest in their daughters' health and deep regard for the unity of marriage, which compelled us to craft a framework that acknowledges men as trustworthy stakeholders who deserve increased inclusion. CoFA offers a host of inclusion opportunities, from early reproductive health education for the boys who will someday grow up to be husbands, to support for fathers who wish to also participate in 'the talk,' to resources for partners who hope to better anticipate and respond to a woman's continuum of needs. CoFA provides a strategy for parents, couples, and providers that brings more equitable responsibilities to reproductive healthcare.

Opportunity #2: Community Education

Reproductive health education in elementary school, if it is available, typically only covers the changes children should anticipate in puberty. Only 39 states mandate reproductive health education beyond that, and most of it

focuses heavily on the act of sex with the goal of achieving or avoiding pregnancy.[5] But the need for information does not stop there, and once people leave school — which could be very early — there are no further structured educational opportunities. This puts the burden on the individual to seek out the information she needs to understand her body as an adult. It also requires her to know what she doesn't know and then find the resources needed to fill the gaps, which is unrealistic. Instead of relying on schools or putting the task on women, developing CoFA programs in the community would provide access to information beyond what applies to pregnancy from both medical experts and other women who have been through similar experiences.

Opportunity #3: Fifth Vital Sign Education

Fertility has become popularized as a fifth vital sign for women, but healthcare has not been so quick to incorporate this approach into practice across age groups.[6] If providers only bring up fertility awareness when women are looking to plan for pregnancy, they may unintentionally prevent women and girls from learning a valuable tool in understanding their overall health. When we are not taught to recognize what is normal for our own bodies, we miss out on clues that can help to identify other issues that may arise. And these aren't just limited to gynecological catastrophes. Irregular cycles and amenorrhea can indicate 'regular' chronic diseases, such as diabetes or thyroid problems, many of which are treatable but may be difficult to diagnose in women.[7, 8] Instead of treating the menstrual cycle as an inconvenience to deal with every month until it is time to become pregnant, teaching women to track what looks and feels normal can help them identify problems earlier. CoFA programs recognize ovaries and uteruses as organs just like lungs, or eyes, or kidneys, and women should be given information for these organs — just as they would for any others — in order to advocate for their own health.

Opportunity #4: Reducing Barriers

Patients who are marginalized by 'typical' healthcare delivery may be prevented from accessing fertility awareness services if they are reserved only for the context of pregnancy; rural populations are particularly susceptible to barriers in access as medical facilities condense into large campuses in lucrative locations; people who prefer a language other than English may encounter difficulties when they must rely on suboptimal phone-based interpreter services; patients who have never been taught about the clinical, physical aspects of timing pregnancies may feel uncomfortable discussing these things in a medical setting, where it can be challenging to understand medicalese or know what questions to ask; other patient groups, such as those who are uncomfortable in an office due to physical limitations — who sometimes can't even get into a physician's office or onto an exam table due to lack of accommodations at that practice — may avoid discussions about timing pregnancies due to the trouble of an in-person visit or the challenge of looking around for a provider willing to make the necessary accommodations. Expanding FABM services into CoFA programs can help to lessen these well-documented barriers to healthcare access, especially considering that most opportunities for CoFA programming can be provided outside of medical office visits. By teaching people about the benefits of fertility awareness in a non-medicalized setting from a young age, we can empower women and men, prevent

or lessen negative experiences due to various healthcare barriers, and further increase the skills and confidence needed for self-advocacy.

CONCLUSION

In healthcare, we often feel compelled to make time for only the most pressing, controversial issues. But our own satisfaction with FABMs as a system of family planning that adheres to the ERDS does not excuse ethicists from neglecting a further examination of its delivery — a simple lack of controversy does not remove the need for scrutiny. Even if FABM services in their current state are enough to 'check the boxes' and meet the criteria set forth by the ERDs, there are still a number of meaningful opportunities to expand them into something that is truly conducive to human flourishing. This is especially important if FABMs, when offered alone, are contributing to health disparities for the most vulnerable among us.

Transitioning from FABMs with a focus on pregnancy to CoFA programs that apply to all people changes fertility awareness from a way of gatekeeping reproductive health information into a self-reinforcing, empowering, lifelong service. We recognize that building CoFA programs will not be without challenges but these meaningful opportunities to improve the lives of so many are certainly worth the effort. Under this new framework, the women who were already benefiting from fertility awareness services in pregnancy can continue to do so, while men and women at multiple life stages, regardless of limits in access to primary care, will be able to benefit as well. Offering fertility awareness services is clearly not enough anymore; it is time for Catholic healthcare to explore how these programs can provide for the flourishing of everyone we serve.

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Standardizing Virtual Medical Residency Ethics Curriculum: A High Reliability Endeavor

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INTRODUCTION

As one of the largest Catholic healthcare systems in the United States, Ascension has 154 accredited Graduate Medical Education (GME) Residency programs with 66 specialties and subspecialties dispersed across 12 states. On average, we educate over 2,700 residents annually. Accordingly, Integration of ethics education into Graduate Medical Education Residency is recognized as an essential component of the ACGME Milestones leading to competency in Professionalism.[1] The delivery of high quality, standardized yet customizable, collaborative ethics education is a significant strategic priority for Ascension. In addition, the need to move to a virtual curriculum in the context of the COVID-19 pandemic created both challenges and opportunities for engaging in medical resident education as a high reliability endeavor, which leveraged the expertise of our Medical Residency Program faculty, our community of ethicists (called our Ethics Advisory Community) across our system, as well as the perspectives and experiences of our Medical Residents themselves.

CURRICULUM OVERVIEW

In partnership with the Directors of Residency Programs across Ascension, the Ethics Advisory Community designed and is in year two of a two-year, case-based methodology curriculum in ethics specifically designed to be delivered nationally using a virtual format. Specific residency programs rotate facilitation responsibilities with the support of and collaboration with their Ministry Market Ethics colleagues. Drawn from the ACGME Milestones, topics covered in the curriculum include: Do Not Resuscitate, Withdraw/Withhold of Medical Interventions, Competence and Decision Making Status, Inappropriate Demands for Medical Interventions, Informed Consent, Confidentiality and Privacy, Advance Directives, Physician Assisted Suicide, and Professionalism/Duty to Care. All presentations are encouraged to integrate ethical principles, the *Ethical and Religious Directives for Catholic Healthcare Services* (ERDs) and aspects of the case study/education related to cultural competency, diversity and inclusion.

FORMAT

Each Medical Resident Ethics Grand Rounds is offered nationally to all Residency programs during their set Residency Grand Rounds structure on a quarterly basis such that the curriculum is completed over the course of a two-year cycle. The sessions are designed to be 60-minute didactics that include: a case study selected and presented by a Medical resident

or residents from the hosting Ministry Market, with subsequent discussion co-facilitated by Director or Faculty of the Medical Residency Program and Ascension Market ethicists utilizing the Ascension *Assess, Analyze, Act* Clinical Ethics Decision-making Process relative to topic, and open Q&A, time allowing. The standard presentation will include:

1. Overview of Case Related to Designated Topic
2. Identification of the Central Ethics Question posed by the case
3. Applicable Ethical Principles, Policies, and *The Ethical and Religious Directives* relative to the topic
4. Familiarity for Residents in referencing the Ascension myEthicsRx App relative to the topic

A standardized yet customizable slide deck template is provided to assist hosting Ministry Markets in preparing their didactic sessions. Each module is recorded, and the video/supporting materials are made available to Program Directors for future use, and National Continuing Medical Education (CME) credit is available for both the live and recorded sessions.

ROLL OUT

As mentioned above, various Ministry Market GME programs within Ascension rotate "hosting" of Medical Resident Ethics Grand Rounds. Planning meetings are scheduled at least two months in advance of the Grand Rounds date to allow for selection of a relevant case and Medical Resident(s) to present the case study, and for the collaborative development of the presentation itself. Lead national faculty from Graduate Medical Education and Ethics support Market Program Directors, Designated Institutional Officers (DIOs), Residents and Ethicists in the planning and development of the presentation, and all Ascension Residents, faculty, program directors and ethicists are invited to attend.

LESSONS LEARNED (SO FAR)

1. The physician voice is key: A crucial element in the success and dialogical nature of the Grand Rounds is to have the Residents and faculty lead the conversation and the ethicists to facilitate and provide support and subject matter expertise where needed. In short, ethicists are supposed to care about integrating ethics into all facets of the organization; when a Medical Resident peer speaks to her/his colleagues utilizing an ethics lens to examine a case with which they struggled or in which they found meaning, this is a powerful message. And, when Residents hear their faculty speak to the ethical dimensions of their vocation as a physician, this sends a very powerful message.

2. Standardize when necessary, but be flexible: As we began to gain some experience in delivering national virtual Grand Rounds, we found that there were a few key elements (those outlined above) which we would want to have included in any of our Ethics Grand Rounds presentations, both to meet the requirements laid out in the ACGME Milestones for Professionalism, and to also endeavor to establish a common way of approaching ethical dilemmas across our system using standardized tools and resources (like *Assess, Analyze, Act* and Ascension's *myEthicsRx* app). However, the most effective and engaging presentations thus far seemed to be those that left space

for discussion, debate, and sometimes even going a bit "off script."

3. Don't let the perfect be the enemy of the good: As mentioned above, customarily, we begin the planning process for the Quarterly Grand Rounds immediately after the previous one finishes. This allows three months for planning and collaboration. However, sometimes it is difficult to coordinate schedules, select a relevant case, and have a draft presentation ready in time for a "dry run" a few days before the live presentation. And, even with all the elements of planning in place, sometimes technical difficulties inherent in a virtual delivery modality are unavoidable. These "imperfections," as long as they do not stall the whole presentation, are unavoidable, and may actually make the presentation more authentic.

4. Give them credit: Ascension's ability to coordinate Continuing Medical Education (CME) credit on a national level across all of our Ministry Markets through one centralized clearing house makes both the process for securing CME credits for the program and the participants' ability to receive credit for participation much more streamlined. It also allowed for us to advertise the program nationally and offer CME credits for those who participated in the live session or viewed the recorded program.

5. Include discussion of implicit/explicit bias if applicable: One key learning we had as we engaged in these presentations is that many of the cases presented had elements of cultural competence, implicit or explicit bias present in them in some form, and that recognizing and addressing these elements, if possible, contributed to a positive resolution to the case and significant learnings for those involved. Any opportunity to draw these elements out of cases, when they exist, helps to connect Residents to the mission of Catholic healthcare, and to the principles of inclusion, diversity and human dignity.

6. "If you build it, they will come": Word spread across our national ministry. After each Grand Rounds, more GME programs reached out to access the recordings and to offer to participate in future Grand Rounds. GME programs need assistance to deliver on all of the ACGME requirements and meet the needs and interests of the learners. This is a great example of the interprofessional teaming expected by the ACGME to deliver a highly reliable clinical learning environment.

7. Yes, it is still a pandemic: As mentioned above, the COVID-19 pandemic necessitated that we explore a new delivery modality for medical education, since many in-person avenues of education were suspended. This provided the impetus for the creation of this virtual curriculum. However, the pandemic has and continues to have a tremendous impact on our hospitals, healthcare systems, and communities, including our Medical Residents and the faculty who support them. For many, the Ethics curriculum has provided a strong reminder of why the vocation of the physician is so important, and why a moral compass, rooted in our identity as a healing ministry of the Church and guided by foundational social and ethical principles, is indispensable.

Yet, we have had to recognize the strain our physician colleagues are under, and postpone or even cancel some scheduled sessions. Again, flexibility, and above all, compassion, is key. The Curriculum, and the work of ethics more broadly, is to support clinicians, not to impose additional burdens. Ideally, programs such as this can help ease moral distress, soothe compassion fatigue, and provide a forum in which ethicists and physicians can mutually support each other in the important work of healing.

ENDNOTE

1. https://www.acgme.org/globalassets/milestonesguidebook.pdf

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Is There a Moral Obligation to Be Vaccinated for COVID-19?[1]

Jason T. Eberl, Ph.D.

As the COVID-19 pandemic surges with the highly infectious Omicron variant, while cases of the less infectious but deadlier Delta variant persist, debates concerning vaccination mandates have not subsided. The Catholic Medical Association (CMA) and the National Catholic Bioethics Center (NCBC) argue for exemptions for those who object to receiving a COVID-19 vaccine for religious or moral reasons.[2] Yet, several Catholic prelates have instructed their priests not to sign religious exemption requests or have mandated vaccinations for diocesan employees, and Vatican City has instituted a mandate without allowing non-medical exemptions.[3] I argue that principles of secular public health and Catholic social ethics justify such mandates. I further show why certain objections Catholics may have are ill-founded and conclude that there is no moral reason for a Catholic to refuse to be vaccinated for COVID-19; rather, it is a *moral obligation*.[4]

ETHICAL PRINCIPLES SUPPORTING COVID-19 VACCINATION MANDATES

The commonly-held principles of biomedical ethics — respect for autonomy, nonmaleficence, beneficence, and justice — are primarily applicable in the clinical and research contexts, in which the primary concern is the protection of individual patients or research participants.[5] A complementary set of principles for the public health context primarily concerns the general welfare of society, which may be impacted by individuals' choices.[6] The first principle stipulates that one's liberty may be restricted to prevent *risk of harm* to others[7] — and there is ample evidence of the risks from lack of vaccination.[8] If restriction of liberty is warranted, the *least restrictive means* should be used: one should start with education, then inducement, and, if such measures are not effective and the public health threat is sufficiently significant, coercive or punitive measure may be employed — we have witnessed each of these steps since the vaccines became available. *Reciprocity* demands that mandated vaccines be made freely available and also informs efforts to minimize the penalties for those who choose not to be vaccinated under a mandate — such as requiring regular testing or mask-wearing,[9] or reconfiguring one's job (e.g., reassigning a nurse to perform non-patient-facing functions within a hospital). Finally, *transparency* demands that all stakeholders have a voice in the public deliberation and ultimate determination of public policy, which does not entail that all stakeholders will get their way.

These secular public health principles cohere with key principles of the natural law and Catholic Social Teaching. We begin with Thomas Aquinas's exhortation to exercise proper *stewardship* over one's body: "It is prescribed that a human being sustains his body, for otherwise he murders himself. … Therefore, one is bound to nourish his body,

and we are bound likewise with respect to all other things without which the body cannot live."[10] There is both a personal moral obligation to safeguard one's health and an obligation for public authorities to help cultivate this and other virtuous dispositions: "Legislators make men virtuous by habituating them to virtuous works by means of statutes, rewards, and punishments."[11] Aquinas defines civil laws as those made by appropriate authorities, utilizing prudential reason to craft ordinances that serve the *common good*.[12] Vaccination mandates that have been made by public authorities, and within Catholic health care and educational institutions,[13] having reasoned through the relevant epidemiological evidence, are licit expressions of civil law serving the common good and fostering a more virtuous citizenry.

The *common good* is "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily."[14] The *Catechism* further exhorts, "The dignity of the human person requires the pursuit of the common good. Everyone should be concerned to create and support institutions that improve the conditions of human life."[15] Concerning the proper function of public authorities, the *Catechism* concludes, "It is the role of the state to defend and promote the common good of civil society"[16] and that "it is the proper function of authority to arbitrate, in the name of the common good, between various particular interests."[17] Insofar as vaccination mandates create a social condition — herd immunity[18] — that allows people to reach their fulfillment more fully and more easily — and it is evident how the pandemic, particularly when lockdowns and social-distancing have been required, has inhibited such fulfillment in terms of the economy, education, and mental health[19] — the state is fulfilling its proper role to promote the common good and respect *the dignity of the human person*. Furthermore, the common good requires considering the "sum total" of relevant social conditions while also keeping in the forefront the Church's exhortation of a *preferential option for the poor and vulnerable*.[20] Hence, the vulnerability of persons who cannot be vaccinated for medical reasons, the economic impact of lockdowns and quarantines, the amelioration of politically-created health disparities,[21] and the particular vulnerabilities experienced by persons with disabilities[22] should be taken into account.

ILL-FOUNDED CONSCIENCE-BASED OBJECTIONS TO COVID-19 VACCINATION

The primary basis for refusals to be vaccinated on the part of pro-life Catholics is a remote material causal link to abortion. The Johnson & Johnson/Janssen vaccine was manufactured using an immortalized cell line (PER.C6) that was developed from the retina of a fetus aborted in 1985; the Moderna and Pfizer/BioNTech vaccines were tested using a cell line (HEK 293) developed from the kidney of a fetus that either was aborted or had naturally miscarried in 1972.[23] The Congregation for the Doctrine of the Faith (CDF) has ruled definitively that *"it is morally acceptable to receive Covid-19 vaccines that have used cell lines from aborted fetuses in their research and production process."*[24] Without delving into the details of how the CDF arrived at this conclusion,[25] it is evident that Catholics who seek an exemption from a vaccination mandate due to the remote — and, in the case of the Pfizer/BioNTech and Moderna vaccines, merely *probable*[26] — material connection to past abortions

are operating from a *misinformed conscience* that public authorities need not respect,[27] especially since these cell lines have been used to develop other pharmaceuticals, cosmetics, and processed food additives with. no moral objections being voiced.[28]

The CMA and NCBC have centered their call for exemptions on the requirement for authorities to respect the right to express one's conscience, citing the *Catechism*:

> Man has the right to act in conscience and in freedom so as personally to make moral decisions. 'He must not be forced to act contrary to his conscience. Nor must he be prevented from acting according to his conscience, especially in religious matters.'[29]

The Church's teaching on the nature of conscience, however, is nuanced in ways not explicitly appreciated by these organizations.[30] For example, this quotation is derived from Vatican II's declaration on religious freedom, a document primarily concerned with totalitarian political regimes — primarily Nazism and Soviet-style communism — that inhibit the practice of religious faith, religious education, missionary outreach, etc. The above assertion does not directly entail that public authorities have no role to play in restricting certain behaviors — conscientious though they may be — that threaten the common good:

> The right to religious freedom is exercised in human society: hence its exercise is subject to certain regulatory norms. In the use of all freedoms the moral principle of personal and social responsibility is to be observed. In the exercise of their rights, individual men and social groups are bound by the moral law to have respect both for the rights of others and for their own duties toward others and for the common welfare of all. Men are to deal with their fellows in justice and civility. … Furthermore, society has the right to defend itself against possible abuses committed on the pretext of freedom of religion. It is the special duty of government to provide this protection.[31]
>
> [N]ot a few can be found who seem inclined to use the name of freedom as the pretext for refusing to submit to authority and for making light of the duty of obedience. Wherefore this Vatican Council urges everyone, especially those who are charged with the task of educating others, to do their utmost to form men who, on the one hand, will respect the moral order and be obedient to lawful authority, and on the other hand, will be lovers of true freedom-men, in other words, who will come to decisions on their own judgment and in the light of truth, govern their activities with a sense of responsibility, and strive after what is true and right, willing always to join with others in cooperative effort. Religious freedom therefore ought to have this further purpose and aim, namely, that men may come to act with greater responsibility in fulfilling their duties in community life.[32]

The Church's carefully balanced view eschews the subjectivism entailed by defending a right to conscience as an absolute and denying that just civil laws bind one's conscience.[33] John

Paul II echoes this concern:

> The individual conscience is accorded the status of a supreme tribunal of moral judgment which hands down categorical and infallible decisions about good and evil. To the affirmation that one has a duty to follow one's conscience is unduly added the affirmation that one's moral judgment is true merely by the fact that it has its origin in the conscience. But in this way the inescapable claims of truth disappear, yielding their place to a criterion of sincerity, authenticity and "being at peace with oneself", so much so that some have come to adopt a radically subjectivistic conception of moral judgment.[34]

The Vatican II Fathers connect this concern regarding "individualistic morality" with safeguarding the common good, including "the protection of health":

> Profound and rapid changes make it more necessary that no one ignoring the trend of events or drugged by laziness, content himself with a merely individualistic morality. It grows increasingly true that the obligations of justice and love are fulfilled only if each person, contributing to the common good, according to his own abilities and the needs of others, also promotes and assists the public and private institutions dedicated to bettering the conditions of human life. Yet there are those who, while possessing grand and rather noble sentiments, nevertheless in reality live always as if they cared nothing for the needs of society. Many in various places even make light of social laws and precepts, and do not hesitate to resort to various frauds and deceptions in avoiding just taxes or other debts due to society. Others think little of certain norms of social life, for example those designed for the protection of health … they do not even avert to the fact that by such indifference they imperil their own life and that of others.[35]

Carter Snead has rightly criticized the "expressive individualism" embodied by most public bioethics laws in the U.S.,[36] but Catholics must be careful not to utilize the same foundation of the expression of individual autonomy — recast in the name of "conscience" — above other moral concerns, such as public health as partially constitutive of the common good.

MORAL OBLIGATION TO BE VACCINATED FOR COVID-19

The CDF states that, while receiving the COVID-19 vaccines is *permissible*, "vaccination is not, as a rule, a moral obligation and that, therefore, it must be voluntary."[37] On this basis, the CMA and NCBC defend exemptions to mandates. However, there are a couple key ambiguities in the language the CDF uses.[38] First, there are two ways in which something could be a "rule": absolutely or prima facie. Understanding the CDF as asserting an absolute rule would contradict Pope Francis's exhortation, "I believe that morally everyone must take the vaccine. It is the moral choice because it is about your life but also the lives of others."[39] The Pope and the CDF would be in alignment if we understand "as a rule" in a *prima facie* sense, meaning that, under ordinary circumstances, vaccination is not a moral obligation; however, the current pandemic

has arguably created a "state of exception" in which moral rules, though not abrogated, may be applied in different ways.[40] In this case, another moral rule — the requirement to safeguard one's health and promote the common good — overrides the prima facie rule against vaccination being a moral obligation. Second, the term "voluntary" is inherently ambiguous as it could mean either that one should not be coerced in any way to be vaccinated or that one should not be held down and jabbed against their will. While mandates could be construed as "coercive," they are not forcing anyone to be vaccinated against their will.

I conclude that there is a moral obligation to be vaccinated based on epidemiological evidence that vaccination — except for those with medical contraindications[41] — is the most effective means of fulfilling one's duty to safeguard their own health and promote the common good, which inherently respects the dignity of human persons, particularly those at higher risk of severe illness or death — including by attenuating the virus' potential to mutate into more infectious and deadlier forms. No countervailing moral reason of sufficient weight to forego vaccination has been provided by Catholic or secular critics of vaccination mandates.

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ENDNOTES

1. This essay develops further arguments initially put forth in three previous essays: https://www.americamagazine.org/faith/2021/08/10/covid-vaccine-mandate-exemptions-voluntary-ignorance-241196, https://www.ncronline.org/news/coronavirus/catholics-have-no-grounds-claim-exemption-covid-vaccine-mandates, and https://www.healthaffairs.org/do/10.1377/forefront.20211029.682797/full/, as well as a series of podcasts (Episodes 76-78) sponsored by the National Catholic Bioethics Center: https://www.ncbcenter.org/bioethics-on-air-podcast-cms. All links throughout accessed 28 December 2021.
2. See https://www.cathmed.org/catholic-medical-association-opposes-vaccine-mandates-without-conscience-and-religious-exemptions/ and https://www.ncbcenter.org/ncbc-news/vaccinemandatestatement.
3. See https://www.ncronline.org/news/coronavirus/ny-priests-urged-not-give-religious-exemptions-covid-19-vaccines; https://www.sdcatholic.org/wp-content/uploads/news/documents/8.11.2021-Letter-from-Bishop-McElroy.pdf; https://www.catholicnewsagency.com/news/248775/archdiocese-of-chicago-mandates-covid-vaccination-for-clerics-employees; https://cruxnow.com/vatican/2021/12/vatican-issues-vaccine-mandate-for-all-employees (the Vatican City mandate allows for proof of previous COVID-19 infection in place of vaccination).
4. I set aside legal debates regarding the constitutionality of governmental mandates or whether mandates by employers are discriminatory, as well as the disputed question of whether previous COVID-19 infection provides sufficiently robust immunity—equivalent to or better than the currently available vaccines in efficacy and duration of protection—to warrant an exemption from vaccination: https://www.wsj.com/articles/some-workers-want-covid-19-recovery-accepted-as-evidence-of-immunity-11634648215?mod=Searchresults_pos2&page=1.
5. See Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (New York: Oxford University Press, 2019).
6. See R.E.G. Upshur, "Principles for the Justification of Public Health Intervention," *Canadian Journal of Public Health* 93:2 (2002): 101-3.
7. The historical root of this "harm principle" may be found in John Stuart Mill's seminal essay "On Liberty."
8. Not only are the vast majority of COVID-related hospitalizations and deaths among the unvaccinated (https://ourworldindata.org/covid-deaths-by-vaccination), the mutation of the SARS-CoV-2 virus into new variants is correlated with lower levels of vaccination (https://hub.jhu.edu/2021/07/19/andrew-pekosz-delta-variants/).

9. Though such measures may be insufficiently effective against the Omicron variant. Vatican City's vaccination mandate previously allowed for regular testing as an alternative, but it recently disallowed this alternative as the Omicron variant has surged.
10. Thomas Aquinas, *Super secundam Epistolam ad Thessalonicenses lectura*, cap. III, lect. 2; my translation.
11. Thomas Aquinas, *Commentary on Aristotle's Nicomachean Ethics*, bk. II, lect. 1, §251; trans. C.I. Litzinger (Notre Dame, IN: Dumb Ox Books, 1993).
12. Thomas Aquinas, *Summa theologiae*, Ia, q. 95; trans. English Dominican Fathers (New York: Benziger, 1948).
13. See https://www.chausa.org/publications/catholic-health-world/archives/issues/august-1-2021/require-vaccinations-or-just-encourage-them-systems-are-split-on-decision and https://www.ncronline.org/news/coronavirus/some-catholic-colleges-forgo-vaccine-mandates-worrying-public-health-experts.
14. *Gaudium et spes* (1965), n. 26: https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html.
15. *Catechism of the Catholic Church* (1997), n. 1926: https://www.vatican.va/archive/ENG0015/_INDEX.HTM.
16. Ibid., n. 1927.
17. Ibid., n. 1908.
18. See https://www.idsociety.org/multimedia/podcasts/herd-immunity-how-far-back-has-the-delta-variant-set-us/.
19. See https://irle.berkeley.edu/files/2020/07/Unemployment-Effects-of-Stay-at-Home-Orders.pdf; https://www2.ed.gov/about/offices/list/ocr/docs/20210608-impacts-of-covid19.pdf; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7461541/.
20. See https://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/option-for-the-poor-and-vulnerable.
21. See Daniel E. Dawes, *The Political Determinants of Health* (Baltimore: Johns Hopkins University Press, 2020).
22. See https://www.health.harvard.edu/blog/the-pandemic-isnt-over-particularly-for-people-with-disabilities-202105252464, and Tom Shakespeare, Florence Ndagire, and Queen E Seketi, "Triple Jeopardy: Disabled People and the COVID-19 Pandemic," *The Lancet* 397:10282 (2021): 1331-3.
23. See https://theconversation.com/cells-from-human-foetuses-are-important-for-developing-vaccines-but-theyre-not-an-ingredient-157484.
24. CDF, "Note on the Morality of Using Some Anti-COVID-19 Vaccines" (2020): https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20201221_nota-vaccini-anticovid_en.html (emphasis original). This position was recently reaffirmed by the Pontifical Academy for Life: https://www.americamagazine.org/politics-society/2021/12/22/covid-vaccine-ethics-papal-academy-242110.
25. Further justification of the CDF's position has been provided by prominent Catholic pro-life scholars: https://eppc.org/news/statement-from-pro-life-catholic-scholars-on-the-moral-acceptability-of-receiving-covid-19-vaccines/.
26. As Becket Gremmels suggested in correspondence, objections to HEK 293-derived vaccines (which also includes the AstraZeneca vaccine used outside the U.S.) may be expressions of *rigorism* or *tutiorism*, which demand 100% certainty that no directly intended abortion was involved.
27. One who acts from a misinformed conscience may be excused from moral culpability if their conscience is misinformed due to *invincible ignorance*, but not if one's ignorance is caused by willfulness or negligence; see Aquinas 1948, Ia-IIae, q. 19, a. 6.
28. See https://www.patheos.com/blogs/throughcatholiclenses/2021/04/comparing-covid-vaccine-to-other-vaccines/.
29. *Catechism*, n. 1782.
30. See https://www.ncronline.org/news/opinion/catholics-seeking-religious-exemptions-vaccines-must-follow-true-church-teaching.
31. *Dignitatis humanae* (1965), n. 7: https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decl_19651207_dignitatis-humanae_en.html.
32. Ibid., n. 8.
33. Aquinas 1948, Ia, q. 96, a. 4.
34. John Paul II, *Veritatis splendor* (1993), n. 32: https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html.
35. *Gaudium et spes*, n. 30.
36. O. Carter Snead, *What It Means to Be Human: The Case for the Body in Public Bioethics* (Cambridge, MA: Harvard University Press, 2020).
37. CDF 2020.
38. For a similar interpretation of this statement, see Peter J. Cataldo, "Why the CDF *Note on the Morality of Using Some Anti-Covid-19 Vaccines* Suggests a Moral Obligation to Receive SARS-CoV-2 Vaccines" *Health Care Ethics USA* (Fall 2021): https://www.chausa.org/docs/default-source/hceusa/why-the-cdf-note-on-the-morality-of-using-some-anti-covid-19-vaccines-suggests-a-moral-obligation-to-receive-sars-cov-2-vaccines.pdf?sfvrsn=0.

39. https://www.ncronline.org/news/vatican/pope-francis-suggests-people-have-moral-obligation-take-coronavirus-vaccine. The Pope continues, "There is a suicidal denialism that I would not know how to explain but today people must take the vaccine." Francis reiterated his call to be vaccinated in a Spanish-language PSA with several other prelates: https://www.youtube.com/watch?v=rU0prPIbfZ8&t=2s. One could view this PSA as a form of *public fraternal correction* for the sake of the common good, which is a proper function of prelates; see Aquinas 1948, IIa-IIae, q. 33, a. 3.

40. Other examples of "states of exception" include just war and circumstances of dire material scarcity; see Jason T. Eberl, "Unilateral Withdrawal of Life-Sustaining Treatment within Crisis Standards of Care" *Health Care Ethics USA* (Winter 2021): https://www.chausa.org/docs/default-source/hceusa/unilateral-withdrawal-of-life-sustaining-treatment-within-crisis-standards-of-care.pdf?sfvrsn=4.

41. See https://www.nbcnews.com/health/health-news/mandates-roll-out-some-may-ask-medical-exemptions-what-s-n1278264.

How Much of What We Do in Catholic Health Care Is Uniquely Catholic?

Valerye M. Milleson, Ph.D.

There is a presumption that to be competent as an ethicist in Catholic healthcare, a certain amount of expertise in Catholic moral theology is required.[1] What is undetermined, however, is how much expertise? As a clinical ethicist who trained and practiced in non-Catholic institutions before working in Catholic healthcare, I became intrigued by the question: How much of what I was doing now is 'uniquely Catholic'?

My anecdotal experience was that when it came to patient-specific ethics consultations[2], for the vast majority of cases there was no significant difference (and perhaps no real difference at all) in the consultation process itself or in the ethics recommendations. Obviously if a patient, family, or care team member was explicitly Catholic, there was reason to use language related to Catholic moral theory or the Ethical and Religious Directives (ERDs)[3] within the context of the consultation conversations and recommendations. However, knowing when and how to do this would arguably be the same in a non-Catholic institution provided one was a culturally competent clinical ethicist.

Anecdotes being questionable evidence, I decided to review data collected from patient-specific ethics consultations for the previous year within my Ministry Market.[4] While there were limitations to the data available[5], some of the highlights were as follows:

- Over 40% of documented clinical ethics consultations were related to surrogate decision-making (e.g., determination of a surrogate decision-maker, surrogate decision-maker hierarchy, unbefriended patients) and the advance care planning process and interpretation and implementation of advance care planning documents.
- Over 80% of clinical ethics consultations were related to patient-provider relationships more broadly (this includes surrogate decision-making and advance care planning issues, as well as issues of, e.g., informed consent, decision-making capacity, goals of care, confidentiality, risk to self and others, and vulnerable populations).
- Most ERD-related issues were also encompassed by an existing hospital policy or otherwise described using a similar non-Catholic bioethics principle.
- While ERD-related language may have been utilized in conversation during the consultation process, it rarely was documented in the electronic medical record.

Based on the information available, the majority of ethics consultations documented were not the sort that would require significant understanding of Catholic moral teaching or the ERDs, as they could otherwise be fully managed using more general bioethics concepts or hospital policy.

Part of the issue here could be the types of situations that came to the ethics consultation service within the given timeframe at this particular Ministry. In thinking more objectively about what topics or issues *would* be specifically Catholic for clinical consultations, and therefore require a more robust knowledge of Catholic moral teaching and/or the ERDs, the following stand out to me as the more obvious candidates:

Issues in the Professional-Patient Relationship

- One key feature of Catholic healthcare is the strong emphasis on the dignity of the human person. While this may be implicit in the concepts of autonomy or beneficence (i.e., doing good), the ERDs make human dignity foundational and explicit in ways that are less common within a non-Catholic approach.
- Another key feature of Catholic healthcare is the emphasis on caring for those individuals on the margins of society (see, e.g., ERD 3). Again, while this may be implicit in some ways in the concepts of beneficence and justice, it likely carries less weight in non-Catholic approaches to healthcare.

Issues in the Beginning of Life

- Catholic ethics surrounding beginning of life and conception are more likely to be grounded in the sanctity of life and dignity of marriage, rather than the more secular emphasis on patient autonomy, bodily integrity, and maternal-fetal conflict.
- Catholic moral teaching and the ERDs provide specific rules and prohibitions that would not necessarily exist in a non-Catholic institution, such as those surrounding abortion, contraceptives, and sterilization [ERD 45, 52, 53].

Issues Related to the Seriously Ill and Dying

- Catholic moral teaching makes fundamental the position that human life is a gift from God. This can influence ethical decision-making surrounding the seriously ill and dying in ways that are different from a non-Catholic setting, which might otherwise focus more on issues of autonomy and non-beneficence (i.e., non-harming).
- Catholic moral teaching and the ERDs provide specific philosophy, rules and prohibitions that would not necessarily exist in a non-Catholic institution, such as the distinction between ordinary and extraordinary means, artificial nutrition and hydration, and physician-aid-in-dying and euthanasia [ERD 56, 58, 60].

For any of these scenarios, a greater-than-cursory knowledge of Catholic moral theory and the ERDs would likely be helpful, if not indeed necessary. However, if these concerns

do not appear prominent within a particular hospital or healthcare system, should expertise in Catholic moral theology be required? Might it be more efficient and economical to have a competently trained clinical ethicist with minimal understanding of Catholic moral theory and the ERDs, who by virtue of their training and the needs of the Market can perform a sizeable number of clinical ethics consultations that arise in their day-to-day work and need only be able to recognize when assistance from someone with greater expertise in Catholic moral theory is necessary?

Or is there something deeper at play here? Was the predominant absence of Catholic or ERD-related language in documentation and data collection a potential misstep for a professed ministry of the Catholic church? If, in fact, there are relevant values and directives that could be showcased in EMR documentation — regardless of whether the advice could otherwise be provided utilizing only non-Catholic ethics principles and policies — should we? Is this in itself a teachable moment, potent with the capacity to further engender a broader understanding and awareness of our Catholic identity?

And what about the data? If our data collection system tracks largely on more general bioethics principles, and there isn't a clear method for documenting a Catholic emphasis on these principles, are we liable to miss an opportunity to showcase Ethics' role, however subtle, in mission and ministry outreach? If Catholic-specific metrics are either absent or underemphasized, does this downplay their importance in the consultation process, and perhaps even discourage efforts at ensuring Catholic moral teaching and ERDs are part of the ongoing cultural transformation through ethics consultation?

I admittedly do not have answers for these questions. But, if I'm honest, they trouble me.

If indeed there is something special about being a Catholic healthcare ethicist, if there is a true sense of vocation and mission and identity, if we are really the 'hands and feet' participating in the healing ministry of Jesus Christ, shouldn't the answer to at least some of the questions in the preceding two paragraphs be '*Yes*'? And if not, at the end of the day, how much of what we do in Catholic healthcare is actually uniquely Catholic? ✠

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ENDNOTES

1. CHA, Qualifications and Competencies for Ethicists in Catholic Health Care, May 2018.
2. Cases that involve a specific, identifiable patient in the hospital or other healthcare setting.
3. USCCB, Ethical and Religious Directives for Catholic Health Care Services, 6th Edition, June 2018.
4. Nine hospitals and multiple ambulatory surgical centers across Middle Tennessee.
5. Not all consultations performed by ethics committee members were entered into the new database so the data is technically incomplete and analysis is based on existing entries; review of EMR documentation was done as a random sample of Ethics chart notes.

Book Review:
"Pope Francis and the Transformation of Health Care Ethics"

Reviewed by Tobias Winright, Ph.D.

Todd A. Salzman and Michael G. Lawler, *Pope Francis and the Transformation of Health Care Ethics* (Washington, DC: Georgetown University Press, 2021), 240 pp., paperback, $34.95.

Coauthored by a pair of senior, prolific Catholic theological ethicists, who have previously collaborated on numerous books and articles, I eagerly anticipated reading and discussing *Pope Francis and the Transformation of Health Care Ethics* with my graduate students in our seminar on Catholic bioethics this past fall semester. Todd Salzman is the Amelia and Emil Graff Professor of Catholic Theology at Creighton University, and Michael Lawler is Professor Emeritus of Catholic Theology, also at Creighton. Although their latest work's title is undeniably eye-catching, it is slightly misleading in that the book focuses more on recasting the way that the US Catholic bishops ought to regard health care ethics.

Indeed, within its introductory pages and the subsequent seven chapters, the authors critically assess the sixth edition of the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), released in 2018 by the United States Conference of Catholic Bishops (USCCB). Highlighting anthropological, ecclesiological, ethical and methodological tensions that they discern within the ERDs, especially in light of the shifts in these theological areas encouraged by Pope Francis in *Amoris Laetitia* and *Laudato Si'*, Salzman and Lawler ultimately offer their recommendations for revisions for the next edition of the ERDs. An ambitious endeavor, surely, but one that should not be unexpected, including on the part of the bishops. After all, near the end of the Preamble, it is noted that the ERDs "will be reviewed periodically … in the light of authoritative church teaching, in order to address new insights from theological and medical research or new requirements of public policy" (ERDs, pp. 4-5). This opening is something Salzman and Lawler highlight more than once, and they rightly regard it as an opportunity. Not only are there new insights and requirements from theology, medicine, and public policy, which Salzman and Lawler consider, but there is new light, too, from the authoritative church teaching reflected in Francis's papacy. However, evidence of such illumination, in their view, remains lacking in the sixth edition of the ERDs.

In the Introduction, Salzman and Lawler provide an overview of the ERDs, beginning with the first set of guidelines formulated by Michael Burke for the Archdiocese of Detroit in 1921, and the first edition of the ERDs, authored principally by Gerald Kelly SJ in 1948. Also considered are articles and

commentaries about the ERDs by Kelly, Richard McCormick SJ, Orville Griese, Kevin Wildes SJ, Jean deBlois, Kevin O'Rourke, Thomas Kopfensteiner, and Ronald Hamel. In my view, Salzman and Lawler's book echoes and expands the corrective vision of McCormick's *Health and Medicine in the Catholic Tradition: Tradition and Transition* (NY: Crossroad, 1984), with its proposal for revision in light of anthropological, ethical methodological, and ecclesiological developments of Vatican II and its wake. This introductory overview of the history and contents of the ERDs traces some expansion from rule-based applications to clinical concerns to more complex ethical issues such as advance directives, reproductive technologies, artificial nutrition and hydration, and institutional delivery systems mergers. In the Introduction, Salzman and Lawler also offer a metaethical primer about ontology (physicalist or personalist?) and epistemology (ecclesial positivism or perspectivism?). Salzman and Lawler regard their Catholic theological ethics as encompassing both the biological and the relational aspects of the human person, and as aligned with Bernard Lonergan's account of perspectivism, which is not relativism, but a humble recognition of human finitude and partiality when it comes to knowledge of truth.

Chapter One shares the authors' understanding of the four traditional sources of moral guidance (i.e., the Wesleyan Quadrilateral) — scripture, tradition, science, and human experience — and shows "how their selection, interpretation, prioritization, and integration (SIPI) lead to different perspectives on the teachings and directives" of the latest version of the ERDs (p. 25).[1] Salzman and Lawler argue that the ERDs narrow the scope of tradition to the magisterium and that the other three sources — scripture, experience, and science — are subordinated to that hierarchical perspective. In contrast, Pope Francis has sought "greater integration of science and Church teaching," for instance, and Salzman and Lawler propose more integration "on health care and sexual ethical issues" (p. 38). They also hold that conscience should not be reduced to obedience to the magisterium. They consider the 2009 case of Bishop Thomas J. Olmsted of Phoenix and Saint Joseph's Hospital and Medical Center to illustrate their points about how the four sources of ethical knowledge are misunderstood and misused by the episcopacy and the ERDs.

In Chapter Two, the authors highlight anthropological tensions within the ERDs. Anthropologically, the ERDs, like John Paul II's teaching on sexual ethics, continue to prioritize a biological over a relational ontology. Human dignity, while rightly considered foundational in Catholic bioethics, should be understood more holistically, Salzman and Lawler argue, as it is in Catholic social teaching.

Chapter Three continues to be devoted to tensions within the ERDs regarding ethical method. The ERDs exhibit three ethical methods — social, sexual, and health care — which are at times at odds or inconsistently employed. Salzman and Lawler call for a "holistic ethical method" that strives to integrate the best of the methods applied to a range of ethical issues: social, sexual, environmental, and health care. Pursuing this integrated approach includes a consistent ethic of life, dialogue or synodality, attention to virtues, an inductive rather than solely deductive methodology, and a preference for the poor. Health care issues

addressed within this substantive chapter include administration of artificial nutrition and hydration, direct and indirect abortion, the greening of Catholic health care institutions, and artificial contraception.

Ecclesiological tensions within the ERDs are the focus of Chapter Four. Salzman and Lawler critique the hierarchical model of Church that characterizes the ERDs, especially the authority of the bishops, and propose integrating a mutually reciprocating teaching and learning communion model with an appreciation for the *sensus fidelium*. As Pope Francis advises, "Keep an open mind. Don't get bogged down in your own limited ideas and opinions, but be prepared to change or expand them. The combination of two different ways of thinking can lead to a synthesis that enriches both" (*Amoris Laetitia*, §139, quoted on p. 108). Relatedly, Salzman and Lawler extend their critique of the hierarchical authority of the episcopacy to include the diocesan bishop's reliance upon "approved authors" for guidance on moral questions in health care. Indeed, numerous times in the book, the Salzman and Lawler lambaste the line within the ERDs (p. 7) about "the guidance of *approved authors* can offer appropriate guidance for ethical decision making" (pp. 12, 35, 86, 110, italics added by Salzman and Lawler). Salzman and Lawler rightly argue that the theologian's task includes but goes beyond catechesis, and they call for broader theological consultation, as "equal partners" (p. 117), including lay women and men across expanding demographics amongst the entire body of the baptized faithful. The authors also believe that doing so will prove helpful when bishops sometimes disagree amongst themselves, including when Catholic health systems bridge across dioceses.

The ERDs emaciated perception of and prescriptions for pastoral and spiritual care are dealt with in Chapter Five. In Salzman and Lawler's judgment, the ERDs focus too narrowly on the sacraments and are insufficient regarding spirituality and the human experience of sickness. My students and I had an engaging discussion of the authors' recommendation "that unconscious sick persons should not be involved in the celebration of any sacrament" (135), and their suggestion to expand our awareness of small-"s" sacramental presence beyond the seven Sacraments stimulated reflection and creative brainstorming about discernment, empathy, mercy, and being present to those in our care.

In Chapter Six, the authors tackle part 6 of the ERDs on "Collaborative Arrangements with Other Health Care Organizations and Providers," which is where the sixth edition noticeably has been revised compared to the previous one. Salzman and Lawler critically consider three revisions within this section. First, the ERDs reinforce the authority of the local bishop. Here Salzman and Lawler note that although directive 69 of the ERDs recognize that Catholic health care systems may span numerous dioceses, there are no guidelines for achieving consensus between bishops who may be in disagreement (p. 159). A remedy, in their view, would be the "communional-synodal approach to decision-making in the Church" (p. 164). Second, the ERDs attempt to clarify the principles governing cooperation, but Salzman and Lawler note its failure to consider proximate and remote material cooperation, as well as its lack of clarity concerning individual and institutional (e.g., a Catholic health care institution as "juridic person") aspects, including conscience,

the common good, and the "moral act" (i.e., object[s], end, and circumstances). Third, the ERDs continue to be concerned about *scandal*, but Salzman and Lawler wonder "how claims of scandal are to be justified" (177).[2] As for *witness*, the authors recommend reorienting it so that it includes Pope Francis's teachings on synodality and accompaniment.

The final chapter is the most constructive and, I suspect for most readers of *Health Care Ethics USA*, the one that will be of most interest. In Chapter Seven, Salzman and Lawler offer their suggestions for revisions of the ERDs. I don't want to spoil it for anyone, but I appreciate their extension of attention in Catholic health care to include the environment and climate change, race, immigration, technological developments, sex and gender, poverty, and law, policy, and religious freedom.

Because I share most of the concerns raised by Salzman and Lawler, whom for the sake of transparency I should say I count as friends, identifying weaknesses and offering criticisms of their work is difficult. A worry I have is that, while they rightly highlight the sex-abuse crisis and its impact on episcopal authority, repeatedly doing so may backfire by making bishops instead even more defensive against, and resistant to, Salzman and Lawler's criticisms and recommendations.[3] Relatedly, Salzman and Lawler rightly call for "the way of dialogue of charity recommended by Popes John Paul II and Francis" (p. 4), and although the bishops might at times fall short on this, I worry that they might feel the same about Salzman and Lawler on occasion in the book. To mitigate the likelihood of such defensiveness, instead of spending most of the book's pages criticizing the bishops and critiquing the ERDs, perhaps it would have been better to expand the last chapter's excellent suggestions for revising them. Still, I do hope that future revisions of the ERDs will include attention to Salzman and Lawler's book.

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ENDNOTES

1. The four sources of the so-called Wesleyan Quadrilateral are often invoked, although the third and fourth fonts are explicated variously amongst authors. For example, where Salzman and Lawler refer to s*cience*, many others highlight *reason*. See Tobias Winright, "Introduction: Christian Ethics and the Four Sources," in *T&T Clark Handbook of Christian Ethic*s, ed. Tobias Winright (London: Bloomsbury/T&T Clark, 2021), 1-4, and the subsequent four chapters devoted to each source by Kathryn D. Blanchard (on scripture), D. Stephen Long (on tradition), Laurie Johnston (on experience), and Kathryn Lilla Cox (on reason). Interested readers may also wish to see in this same volume the chapter by Todd A. Salzman and Michael G. Lawler, "Nondiscrimination Legislation and Sexual Orientation and Gender: A Critical Analysis of the Catholic Position," 473-481.
2. Although Salzman and Lawler do not offer one, a helpful account of scandal and constructive framework for its justification, see Nathaniel Blanton Hibner, "Scandal: Delving Into Popular Versus Theological Definitions," *Health Progress* 99, no. 6 (November-December 2018): 71-72; and his "Discerning Scandal: Theological Scandal in Catholic Health Care Decision Making" (PhD diss., Saint Louis University, 2019).
3. As I see it, such defensiveness would be similar to the way that some police in the United States react to criticisms such as "defund" or "abolish" the police. See Tobias Winright, "American policing on trial," *The Tablet* (May 6, 2021): https://www.thetablet.co.uk/features/2/19975/american-policing-on-trial.

Legal Lens

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, Associate Director, supervised contributions by Jessie Bekker (J.D., M.H.A. anticipated 2023) and Darian Diepholz, M.B.A., M.P.H. (J.D. anticipated 2022).

UNVACCINATED? DON'T COUNT ON LEAVING YOUR FAMILY DEATH BENEFITS

Michelle Andrews, *Kaiser Health News*, November 3, 2021. https://khn.org/news/article/unvaccinated-workers-death-benefits/

The New York Metropolitan Transportation Authority (MTA) has excluded workers who were unvaccinated and died of COVID from their death benefit policy. MTA announced the policy in June, disqualifying bereaved families of the unvaccinated from receiving a $500,000 payout. About 70% of MTA employees were vaccinated as of early November 2021. Generally, people working risky jobs, including firefighters and transit workers, are provided extra coverage for on-the-job deaths. Disease was not typically considered to be a reason for death payout, because it was presumed disease was contracted outside of working hours. Some employers are flipping the presumption when it comes to COVID. Companies are also considering limiting short-term disability benefits to unvaccinated employees.

RURAL HEALTH CARE PROVIDERS GET $7.5 BILLION IN RELIEF FUNDS

Mark Walker, *The New York Times*, November 23, 2021. https://www.nytimes.com/2021/11/23/us/politics/rural-health-care-relief-funds.html

The Department of Health and Human Services is disbursing $7.5 billion across 40,000 rural health care providers to help hospitals ravaged by the COVID-19 pandemic keep their doors open. The funding, allocated to rural providers by the American Rescue Plan, passed by Congress in March, aims to secure health care access despite the unique financial struggles rural providers faced as a result of the pandemic. Most rural providers disproportionately receive public insurance payments for patients with complex needs, thinning margins; since 2020, 21 rural hospitals have ceased operations. Providers in rural areas are eligible for payments if they serve at least one Medicare, Medicaid or Children's Health Insurance Program (CHIP) beneficiary. Payments range from $500 to $43 million, averaging around $170,000, based on the number of claims the provider submitted through 2019 up until September 2020. Providers have some discretion over how they spend funds, including coverage of labor costs, personal protective equipment, and ventilators. Vice President Kamala Harris also announced a $1.5 billion commitment to address provider shortages in both rural and urban areas.

HEALTH SPENDING GROWTH MORE THAN DOUBLED IN FIRST YEAR OF PANDEMIC

Rachael Levy, *Politico*, December 15, 2021.
https://www.politico.com/news/2021/12/15/health-care-spending-increase-pandemic-524793

By the end of 2020, the medical system accounted for almost one-fifth of the U.S. economy. Health care spending increased 9.7 percent, resulting from the federal spending to contain the spread of the COVID-19 virus. Specifically, funding for health care providers, public health programs, and Medicaid payments increased 36 percent. For example, the Provider Relief Fund and Paycheck Protection Programs were created to compensate providers for lost revenue and increased costs. Medicaid spending increased as 3.7 million people signed up for Medicaid after the pandemic struck due to reasons such as job cuts. This was the biggest rise in Medicaid enrollment since 2015. With the increased enrollment in Medicaid, program spending rose by 9.2 percent (16 percent of the U.S.'s total health care spending). Plus, Medicaid hospital spending increased by 6.7 percent. Finally, out-of-pocket spending declined by 3.7 percent for consumers due to less health care being used and little cost-sharing for COVID-19 testing and treatment.

OPIOID VERDICT PUTS HEALTH SYSTEMS NEXT IN LINE FOR LAWSUITS

Ian Lopez, *Bloomberg Law*, December 15, 2021.
https://www.bloomberglaw.com/bloomberglawnews/health-law-and-business/X4FF96S000000?bna_news_filter=health-law-and-business#jcite

Over the past four years, litigation has ensued over the opioid epidemic leading to over 800,000 overdose deaths in the U.S. These lawsuits have already moved through the drug manufacturers to distributors and recently to pharmacies. Walmart Inc., CVS Health Corp., and Walgreens Boots Alliance Inc. have joined others as the newest drug supply chains that have been blamed for fueling the opioid crises. The court found the chains failed to monitor illegitimate opioid prescriptions properly. A recent case, out of Cleveland, departed from earlier wins, as the court found the pharmacies created a public nuisance, while past judges have tossed the claims out. Such differing conclusions could lead to future forum shopping for courts likely to rule in the plaintiff's favor. Additionally, the Cleveland case could mark a shift in lawsuits, as plaintiffs start assessing other entities who may be responsible for the dispersal of opioids, such as health systems or large, managed care medical groups. David Nool, Rutgers law professor, stated that Walmart, CVS, and Walgreens were in unique situations where "robust compliance systems would have made a difference." Therefore, future litigations will be looking for similar situations of high volume and substandard compliance systems, such as hospitals with large networks. Others who may be liable include marketers for drugmakers and "data aggregators" who collect data for marketing.

MEDICARE WON'T COVER CONTROVERSIAL ALZHEIMER'S DRUG — UNLESS PATIENTS ARE IN A CLINICAL TRIAL

Katherine Ellen Foley, *Politico*, January 11, 2022.
https://www.politico.com/news/2022/01/11/medicare-alzheimers-drug-trial-526943

The Centers for Medicare and Medicaid Services (CMS) will provide coverage for a controversial Alzheimer's treatment for those enrolled in clinical trials. The drug, Aduhelm, manufactured by Biogen, "targets amyloid build-ups in the brain thought to cause the disease." While FDA approved, it is unclear whether the decrease in amyloid it causes helps patients' cognition. It is also unclear whether the drug is safe, as some clinical trial participants have experienced brain bleeding or swelling. The drug costs over $28,000 per year, though Medicare does not consider drug price when making a coverage determination. Instead, Medicare uses a cost-benefit analysis to determine whether the drug's benefits outweigh its potential harms to patient health. CMS has proposed coverage for one scan per patient to detect the proteins Aduhelm attacks. Biogen would be responsible for other clinical trial costs. Biogen's drug is the only one of its kind on the market now, though other drugs are in late-stage clinical trials and would be covered under CMS' proposal. The final coverage decision is expected by April 11.

GEORGIA BILL AIMS TO LIMIT PROFITS OF MEDICAID MANAGED-CARE COMPANIES

Andy Miller and Rebecca Grapevine, *Kaiser Health News*, January 27, 2022.
https://khn.org/news/article/georgia-legislation-limit-profits-medicaid-managed-care-companies/

Georgia's Medicaid managed care programs may be required to spend a certain amount on medical care or repay millions of dollars should a bipartisan bill pass. The House of Representatives is weighing a mental health parity act, within which is a provision that would require Medicaid managed care companies in the state to spend more on medical care and quality improvements or send its unspent dollars back to the state. On average, the state's managed care insurers pocket $189 million in profits. Of the 40 state Medicaid programs which contract with managed care companies to insure the state's Medicaid beneficiaries, 36 and the District of Columbia mandate a minimum threshold of dollars spent on medical care. Six, including Georgia, do not. If the bill becomes law, mandatory spending limits would begin in 2023. The state Department of Community Health, which runs the Medicaid program, did not comment on the legislation.

NURSES MADE $1.5 MILLION SELLING FAKE VACCINATION CARDS, PROSECUTORS SAY

Hannah Knowles, *The Washington Post*, January 30, 2022. https://www.washingtonpost.com/health/2022/01/30/nurses-fake-vaccination-cards-long-island/

Julie DeVuono, a pediatric nurse who for years taught "vaccine exemption workshops," was arrested in January, along with an employee, for allegedly selling falsified COVID vaccine cards. In about three months, DeVuono, 49, and Marissa Urraro, 44, raked in $1.5 million in profits. Both were charged with forgery, and DeVuono was also accused of knowingly providing false information to a public office, or offering a false instrument for filing under New York law. They are accused of providing false information to the state through New York's immunization information system. Both have pleaded not guilty. Across the country, cases alleging illegal attempts at dodging COVID vaccination requirements are surfacing. A paramedic in Delaware and a woman in New Jersey were accused of selling fraudulent or blank COVID vaccination documents, respectively.

MENTAL HEALTH THERAPISTS SEEK EXEMPTION FROM PART OF LAW TO BAN SURPRISE BILLING

Julie Appleby, *Kaiser Health News*, February 3, 2022. https://khn.org/news/article/surprise-billing-mental-health-therapists-exemption-no-surprises-act/

Mental health therapists are worried about the price transparency provision of the No Surprises Act, which requires licensed medical practitioners to provide detailed upfront cost estimates. These estimates include information on the length of a course of treatment. Therapists are concerned because diagnoses take time and can change. If they over estimate by at least $400, the law allows uninsured or self-pay patients to challenge the bill in arbitration. Mental health providers sent a letter on January 25, 2022, to the Department of Health and Human Services seeking exemption from these "good faith" estimates. The therapists claim requiring billing codes in the estimates before ever seeing a new patient is unethical, and tallying up months of treatment costs could discourage patients from seeking care. They fear insurers could also use estimates to limit treatment for those insured or to negotiate pay. The Center for Medicare & Medicaid Services says mental health providers are not exempt but are working on technical assistance for mental health providers. Additionally, in an email to KHN, CMS noted that mental health providers could provide an estimated cost for screening and follow-up with future estimates after a diagnosis is made.

BILL SEEKS TO LIMIT OUT-OF-POCKET SPENDING ON INSULIN

Steve LeBlanc, *AP News*, February 10, 2022. https://apnews.com/article/health-business-massachusetts-medication-prescription-drugs-bb30f93e339efb00474e485523fbac63

The Massachusetts Senate approved a bill in February 2022 that addresses the rise in prescription drug costs. The bill proposes to eliminate deductibles and coinsurance, plus cap co-pays at $25 for a 30-day supply of insulin. Supporters of the bill point to the out-of-pocket costs for insulin reaching over $1,000 a year for some patients. Beyond insulin, the bill

would direct the Massachusetts Health Policy Commission to create a process for finding other drugs with a price threshold that could pose a public health risk. The Commission could recommend pricing to increase access and manufacturers that do not comply would have to pay a fee towards new drug cost assistance programs to support patients, specifically communities of color and low-income disproportionately harmed. Additionally, the bill would provide easier access to mail-order prescriptions and allow patients to choose their pharmacy by new specialty drug licensing for pharmacists. Finally, pharmacy benefit managers would have more oversite with the bill, and pharmaceutical companies would be required to alert the state of new drugs coming to market and significant prices increases of current drugs. The bill is now headed to the House for review.

Literature Review

Reviewed by Jordan Bauer, RN, MS

Sheppard, Katherine N, Barbara G Runk, Ralitsa S Maduro, Monica Fancher, Andrea N Mayo, Donna D Wilmoth, Merri K Morgan, and Kathie S Zimbro. 2022. "Nursing Moral Distress and Intent to Leave Employment During the COVID-19 Pandemic." *Journal of Nursing Care Quality* 37 (1): 28-34. doi:10.1097/NCQ.0000000000000596.

This research study was performed by nurses and for nurses. It arose out of a concern that the increasing number of COVID-19 cases with limited resources to care for them in the healthcare system would harm nurses. Specifically, the authors suspected that an increase in moral distress among nurses would cause them to seek employment elsewhere. Moral distress, which is defined as a phenomenon that occurs when one knows the ethically correct action to take but is constrained from acting, has been shown to increase nurse turnover. This study claims to be the first to connect that datum with the COVID-19 pandemic and took place during the late summer months of 2020 when there was a particularly high incidence of COVID-19 occurring in healthcare systems across the country.

In short, their suspicions were confirmed. They identified two factors in moral distress that influence nurses in leaving their position: 1) poor patient care quality and safety; 2) work environment. On the one hand, nurses who expressed moral distress regarding patient care quality and safety were almost three times more likely to state they were considering leaving their position due to moral distress. For these, the moral distress arose from such things as witnessing violations of standards of practice or medical errors and not feeling sufficiently supported to report the violation. Other factors may have included taking care of patients that a nurse did not feel qualified to care for. On the other hand, and perhaps even more dramatically, nurses who expressed moral distress over issues with work environment were nine times more likely to state that they were considering leaving their position due to moral distress. Some of these influences in the work environment may have included working with a lack of resources or perceiving a lack of respect for patients. Additionally, poor work environment may have involved feeling pressured or required to do things that the nurse was not comfortable with or in the patients' best interest.

In their discussion and summary, these authors emphasize the importance of both minimizing moral distress where possible and helping nurses develop good coping strategies for moral distress. In their hospital system, the nurse executive took charge in engaging nurses for the sake of minimizing moral distress and helping them feel supported ethically. The nurse executive also tried to foster a sense of belongingness among the nursing staff. Regarding coping, the authors noted a shocking deficiency in nurse familiarity with ethics consultation and thus suggest greater ethics education on such resources. They also recommend ensuring that nurses are utilizing the employee assistance programs, such as

counseling, already in place for the sake of mental health. Apart from addressing these deficiencies, the study is weak in making suggestions for mitigating moral distress on a systemic level. However, it drives home the connection between the moral harm that is occurring among nurses with poor employee retention, particularly during COVID-19. The researchers in this study emphasize that nursing turnover presents a tremendous expense to the health care organization (recruiting, hiring, orienting, etc.) over several months. This makes keeping frontline nurses in place and in action a huge priority for maintaining the bottom line. For those who may not prioritize the moral health of nurses, this nurse-driven study advocates for greater attention to moral distress among nurses on the grounds of expense to the organization, as if to say, "Maybe this will get their attention."

Spilg, Edward G, Cynda H. Rushton, Jennifer L Phillips, Tetyana Kendzerska, Mysa Saad, Wendy Gifford, Mamta Gautam, et al. 2022. "The New Frontline: Exploring the Links Between Moral Distress, Moral Resilience and Mental Health in Healthcare Workers During the COVID-19 Pandemic." ***BMC Psychiatry*** **22 (19): 1-12. doi:10.1186/s12888-021-03637-w**

This study performed in Canada from April to September, 2020, stresses the point that healthcare organizations should do more to protect their most valuable assets, namely their employees. The study observes that health care workers will unavoidably face moral adversity in the workplace. Situations of moral conflict persist and are exacerbated by such tremendous triggers as the culmination of the COVID-19 pandemic. The study investigates the relationships between the moral resiliency, moral distress and mental health of health care workers in the midst of the pandemic. Moral distress, according to these authors, is described as the distress that comes from ethically judging and acting when the consequences seem to challenge one's own integrity. It comes from frequently making tough ethical choices like triaging patients in the context of limited resources or whether to follow directions that go against professional standards. Moral resiliency, on the other hand, is the ability to sustain or restore one's integrity in response to such adversity. The study hopes to demonstrate the protective potential of developing moral resilience against the onslaught of potentially morally distressing events that health care workers are exposed to.

There are four notable results from this study. First, health care workers who are exposed more frequently to COVID-19 patients have a correspondingly higher likelihood of experiencing moral distress, a trend that continues despite passing time and exposure. It does not just improve with time or experience. Secondly, health care workers with such frequent exposure are prone to higher moral distress if their moral resiliency is low. Third, there is a correlation between high moral resilience and better mental health outcomes. Finally, some populations (particularly males, those without current mental disorders, those who sleep well and those who experience high levels of support) are more prone to moral resilience than others.

Above all, this study demonstrates that moral resilience does temper the development of moral distress while being exposed to potentially morally distressing events (such

as frequently caring for COVID-19 patients). The authors acknowledge the need to reduce the frequency and intensity of exposure to COVID-19 patients on a systemic level, but they underscore the need to simultaneously cultivate healthcare workers' capacities of moral resilience. Moral adversity will occur, the researchers admit, but the healthcare system should acknowledge and confront the internal sources of distress by promoting self-regulatory skills such as mindfulness and inculcating moral efficacy, self-stewardship, and buoyancy among their health care workers. They should also develop a community of support and interconnection that honors individual integrity and values. In short, health care systems (and health care as a whole) need to train health care workers to deal with moral adversity in a confident and mutually supportive way. If it was not obvious before, COVID-19 has made this very clear: this is how we protect our greatest assets.

Jackson-Meyer, Kate. 2020. "Moral Distress in Health Care Professionals." ***Health Progress:*** **23-29.**

This article by Kate Jackson-Meyer offers a more comprehensive view of what moral distress is and how it impacts health care workers, both before and during the COVID-19 pandemic. She provides a very helpful overview of the development of the term. When first coined, moral distress applied to those who know the right thing to do but are constrained by the institution from doing so. Now, however, a broader definition of moral distress is called for which consists of negative self-directed emotions or attitudes in response to perceived involvement in situations one perceives to be morally undesirable. Admittedly, this definition includes almost all situations that stimulate moral discomfort and encompasses, to varying degrees, the vast majority of health care professionals during the COVID-19 pandemic. Yes, she suggests, the problem is that big. Somewhat presciently, Jackson-Meyer envisions that the moral effects of the pandemic on health care professionals will be long lasting (and she is writing in 2020).

Moral distress, Jackson-Meyer points out, is rooted in challenges to one's self-understanding as a moral being. Its effects occur in waves including initial distress, reactive distress and moral residue. Further, the effects are physical, emotional, behavioral, and spiritual. They may manifest as fatigue, anger, guilt, anxiety, depression, spiritual distress, loss of meaning. These effects may lead to burnout, and they clearly reveal the vulnerability of the healthcare professional and their need for considerable care.

How do we care for our health care professionals, particularly in light of the pandemic? Jackson-Meyer proposes a substantial and multi-layered approach for health care systems. Of note, she emphasizes the need to address three levels of moral distress: moral, psychological, and spiritual. Each level deserves its own interventions, calling for the involvement of ethicists, spiritual advisors, and mental health professionals. She also advocates for both immediate and long-term action plans rooted in ethical education, moral distress assessments, and ethical discussions. Some of her interventions include using the MMD-HP (Measure of Moral Distress for Health Care Professionals) assessment, practicing interdisciplinary moral health rounds, and offering ethics workshops and webinars. Further, Jackson-Meyer invites

further investigation into moral distress along the lines of Catholic morality, social teaching, and theology. In her view, there is work to be done on all fronts.

SYNTHESIS

As a hospice nurse in the early stages of the COVID-19 pandemic, I recall being hit with the enormity of potentially morally distressing events such as limiting visitors for dying patients. It is heartbreaking and it is personal. These three articles all demonstrate that health care organizations need to take serious action in addressing moral distress among health care workers during the COVID-19 pandemic. As nurse shortages now challenge health care systems, travel nurses are filling in gaps at a tremendous cost, and large sign-on bonuses are being used for recruitment. Now is the time to take an honest look at the real issues behind health care worker burnout. Money cannot fix it. Beyond mere concern for the bottom line or employees as our greatest assets, Jackson-Meyer admirably perceives health care workers as themselves worthy of the same compassion and care provided to patients. Her proposed interventions beautifully resemble acts of mercy. It is a matter of Christian charity. For me, as a nurse working in the field, her analysis and action plan ring true and re-enkindle in me a desire to engage with and care for my colleagues on the front lines with me.

Despite their different perspectives, all three articles point out the tragic inadequacies of the current health care environment in dealing with moral distress. Likewise, all three call for greater assessment, some level of systemic change, and the development of moral resiliency or coping among health care workers. Health care organizations need to start by assessing underlying levels of moral distress and daring to ask the difficult questions about whether their employees feel supported in ethical decision making. This is no small task. However, our health care workers, our colleagues or mission partners, are suffering from moral distress and feeling like they cannot do their jobs anymore. Attending to these wounds must be part of our Catholic mission.

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