WINTER 2021
volume 29, number 1

HCEUSA

Health Care Ethics USA

A quarterly resource for the Catholic Health Ministry

QUARTERLY

FEATURES

The Second Annual Catholic Healthcare Innovation in Ethics Forum | 2

Rachelle Barina, Ph.D.
Becket Gremmels, Ph.D.
Jenny Heyl, Ph.D.
Nicholas Kockler, Ph.D.
Kevin Murphy, Ph.D.
Mark Repenshek, Ph.D.

On the Purpose, Role(s) and Function(s) of Catholic Health Care Ethics Leaders | 5

Elliott Louis Bedford, Ph.D.

Unilateral Withdrawal of Life-Sustaining Treatment Within Crisis Standards of Care | 8

Jason T. Eberl, Ph.D.

A Proposed Pipeline for Ethicists | 11

Becket Gremmels, Ph.D.

The Virtual Clinical Ethics Intensive | 15

Matthew R. Kenney, Ph.D., HEC-C

Global Bioethics in a Pandemic: A Dialogical Approach | 18

Alexandre A. Martins, MI, Ph.D.

Integrating Ethics in Formation: Exploring Courses in Leadership Formation | 21

Mark Repenshek, Ph.D.
Matthew Kenney, Ph.D.
Celeste Mueller, D.Min.

Hiring Clinical Ethicists: Building on Gremmels' Staffing Model Approach | 24

Mark Repenshek, Ph.D.

Shared Ethics Call: Responding to the Needs of the Organization and the Health of Its Ethicists | 28

Jenna Speckart, D.Be., M.A.

Integrating Formative Practices into Ethics Education | 31

Emily Trancik, Ph.D.

ALSO IN THIS ISSUE

Legal Lens | 34

Literature Review | 39

© Catholic Health Association of the United States. Published quarterly by the Catholic Health Association of the United States (CHA) and the Albert Gnaegi Center for Health Care Ethics (CHCE) at Saint Louis University. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposed. ISSN 2372-7683

CHA Catholic Health Association of the United States

SAINT LOUIS UNIVERSITY™

The Second Annual Catholic Healthcare Innovation in Ethics Forum

Rachelle Barina, Ph.D.
Becket Gremmels, Ph.D.
Jenny Heyl, Ph.D.
Nicholas Kockler, Ph.D.
Kevin Murphy, Ph.D.
Mark Repenshek, Ph.D.

***Editor's Note**: We are pleased to present this special Winter 2021 edition of Health Care Ethics USA that features a series of articles presented by Catholic health ethicists at the Catholic Healthcare Innovation in Ethics Forum (CHIEF). The second annual forum was hosted by Providence Center for Health Care Ethics and CommonSpirit Health in September 2020. In light of the scope, range and depth of the articles, we are publishing the entire collection for our readers in this special edition. An overview of CHIEF is provided below. We will resume our normal publication of HCEUSA with the Spring 2021 issue.*

INTRODUCTION

The second annual Catholic Healthcare Innovation in Ethics Forum (CHIEF) was hosted by Providence Center for Health Care Ethics and CommonSpirit Health in September 2020.[1] While Providence had planned to host in person, due to the COVID-19 pandemic, CHIEF was held virtually in conjunction with CommonSpirit Health. Regardless of venue, the goals of CHIEF remained the same: 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. This year we identified five focal areas for submissions:

1. Ethics Across the Continuum
2. Ethics and Data Science
3. Ethicist Pipeline and Career Trajectory
4. COVID-19
5. High Reliability in Clinical Ethics

Once again, the presentation format featured 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 three days, there were 29 presentations from 24 ethicists on topics ranging from crisis standards of care to creating

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

a shared call schedule for ethics consults throughout a health system. There were 59 attendees, more than double from the inaugural CHIEF.

The planning committee approached the transition to a virtual format with the intention to leverage the benefits of the technology while also making the conference engaging and faithful to its original intent and structure. The committee designed the structure 'with the brain in mind.'[2] Thus, the committee preserved the lightning round presentations with Q&A sessions, but thematic breakout groups and "brain breaks" were introduced.

In addition, we were blessed that one of the presentations was a keynote from Johnny Cox, Ph.D. The committee's intent behind introducing a keynote was to incorporate a more retreat-like atmosphere during the conference that encouraged prayer and introspection into an ethicist's vocation. A hope for this keynote was that it not only spurred participants' reflections on their own vocation, but also enriched the fellowship we have grown to appreciate and enjoy in this field. Specifically, we invited Dr. Cox to share a deep sense of the professional and spiritual dimensions of this work and how this wisdom might lead us through our careers. As the keynote took shape, it became clear that it was going to be a natural extension of Paul Wadell's, "The Inner Life of Ethicists: The Importance of Cultivating an Interior Life," which was first delivered at CHA's annual Theology and Ethics Colloquium in 2019.[3]

Evaluation data indicate that CHIEF was once again a success. Survey respondents indicated that, on average, they would be likely to make changes to the ethics services at their respective organizations as a result of attending CHIEF. Such changes include but are not limited to developing formalized ethics education processes; articulating and using criteria on when to hire ethicists and structuring career pathways; and deepening the integration of ethics and mission formation. Generally, the quality and value of the CHIEF program and structure compared favorably to other professional events respondents attend. Overall, the experience of the virtual format of the CHIEF conference was viewed very positively by respondents. The one area where opportunity for improvement was most obvious was the newest addition: the thematic breakout sessions. Eighty-seven percent of respondents indicated they would attend CHIEF again in the future.

As with last year's CHIEF, the Catholic Health Association offered to publish summaries of presentations in *Health Care Ethics USA* for presenters who wished to submit one. We look forward to holding CHIEF again this fall, and a day when we can once again meet in person with our colleagues.

Acknowledgements: *The Committee would like to extend special thanks to Katie Hoff (Ascension) for her assistance in designing the conference; to Russell Keithline (CommonSpirit Health) for his virtual hosting and technical skills; to Christopher Ostertag (Ascension) for his assistance*

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

in getting the conference designed and launched; and to Kelsi Charlesworth and Eileen Mooney (Providence) for their vigilant support, know-how, and can-do approach to collaboration and commitment to service excellence. The Committee also extends deep appreciation for the support and collaboration with the Catholic Health Association for CHIEF and the opportunity to publish papers presented during the conference.

ENDNOTES

1. For the inaugural CHIEF, see Gremmels, Becket, Nicholas Kockler, Kevin Murphy, and Mark Repenshek. "The Inaugural Catholic Healthcare Ethics Innovation Forum." *Health Care Ethics USA,* Winter-Spring 2020, 28:1.
2. For example, see David Rock, "Rethinking How We 'Conference'," PsychologyToday.com, posted April 22, 2011, accessed January 25, 2021.
3. Paul J. Wadell, "The Inner Life of Ethicists: The Importance of Cultivating an Interior Life," *Health Care Ethics USA,* Spring 2019, 10-21.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

On the Purpose, Role(s) and Function(s) of Catholic Health Care Ethics Leaders

Elliott Louis Bedford, Ph.D.

OUR PRESENT CONTEXT

The pace of change in our national health care landscape has accelerated since the novel coronavirus, COVID-19, made its way from Wuhan, China to American shores. For many in health care, the biggest changes have been not so much *what* we are doing but *how* we are doing it.

Front-line clinical care has increasingly focused on higher acuity areas like ICUs, sometimes limiting resources for non-COVID related care such as elective surgeries, as well as workforce realignment.

Large numbers of administrative or non-clinical personnel have begun working remotely. Virtual meetings are now seemingly the default. Virtual health visits have skyrocketed and are now seen as a standard approach to addressing concerns.

For institutions, public health discussions and plans for allocating scare resources — such as personnel, protective equipment, ventilators, emergency use drugs and vaccines — have all come to dominate our attention.

At the sociopolitical level, ethical issues related to the common good have become impassioned topics of discussion. Consider the ongoing tension between the social, economic and health-related damage imposed on people through gubernatorial shutdowns and mandates compared to the benefits of preventing the overrun of health systems and minimizing spread of the disease.

In many ways, COVID-19 has come to dominate not only what health care is focused on, but also, for good or for ill, the lens through which we view life in general. This changing context provides a very practical reason to reflect on the purpose, role and function of ethicists in Catholic health care as well as the appropriate education, training and mentorship of young talent coming into a field and workplace that has experienced rapid change.

SHIFTS IN THE PROFESSION

Such questions, however, are not new or unique to the COVID reality. In response to these issues — both old and new — the Catholic Health Association (CHA) continues to produce helpful resources and information that can help us reexamine these foundational questions.

Consider the surveys of practicing ethicists CHA published in 2009 and 2015.[1] One conclusion drawn from the 2015 survey highlights how, compared to 2009: “The

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

responsibilities of ethicists seem to be changing with rapid changes in the health care delivery system" and such "developments have implications for the adequate preparation of new ethicists.[2] The significance of changes to roles and responsibilities is amplified by a simultaneous shift in educational backgrounds among ethicists that is also noted in the 2015 survey. Newer entrants increasingly have degrees in health care ethics multidisciplinary as distinct from the more historically prevalent discipline, theology.[3] Indeed, this fact speaks to a relatively recent proliferation of educational programs and professional trainings, starting in the mid-1990s to present.

Not only have the specific roles, responsibilities and educational background of ethicists shifted, but the 'model' of the ethics program — how they are attempting 'do ethics' in a particular health system — also varies across health systems. In 2004, for instance, Nancy Parent Bancroft wrote about a committee-focused "Next Generation Model" of ethics committees, "which challenges ethics committees to recommit themselves as instruments of ethical change within their institutions. In the spirit of responsible stewardship, the model invites committee members to hold themselves accountable for measurable outcomes."[4] In 2019, Matthew Kenney outlined the "Proactive Ethics Integration" model, in which ethicists implement a comprehensive program geared towards improving "institutional capacity to influence clinical decision-making [and non-clinical] in *anticipation* of potential ethical concerns."[5]

In short, data and experience show that certain points of variability and change in roles or ethics program models, as well as a lack of shared quality standards and national benchmarks, are present in the field.

WHO ARE WE? WHERE ARE WE GOING?

I raise these points reflecting on the variabilities for two reasons. First, if we are all trying to accomplish the same thing, let's not continually feel like we must reinvent the wheel or tackle the problem in isolation. Second, articulating an explicitly shared understanding of our role, functions and programmatic objectives will better enable solutions to longstanding pipeline issues, including lack of internships or entry level positions.[6]

With these points in mind, I raise the following questions to prompt further discussion and dialogue within our field:

- Do we have a shared vision (whether explicit or implicit) of what it means to be a leader in Catholic health care ethics? Do we need one?
- Is there/should there be common expectations about the role, purposes and programmatic goals of Catholic health ethics leaders within Catholic health care?
    - Is this different from professionalization (e.g., ASBH)?
    - Do we have clarity around what expectations *others within our organizations* have of us (e.g., administration, clinicians)?
- How do we continue to create a more graduated approach for entry into the field?
- How do we build corresponding practical educational experience for students?

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

By discussing these questions and discerning the appropriate answer, our field will be better prepared in the future to know who we are, where are we going, and why we are going there.

ELLIOTT LOUIS BEDFORD, PH.D.
Director, Ethics Integration
Ascension St. Vincent
Elliott.bedford@ascension.org

CITATIONS

Bancroft, N. P. "The "Next Generation" Model." *Health Progress* 85 (May-June 2004): 27-30.

Bedford, E. L. and E. K. Johnson. "Building a Pipeline: Connect Young Talent with the Ministry." *Health Progress* (Saint Louis, Mo.) 93, no. 3 (2012).

Bedford, Elliott Louis. "Catholic Health Ethics Internships: Lessons Learned from Five Years' Experience." *Health Care Ethics USA* 28, no. 1 (Winter-Spring 2020): 3-4.

Gremmels, Becket. "When to Hire a Clinical Ethicist." *Health Care Ethics USA* 28, no. 1 (Winter-Spring 2020): 16-18.

Hamel, R. "A Critical Juncture. Surveys of Ethicists and Mission Leaders Indicate Concerns About the Future of Ethics in the Catholic Health Ministry." *Health Progress* (Saint Louis, Mo.) 90, no. 2 (2009).

Hamel, Ron. "Ethicists in Catholic Health Care: Taking Another Look." *Health Care Ethics USA* 23, no. 1 (2015): 34-44.
Matthew, R. Kenney. "A System Approach to Proactive Ethics Integration." *The National Catholic Bioethics Quarterly* 18, no. 1 (2018): 93-112.

ENDNOTES

1. See, R. Hamel, "A Critical Juncture. Surveys of Ethicists and Mission Leaders Indicate Concerns About the Future of Ethics in the Catholic Health Ministry," *Health Progress (Saint Louis, Mo.)* 90, no. 2 (2009).
2. Ron Hamel, "Ethicists in Catholic Health Care: Taking Another Look," *Health Care Ethics USA* 23, no. 1 (2015): 43.
3. Ibid., 42.
4. N. P. Bancroft, "The "Next Generation" Model," *HEALTH PROGRESS* 85 (May-June 2004): 27.
5. R. Kenney Matthew, "A System Approach to Proactive Ethics Integration," *The National Catholic Bioethics Quarterly* 18, no. 1 (2018).
6. Cf. E. L. Bedford and E. K. Johnson, "Building a Pipeline: Connect Young Talent with the Ministry," *Health progress (Saint Louis, Mo.)* 93, no. 3 (2012); Elliott Louis Bedford, "Catholic Health Ethics Internships: Lessons Learned from Five Years' Experience," *Health Care Ethics USA* 28, no. 1 (Winter-Spring 2020); Becket Gremmels, "When to Hire a Clinical Ethicist," *Health Care Ethics USA* 28, no. 1 (Winter-Spring 2020).

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Unilateral Withdrawal of Life-Sustaining Treatment Within Crisis Standards of Care[1]

Jason T. Eberl, Ph.D.

The COVID-19 pandemic has prompted an unprecedented need for health care institutions to develop and implement policies for allocating scarce resources if they experience a surge of patients requiring life-sustaining treatment for severe acute respiratory distress.[2] In the absence of definitive guidance from the Church's Magisterium concerning specific requirements of such policies, there is space for moral disagreement concerning triage criteria and allowable practices.

As in all moral matters, however, certain guiding principles ought to be operative. For example, respect for each person's *intrinsic dignity* requires that health care professionals not cause a patient's death by either commission or unjustifiable omission of *ordinary/proportionate* forms of care.[3] Another relevant principle, particularly in the context of scarcity, is the *responsible stewardship* of resources, which includes just allocation of life-sustaining treatments with a preferential option for the poor and vulnerable.[4] One point of disagreement among policies developed by Catholic health care institutions is whether non-futile life-sustaining treatment may be unilaterally[5] withdrawn from one patient, who has a relatively poor expected outcome but is currently benefitting from ventilation, to benefit another predicted to have a better chance of survival to discharge. At least one Catholic hospital explicitly disallows unilateral withdrawal for triage reasons;[6] whereas the National Catholic Bioethics Center's "Triage Protocol Guidelines" state that "'Reallocation' of limited resources from current patients to incoming patients may be morally appropriate" but that *unilateral* withdrawal should not be allowed "unless extreme circumstances warrant."[7]

LIVING IN A "STATE OF EXCEPTION"

Every effort should be made by political and public health authorities to stave off a surge of patients that would constitute "extreme circumstances;" yet, such circumstances have arisen during the COVID-19 pandemic in countries such as Italy and (as of this writing) numerous hospitals throughout the U.S. are nearing surge capacity limits.[8] It may thus be inevitable that some Catholic hospitals will have to implement *crisis standards of care* [CSCs] as they are forced to function within a *state of exception* in which ethical norms are not suspended, but are differentially applied.[9] To understand how the notion of a "state of exception" coheres with the Catholic moral tradition, consider Thomas Aquinas's treatment of theft and "just war" theory. Theft is, of course, condemned by the Seventh Commandment; yet, the possibility of theft

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

is premised upon the existence of *private property*, the legitimate possession of which is acknowledged by Aquinas and Catholic Social Teaching.[10] The right to private property is not absolute, however, and Aquinas contends that in circumstances of "manifest and urgent" need, "all things become common property."[11] In a state of exception in which all property has become common, appropriating another's surplus wealth to ameliorate one's dire need does not constitute an act of theft. Another state of exception is *war.* While there is a general prohibition on killing other human beings, if the conditions of a "just" war are met, a soldier who kills another either to defend their own life, to safeguard the lives of others, or to advance the war's justified aims is not guilty of murder.[12] In a context in which CSCs must be implemented in order to exercise responsible stewardship of available resources, an act that would otherwise constitute an unjustifiable omission of care — unilaterally withdrawing non-futile life-sustaining treatment — may become a justifiable discontinuation of treatment that is *disproportionate* with respect to the burden placed on the *community*, which is a legitimate criterion in drawing the ordinary/extraordinary care distinction—though not typically utilized in non-crisis situations.[13]

JUSTIFICATION BY DOUBLE EFFECT

Even within a state of exception, it would be unethical to end a patient's life *intentionally*; hence, unilateral withdrawal should adhere to the *rule of double effect* [RDE].[14] RDE arguably justifies unilateral withdrawal for the following reasons. First, the directly intended good is to make a life-sustaining resource available for others and not to kill the patient from whom it is removed, although their death is foreseen. Furthermore, extubation, not the patient's death, is the necessary means for the directly intended reallocation to occur and is itself a morally neutral act. Finally, the death of the extubated patient is proportionate to the life of any subsequently intubated patient.

SOCIAL JUSTICE IMPLICATIONS

In considering the *common good* and the obligation of Catholic hospitals to exercise responsible stewardship of resources, we should note the social justice implications of disallowing unilateral withdrawal insofar as it would entail a default criterion of "first-come, first-serve" — unless a ventilated patient or their surrogate consented to withdrawal or continued ventilation was deemed physiologically futile. Of course, ventilator withdrawal from such patients should be prioritized before any unilateral withdrawal and all possible measures should be taken to avoid a surge that would require implementation of CSCs. Nevertheless, when such a situation is unavoidably forced upon a Catholic health care institution, due consideration should be given to the *health access disparities* that disproportionately burden the poor and vulnerable for whom we should have a "preferential option."[15] Such disparities may result in members of economically and socially disadvantaged groups not being able to access appropriate health care prior to those who are more well-positioned. A first-come, first-serve policy — whether explicit or by default — is also arguably unjust with respect to those who contract COVID-19 later in the pandemic due to preventive behavior or who are more at risk of infection due to their social roles, such as health care and other essential workers.

While society has an obligation to take all possible measures to prevent a state of exception

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

in which CSCs must be implemented, and unilateral withdrawal of non-futile life-sustaining treatment should always be a "last resort," ruling out the possible justification of such an act unwarrantedly constrains Catholic health care institutions' moral responsibility to exercise responsible stewardship over available resources and to consider in the development and implementation of their triage policies not only the intrinsic dignity of each individual patient, but also the needs of the common good and those of socially disadvantaged persons.

JASON T. EBERL, PH.D.
Director/Professor
Albert Gnaegi Center for Health Care Ethics
Saint Louis University
Jason.eberl@slu.edu

ENDNOTES

1. This paper includes material developed more extensively in Jason T. Eberl and G. Kevin Donovan, "Is it Ethical to Unilaterally Withdraw Life-Sustaining Treatment in Triage Circumstances?" *Health Progress* (2020): https://www.chausa.org/publications/health-progress/article/pandemic-coverage/is-it-ethical-to-unilaterally-withdraw-life-sustaining-treatment-in-triage-circumstances; Jason T. Eberl, "Ethics as Usual? Unilateral Withdrawal of Treatment in a State of Exception" *American Journal of Bioethics* 20:7 (2020): 210-11; and Jeffrey P. Bishop and Jason T. Eberl, "Is It Ethically Permissible to Unilaterally Withdraw Life-Sustaining Treatments during Crisis Standards of Care? Yes" *CHEST* (forthcoming).
2. See Armand H. Matheny Antommaria et al., "Ventilator Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated With Members of the Association of Bioethics Program Directors" *Annals of Internal Medicine,* April 24, 2020: https://doi.org/10.7326/M20-1738.
3. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services [ERDs]*, 6th ed. (Washington, D.C.: USCCB, 2018), nn. 23, 56, and 70.
4. *ERDs*, nn. 3 and 6.
5. By "unilaterally," I mean that such treatment is withdrawn without, and perhaps against, the explicit consent of the patient or an appropriate surrogate.
6. MedStar Georgetown University Hospital, "Ethical Principles of Resource Allocation In the Event of an Overwhelming Surge of COVID-19 Patients": https://kennedyinstitute.georgetown.edu/wordpress/wp-content/uploads/2020/03/CovidEthics-MGUH.pdf.
7. National Catholic Bioethics Center, "Triage Protocol Guidelines," [TPG] April 16, 2020: https://www.ncbcenter.org/resources-and-statements-cms/triage-protocol-guidelines?rq=triage, n. 5.a.
8. National Public Radio, "COVID-19 Hospitalizations Hit Record Highs. Where Are Hospitals Reaching Capacity?" November 10, 2020: https://www.npr.org/sections/health-shots/2020/11/10/933253317/covid-19-hospitalizations-are-surging-where-are-hospitals-reaching-capacity.
9. See Giorgio Agamben, *State of Exception*, trans. Kevin Attell (Chicago: University of Chicago Press, 2005).
10. See Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church [CSDC]* (Vatican City: Libreria Editrice Vaticana, 2004), n. 176.
11. Thomas Aquinas, *Summa theologiae,* trans. English Dominican Fathers (New York: Benziger, 1948), IIa-IIae, q. 66, a. 7; cf. *CDSDC*, n. 177.
12. See Michael Walzer, *Just and Unjust Wars: A Moral Argument with Historical Illustrations,* 5th ed. (New York: Basic Books, 2015).
13. See TPG, n. 5.b.ii.
14. For historical and contemporary formulations and discussions of double-effect, see Joseph Mangan, "An Historical Analysis of the Principle of Double Effect" *Theological Studies* 10 (1949): 41-61; Joseph Boyle, "Toward Understanding the Principle of Double Effect" Ethics 90 (1980): 527-38; P. A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Principle* (Notre Dame: University of Notre Dame Press, 2001); and T. A. Cavanaugh, *Double-Effect Reasoning: Doing Good and Avoiding Evil* (New York: Oxford University Press, 2006).
15. Centers for Disease Control and Prevention, "COVID-19 Racial and Ethnic Health Disparities," December 10, 2020: https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

A Proposed Pipeline for Ethicists

Becket Gremmels, Ph.D.

As part of Project Legacy, the Catholic Health Association (CHA) identified a need for a pipeline of ethics positions to train, hire and develop ethicists in Catholic health care.[1] Having standard terminology, expectations and structure for these positions, even a very loose standard, would help the field of Catholic health care ethics create such a pipeline and ease of entry into the field for potential applicants.

To that end, I propose Catholic health systems should have at least three categories of ethics positions: system, local and student.[2] (Table 1) Given their size, larger systems should consider sub-categories for each level or perhaps add a category. With this proposal, every system would have at least three ethics positions, at least two of which are paid.[3]

Most systems now have an ethicist at the system level. For those with more than one system ethicist, these roles often overlap; differences depend more on individual skill sets and system needs than title. In general, directors work more supporting local ethicists, while vice presidents work less with local needs and more with collective needs, system needs, or the common good of the system itself. However, an exhaustive list of differences between the scope of a vice president and director would be onerous and probably unhelpful.

Most Catholic systems also have at least one local ethicist. For those with multiple local ethicists, differences again likely lie in individual skills, but with scaled responsibilities and scope. Those farther down the organizational ladder are closer to the bedside, while those higher up are farther away from the bedside and more involved in regional decisions. This is why local positions are important for effective succession planning. Perpetually recruiting from outside is not a sustainable model for Catholic health care as a whole, especially since the percent of ethicists who plan to retire soon has not changed much: 67.5% in 2018 down from 70.5% in 2014.[7] Developing consistent entry-level positions with a relatively small scope of responsibility is critical to this process. In no other field would a regional director for six hospitals be considered entry-level, yet for ethics it often is.

Yet, most of the opportunity seems to lie in creating student positions, especially fellowships. Consistency with titles and expectations would assist students in understanding which steps to take when starting their career path. For fellowships especially, the titles should clearly reflect the substance of the work; if the training is primarily clinical, then the title should include "clinical", while those at a system office should have "system" or "organizational". While time consuming for preceptors and mentors, internships and mentorships are crucial for

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

TABLE 1

Level	Position
System[4]	Vice President • Organizational ethics, education, policy review, clinical ethics, collaborative arrangements, service line support (e.g. population health, ambulatory, home health, etc.) • Scope is system wide Director • Organizational ethics, education, policy review, clinical ethics, collaborative arrangements, service line support • Scope is system wide
Local[4]	Vice President • Organizational ethics, clinical ethics, education, policy review, process improvement • Scaled responsibilities and scope • Scope could be a single facility or regional Director • Clinical ethics, consults, education, process improvement, organizational ethics, policy review • Scope could be a single facility or regional Manager / Clinical Ethicist • Clinical ethics, consults, committee meetings, education, process improvement • Scope is for a single facility[5]
Student[6]	Fellowship • Purpose is to prepare the fellow to function independently as an ethicist • Paid • Three tracks: (1) system, (2) clinical (at hospital), and (3) senior (transition from academia) • Functions: attend ethics committee meetings, work on projects and grow to lead them, observe consults and grow to respond independently, grow to develop and provide ethics education Internship • Purpose is to provide orientation and exposure to the practice of Catholic health care ethics • Paid or unpaid • Three tracks: (1) system, (2) clinical (at hospital), and (3) a hybrid of the first two • Functions: attend ethics committee meetings, work on projects, observe consults as appropriate, attend education sessions Mentorship • Purpose is to provide advice or guidance on career path or school plans to those considering entering the field • Unpaid • Functions: job shadowing, attend some ethics committee meetings or educational sessions, reach out to mentor as needed

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

introducing students to the field, even if only for a summer. Many interns choose another career path, so an increase in internship opportunities is necessary to create a sustainable pipeline.

FUNDING FOR CLINICAL ETHICS FELLOWSHIPS

Clinical ethics fellowships are an integral component of training clinical ethicists. They provide practical experience and an opportunity to develop the requisite skills for a career in clinical ethics under the supervision and tutelage of an experienced ethicist. CHA states fellowships are preferred for applicants to local ethics positions, but acknowledges that "not many of these fellowships exist at this time, and therefore, criteria and standards need to be developed further."[8] As of this writing, I am aware of only one recurring ethics fellowship in a Catholic health system, while outside of Catholic health care at least 20 programs exist.[9] A major obstacle to expanding fellowships is cost. One unexplored option for funding of clinical ethics fellowships is reimbursement from Medicare.

The Centers for Medicare and Medicaid Services (CMS) provides funding to hospitals to educate students in allied health professions. Federal statute identifies two possibilities for funding nursing and allied health education programs: if the profession is licensed by the state (which ethics is not) or if the education program "is accredited by the recognized national professional organization for the particular activity".[10] The statute specifically calls out the Association for Clinical Pastoral Education (ACPE) as an example of just such an accrediting organization.

Since the funding is Medicare pass through, it is based in part on fellows' clinical hours and the percentage of Medicare patients at the hospital. Also, as with Clinical Pastoral Education programs, funding would not cover the costs entirely, but it could cover much if not most of a program's budget, including student stipends and faculty salary. No organization currently offers accreditation for clinical ethics fellowships.

There are several other requirements for funding. (Table 2) Given these, a non-clinical ethics fellowship, or one that is primarily located at a system office, would not qualify. However, clinical ethics fellowships theoretically could meet this requirement if an accrediting body for clinical ethics fellowships existed. The difficulties creating or identifying such a body and crafting an accreditation process are numerous, but the potential benefits to the field are unprecedented.

Complete unanimity throughout Catholic health care in ethicists' functions, scope, and role is not achievable or desirable. Titles and modifiers (like senior, executive, or system) will clearly fluctuate and differ by health system. However, more consistency would help the ministry as a whole develop corresponding pipelines and cultivate sustainability for our field.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

TABLE 2

Requirements for Funding Allied Health Education from Medicare
The training must: • Be clinical in nature; and • Involve regular contact with patients. The hospital must: • Directly incur the training costs; • Have direct control of the curriculum; • Control program administration: collect tuition, maintain staff and student payroll, and day to day program operation; • Employ the teaching staff; and • Provide and control classroom instruction and clinical training.

BECKET GREMMELS, PH.D.
System Vice President, Theology and Ethics
CommonSpirit Health
becketgremmels@catholichealth.net

ENDNOTES

1. Smith, Brian. Project Legacy: Succession Planning for the Ministry. *Health Progress*. March-April 2019, 100:2.
2. Thanks to Mark Repenshek and Elliott Bedford for helping develop these categories.
3. I am focusing here on the concept and terminology for these roles. For costs or how to justify the positions, see: 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. CHA's Theology and Ethics Committee, "Qualifications and Competencies for Ethicists in Catholic Health Care", May 2018.
5. Mark Repenshek, "Hiring Clinical Ethicists: Building on Gremmels' Staffing Model Approach." *Health Care Ethics USA*, 29:1, 2021. Gremmels, Becket. "When to Hire a Clinical Ethicist." *Health Care Ethics USA*. 28:1, 2020.
6. CHA, "Fellowships and Internships in Mission and Ethics: A Summary of Current Practices in Catholic Health Ministry", 2019.
7. Hamel, Ron. "Ethicists in Catholic Health Care: Taking Another Look", *Health Care Ethics USA*, 2015, 23:1. Speckart, Jenna. "Ethics Recruitment and Role Awareness: What We're Hearing." *Health Care Ethics USA*, 2018, 26:4.
8. CHA, Qualifications and Competencies for Ethicists in Catholic Health Care.
9. Association of Bioethics Program Directors, Graduate Bioethics Education Programs, www.bioethicsdirectors.net/graduate-bioethics-education-programs-results
10. 42 CFR § 413.85(e).

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

The Virtual Clinical Ethics Intensive

Matthew R. Kenney, Ph.D., HEC-C

Ascension's Clinical Ethics Intensive (CEI) was created to address the desire among ethics committee members for education and a greater understanding of the Catholic bioethics tradition in the context of clinical ethics case consultation. It is a one-day training session, designed to be delivered in person by at least two Ascension ethicists. At the conclusion of the CEI, participants should be able to discuss the *Ethical and Religious Directives for Catholic Health Care Services* and apply the Directives to commonly encountered case situations; identify skills and knowledge required to provide competent clinical ethics case consultations as Embedded Ethics Resources (EERs) utilizing the Clinical Ethics Deliberation Process; demonstrate opportunities for proactive ethics integration in the context of the participant's respective service line and/or unit within the health ministry; and perform continuous quality improvement in ethics initiatives through ethics case consultation documentation in the electronic health record and in Ascension's Ethics Integration Database. Ideally, participants are given a full day's release time or RVU relief in order to participate fully in the Clinical Ethics Intensive.

Covid-19 has changed the face of health care, perhaps indefinitely. Lessons learned from the pandemic and our response, including how to adapt to new learning and teaching environments, and how to take advantage of both the scale and scope of our resources (as well as how to steward these resources more wisely), represent a paradigm shift in how we deliver care and how we do business. Although Covid-19 has presented health care with myriad challenges, it has also created some opportunities. This includes the development within Ascension of a Virtual Clinical Ethics Intensive. The goal, scope and process of delivering the virtual CEI are outlined below.

GOAL:

To provide tools and resources to assist Ministry Market ethicists in the delivery of the Clinical Ethics Intensive (CEI) virtually in a manner that uses technology to take advantage of scalability and the depth of experience and expertise of the Ethics Advisory Community (EAC) while preserving, as much as possible, the dynamic, interpersonal team-building that is an inherent part of the in-person CEI.

SCOPE:

The virtual CEI is intended to be used across Ascension and is customizable to the needs of individual Ministry Markets. The tools and resources include three foundational videos, three didactic videos, a live Q and A session, and three, live, case-based sessions facilitated by Market Ethicists with support from additional EAC members if desired. The three foundational videos and three didactic videos are designed to be "conversational" in nature and were facilitated by an Ascension ethicist who navigated a discussion on the topic with her/his colleagues, and possibly "veteran" ethics committee chairs or EERs. A slide deck facilitator guide is provided for use in each case-based session, and Market ethicists may choose from a bank of seven prepared cases, based on Market needs.

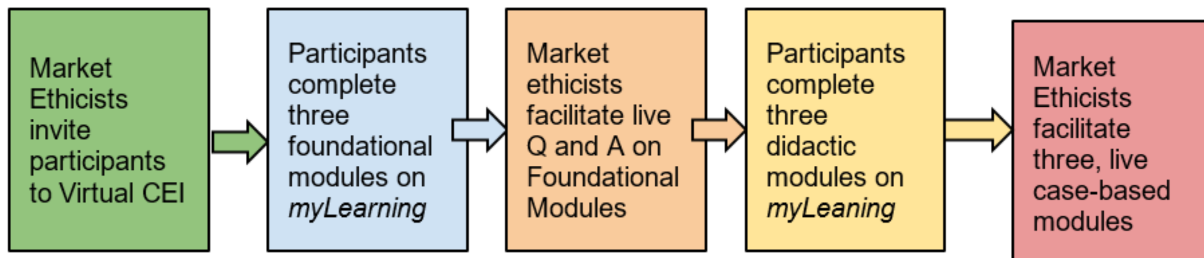
Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

We wanted to make delivery of the Virtual Clinical Ethics Intensive as customizable as possible based on the local ethics team's understanding of the needs of their committees, member feedback, the impact of Covid-19 on their Market(s) and their own pedagogical style. At the same time, we wanted the Virtual CEI to be an "intensive" with all or most of the essential elements of the in-person model. So, we developed the following process:

PROCESS:

Individual Market ethicists determine when to offer a CEI in their Market, and who will attend. An invitation letter is sent to participants, which includes links to the foundational and didactic modules on *myLearning*, the date of the follow-up Q and A session for the foundational modules, instructions on how to download the *myEthicsRx* app (an Ascension in-house ethics app), and other market-specific information. Market ethicists may choose to schedule the live, case-based sessions (which include small group breakouts where participants apply Assess, Analyze, Act to the specific case) in one, three-hour session, or in individual one-hour sessions. Information on these sessions could also be included in the invitation letter.

Market ethicists can track attendance for the CEI and completion of the foundational modules through *myLearning*; participants can earn CME/CEU credits by scanning a QR Code at the end of each module. It is expected that the foundational modules and didactic modules have been completed prior to participation in the live, case-based sessions. The process flow to complete the Virtual CEI is as follows:



Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

AGENDA

The three, 30-minute foundation modules are:

1. An overview of Ascension's Proactive Ethics Integration Model
2. An overview of the ERDs and Foundational Bioethical Principles
3. An overview of the Clinical Ethics Deliberation Process (Assess, Analyze, Act)

The three, 30-minute didactic modules, which provide a framework for the case-based discussion, are:

1. The Professional-Patient Relationship: ERDs Part III and Key Principles
2. Issues in Care at the Beginning of Life: ERDs Part IV and Key Principles
3. Issues in Care for the Seriously Ill and Dying: ERDs Part V and Key Principles

Three, one-hour each, case-based discussions chosen from the following:

1. "Just Let Her Die" - Provider-Patient Relationship, Best Interest, Substituted Judgement and Surrogate Decision-Making
2. "Consent and Mental Illness" - Provider-Patient Relationship: Capacity and Mental Illness
3. "Try and Save My Baby"- Ethical Issues at the Beginning of Life: MFVC
4. "Our Faith Does Not Allow That" - Ethical Issues in the Seriously Ill and Dying: Non-indicated Medical Interventions and Cultural Considerations
5. "She Said She Wanted Everything Done" - Ethical Issues in the Seriously Ill and Dying: Goals of Care and End of Life
6. "Baby Sima" - Pediatrics
7. "RQ" - Provider/Patient Relationship and Goals of Care
8. "It Doesn't Look That Bad to Me"- Patient Refusal of Beneficial Medical Interventions

The total time for the delivery of the Virtual CEI is 6-7 hours, with 3 hours devoted to didactic content, 3 hours to case-based discussions, and possibly an hour for additional discussion, clarifications, and review of next steps.

The verdict is still out on the success or failure of our efforts to create a virtual Clinical Ethics Intensive. Even though we have seen the roll-out, at least to some degree, of the Covid-19 vaccine, our hospitals are still overrun by the virus. Our health care providers, many of whom serve on our ethics committees, are tired and have little time to devote themselves to even self-directed learning. Those who do have the time often report that this endeavor is a welcome respite from their day to day reality, and a chance to be with their colleagues in a different way. We will continue to solicit feedback and advice from those that utilize the virtual CEI resources, and will pivot as necessary to meet the needs of those we serve.

MATTHEW R. KENNEY, PH.D., HEC-C
Vice President, Ethics Integration and Education
Ascension
matthew.kenney@ascension.org

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Global Bioethics in a Pandemic: A Dialogical Approach

Alexandre A. Martins, MI, Ph.D.

In this short essay, I present a work in progress of a research project on the COVID-19 pandemic and the ethical issues that this pandemic and the way it has been handled have raised for clinical practices and public health measures.

Many public health departments, medical institutions and health organizations around the world developed bioethical guidelines to help health professionals, administrators and public authorities in their decision-making processes from triages of COVID-19 patients in a context of scarcity to public health strategies to slow the spread of the coronavirus. These guidelines vary a lot from country to country. This makes sense because each country has different cultural and socioeconomic contexts as well as different health systems which require guidelines able to answer how the challenges of this pandemic are presented within the particularity of each country. Sometimes, the strategy must be even more localized to consider the specificity of a particular region within a country. For instance: challenges to address the COVID-19 pandemic in São Paulo City with 11 million people and in a community in the Amazon region are not the same, although both areas in Brazil are covered by the same public health system. The USA has similar challenges, such as differences between rural and urban areas and the health care resources available for them.

Although bioethical guidelines and protocols for clinical practices and public health measures vary significantly from region to region, I have noticed that these guidelines have been developed by health professionals and leaders from the perspective of where they are located. This is justified considering the urgency for guidelines and support that a pandemic demands. However, most of these bioethical protocols did not include voices from communities, especially from those who use health care services and are likely to need them in case of being infected by the coronavirus. The same criticism applies to public health measures that did not include the voices of those at the bottom, especially representatives of marginalized groups, such as Blacks, immigrants, indigenous persons, and the poor, who were disproportionally impacted by the pandemic. In Brazil and the USA, these communities suffer more with infections, hospitalizations and deaths. In addition, they are more impacted by the socioeconomic consequences of the COVID-19 pandemic, such as unemployment, housing eviction and hunger.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

At the beginning of the pandemic, the context of urgency justified a top-down approach to develop guidelines to address the ethical challenges raised by COVID-19. However, time has passed and it is important to assess and improve these bioethical protocols. Today, we know more about the coronavirus and COVID-19. We know more about what worked and what didn't work. And we know that the challenges created by this pandemic do not impact all people in the same way. We are not all in this together as many of us said in March and April of 2020. An apt metaphor now is: We are all in the same ocean, but while some people are in luxurious boats and yachts, others are in rafts, clinging to a piece of wood while being hit by aggressive waves. Socioeconomic injustices and health disparities that were part of the U.S. and Brazilian societies before the coronavirus outbreak have been crucial in determining the fate of marginalized communities in the middle of the COVID-19 pandemic.

At this point in the pandemic, there is no justification not to include or consider the voices and experiences of marginalized communities in assessing and developing new bioethical guidelines for clinical practice and public health measures for COVID-19 patients along with strategies for resource allocation, mitigation of the spread, and vaccine distribution. Including these voices is an ethical imperative for Catholic health institutions that is rooted in Catholic social principles, such as preferential option for the poor and subsidiarity. These are all highlighted by Pope Francis as essential ethical guides to help us address this pandemic with a "shared passion to create a community of belonging and solidarity" (*Fratelli tutti*, no. 36).

Considering the bioethical challenges raised by the COVID-19 pandemic in clinical practice and in public health and the need to assess ethical protocols and guidelines developed to help address these challenges, this research is seeking to listen to voices of representatives of marginalized communities who have had a significant experience with COVID-19. These include persons who were infected and hospitalized, had a relative who was hospitalized or died, or who lost a job and socioeconomic status due to public health measures to mitigate the spread of the virus.

In numerous documents, texts and speeches, Pope Francis affirmed that we need to go the periphery of the world where the poor, the marginalized, and the most vulnerable are. In the periphery, we must have an encounter with those who are suffering in their reality, listen to them, and be open to learning from them. Although not official, this suggests the possibility of a potential new Catholic social principle: the principle of listening and learning from the other in an experience of encounter in the edges of existence.

In his recent encyclical, Francis affirms: "The ability to sit down and listen to others, typical of interpersonal encounters, is paradigmatic of the welcoming attitude shown by those who transcend narcissism and accept others, caring for them and welcoming them into their lives" (*Fratelli tutti,* no. 48). Moreover, the privileged place of encounter is the periphery, according to Pope Francis in last book *Let Us Dream: The Path to a Better Future*: "You have to go the edges of existence if you want to see the world as it is. I've always thought that the world looks clear from the periphery, but in these last seven years as Pope, it has really hit home. You

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

have to make for the margins to find a new future" (p. 11). This teaching of Pope Francis guides this research in order to assess the ethical guidelines that were created to respond to the bioethical challenges raised by COVID-19.

From a global perspective, the collection of qualitative data and use of the dialogical educational method of Paulo Freire, combined with insights from Catholic Social Teaching, this research project is addressing key ethical challenges that the COVID-19 pandemic presents for socially vulnerable groups in Brazil and the USA, countries with different health systems and the top two with most deaths because of COVID-19. First, I mapped the main ethical dilemmas that COVID-19 pandemic has created for clinical practice and public health strategies, focusing on the experience of socially vulnerable groups, especially the poor and racially marginalized communities. Guidelines and protocols to respond to ethical challenges created by the pandemic are being confronted by narratives of experiences from patients, their families, and others from marginalized groups in order to understand the impact of these responses in their lives. Moreover, the result of this confrontation will be analyzed from the perspective of the Catholic Social Teaching as a guide for decision-making processes in health care that includes the need of socially vulnerable groups when clinical and public health strategies are developed to address a pandemic. The ultimate goal is to create resources for health institutions, particularly for Catholic health systems, and public health authorities to evaluate their current ethical guidelines and protocols, improve them or develop new ones, with the participation of new voices from communities in the context of this pandemic and for future epidemics toward more efficient, inclusive, fair and less controversial actions of health promotion.

ALEXANDRE A. MARTINS, MI, PH.D.
Assistant Professor
Theology Department and College of Nursing
Marquette University
Alexandre.martins@marquette.edu

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Integrating Ethics in Formation: Exploring Courses in Leadership Formation

Mark Repenshek, Ph.D.
Matthew Kenney, Ph.D.
Celeste Mueller, D.Min.

Ascension's Executive Ministry Leadership (EML) Formation is designed to provide working executives with a combination of flexible, self-directed learning and highly interactive retreat experiences. Coursework covers a 12-month period, followed by a six-month practicum. There are a total of 18 retreat days over the duration of the program. Upon completion, it is hoped that participants become personally committed to practices and habits of spiritual reflection that foster deeper relationship with self, God, others, community and the world as part of their ongoing formation journey, and be professionally committed to the healing ministry and mission of Jesus with special attention to those who are poor and vulnerable.

Throughout the program, participants will develop skills and habits to integrate and practice Virtuous Servant Leadership while being in and building community. They will be able to articulate foundational principles from the Catholic theological, moral and spiritual tradition in order to communicate Ascension's Ministry Identity and our Mission while leading integrated strategic, operational, financial, clinical and organizational processes as a full expression of Ascension's identity as a ministry of the Church.[1]

Traditionally, the program is a blend of in-person retreats and virtual learning. The in-person retreats were adapted to the virtual setting during the pandemic. The five, nine-week courses include: "Mystery of God Who Calls" (Course 1); "Jesus: Mission & Ministry" (Course 2); "Mission and Ministry of the Church" (Course 3); "Catholic Moral Vision: Personal and Social" (Course 4); and "Catholic Health Care Ethics: Clinical and Organizational" (Course 5). Each of the courses is "bookended" by retreats designed to support ongoing formation and transition from course to course. The program culminates with an "integration project" which delineates an aspect of Catholic identity to be actualized in and through participants' leadership.

This year presented an opportunity to re-work Courses 4 and 5 of EML in order to seamlessly weave together Catholic Social Teaching, the principles of Catholic identity, and both organizational and clinical ethics. We aligned our course objectives in order to achieve this goal:

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Course Objectives	
Catholic Moral Vision: Personal and Social	**Catholic Health Care Ethics: Clinical and Organizational**
1. to appreciate the uniqueness and complexity of ethical reflection upon social and cultural issues in healthcare;	1. to gain familiarity with the key methodological considerations and moral principles within the Catholic moral tradition relevant to ethical issues in healthcare;
2. to consider the relationship between religious faith and public policy in healthcare;	2. to gain familiarity with the *Ethical and Religious Directives for Catholic Health Care Services, 6th ed.,* as they relate to organizational and clinical decision-making;
3. to consider strategies for fostering a social justice consciousness in administrative and leadership settings in healthcare; and	3. to increase understanding of organizational ethics and participant's ability to lead work-teams at their Health Ministry through Ascension's Organizational Ethics Discernment Process.
4. to assist participants in applying the principles of Catholic Social Teaching to leadership frameworks and decisions in a manner consistent with Ascension's Catholic Identity.	

Our intention in structuring both courses collaboratively was to demonstrate how principles of Catholic Social Teaching such as human dignity, the common good, solidarity, subsidiarity, etc., form the foundation for clinical and organizational ethics, and are constitutive of our Ministry identity. In addition, we sought to make explicit connections to course content from one course to the other to help participants "connect the dots" within their own leadership roles and sphere of influence. The transition to an entirely virtual learning environment also required some pedagogical shifts: both courses integrated podcasts, used varying media platforms, video recordings to introduce course content, case studies and small group discussion boards. We also brought in guest facilitators with subject matter expertise in key content areas. The outline of both courses is provided below:

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Catholic Moral Vision: Personal and Social	Catholic Health Care Ethics: Clinical and Organizational
Week 1: CST History & Background Case: Budget at Federal Poverty Line Week 2: Human Dignity Case: Human Trafficking Week 3: Solidarity & Preferential Option for the Poor Case: Healthcare Disparities Week 4: Subsidiarity Case: Workforce Transition Week 5: Common Good Case: Medicaid Expansion Week 6: Participation Case: Pandemic Preparedness Week 7: Stewardship Case: POSCO Intl Co. Week 8: Values Aligned Partnerships Case: Regent Surgical JV	Week 1: Value Perspectives & Moral Method Case: Memorial Medical and Katrina Week 2: Constitutive Elements of Catholic Identity Case: Dialysis and the Undocumented Immigrants Week 3 :Key Principles of Bioethics Case: Cervical Cancer, Pregnancy and Physician Alignment Week 4: The ERDs: Preamble Through Part Three Case: Covid-19 Visitor Policies and Patient Rights Week 5: The ERDs at the Edges of Life- Parts 4 & 5 Case: "Just Let Her Die" Week 6: The ERDs: Part 6 Case: ACOs and "Other Than Catholic" Partners Week 7: Organizational Ethics in Catholic Health Care Case: Institutional Integrity and Reductions in Force Week 8: Spirituality & Discernment Case: The Organizational Ethics Discernment Process

The feedback we received on the revised course formats and pedagogical approaches was quite positive. We began with the assumption that continuing the coursework in the Executive Ministry Formation program would be a significant additional burden for healthcare leaders already stretched thin and overwhelmed by the demands of responding to the Covid-19 pandemic. To our surprise, several participants commented that they felt "blessed" to be participating in EML during the pandemic, as it provided a structured community of support, and the content of the course was immediately applicable to the scenarios faced in their Ministry Markets. Topics such as equitable distribution of scarce resources, considerations for wage adjustments, application of the preferential option for the poor and vulnerable to care delivery models, stewardship of resources (space, staff, and stuff) and how our Catholic identity shapes our response to crises all had direct application to participants' daily lives, both personally and professionally. The EML community also became a "safe space" wherein participants could voice their concerns and frustrations, and ask the difficult questions facing Catholic healthcare and healthcare in general, in the midst of the pandemic.

MARK REPENSHEK, PH.D.
Vice President, Ethics and Church Relations
Ascension
Mark.repenshek@ascension.org

MATTHEW KENNEY, PH.D.
Vice President, Ethics Education and Integration
Ascension
Matthew.kenney@ascension.org

CELESTE MUELLER, D.MIN.
Vice President, Ministry Formation
Ascension
Celeste.mueller@ascension.org

ENDNOTE

1. Mueller, CD. Formation: Catholic Theology Alive in Catholic Healthcare. *Incarnate Grace: Perspectives on the Ministry of Catholic Healthcare.* Fr. Charles Bouchard, ed. 2017, Catholic Health Association St. Louis, MO, pp. 270-289.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Hiring Clinical Ethicists: Building on Gremmels' Staffing Model Approach

Mark Repenshek, Ph.D.

In an *HCEUSA* article in 2020,[1] Becket Gremmels proposed staffing criteria for clinical ethicists. His approach utilized the conceptual framework of staffing models that exist in many disciplines within healthcare. Moving through three levels of recommendations (i.e., necessary, strongly recommended, conditional), he proposes metrics that would serve as minimum thresholds for staffing a clinical ethicist. This article serves as a response to Gremmels' invitation to further refine the staffing model approach.

Although Gremmels' use of bed count, average daily census, intensive care unit (ICU) beds, and trauma level are worthwhile as common data points to hospital settings, recently metrics have been developed in the field that may serve as a better framework when thinking about staffing. These include ethics consult to bed ratio (CBR), ethics consult to admission ratio (CAR), and ethics consult to ICU bed ratio (CiBR).[2] I will use these ratios in an effort to standardize the criteria for each of the recommended levels (i.e., required, strongly recommended, recommended) unlike the approach used by Gremmels which uses different data points for each level. Additionally, by using standard data points, staffing can be considered within a market or region rather than what may or may not be present for a particular hospital. This allows consideration to be given to the level of need within a health system's structure (i.e., market, region, geography, etc.) that is not dependent on the unique set of clinical services of a particular facility within that structure. That said, I agree with and utilize a number of the criteria Gremmels' offered in his article and, like Gremmels, base this approach largely on experience in the field.

CLINICAL CONSULTATION METRICS AND FTE RECOMMENDATIONS

Table 1 sets clinical ethics consultation levels commensurate with that which I believe would require a full-time equivalent in clinical ethics. For example, for a facility within a region that has 200 beds, a CBR of n > 0.50 would represent 100+ clinical ethics consults annually. If a particular facility or region has 25,000 admissions annually, a CAR of n > 5.00 per 1000 would represent 125+ clinical ethics consults. Or if a facility within a region maintains a 50-bed ICU, a CiBR of n > 1.05 represents 52+ clinical ethics consults. These recommendations suggest that where any facility, or a facility within a defined region, meets any one of these thresholds for clinical ethics consultation volume, an FTE in clinical ethics is required. I readily acknowledge that these levels are entirely based on volume, which suggests that prior to the FTE, an ethics

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

committee or some similar body is responding to these volume thresholds. I do not attempt to address the matter of the quality of the clinical ethics consultation in response to the volume, but I would maintain that an FTE in Clinical Ethics is warranted at these significant volume thresholds to ensure high quality clinical ethics consultation consistent with the standards set by the American Society of Bioethics and the Humanities (ASBH)[3] and The Catholic Health Association (CHA) in its publication, *Striving for Excellence in Ethics.*[4]

Table 1

REQUIRED FTE, Clinical Ethicist	
Any one of the following:	
CBR (annual ethics consult to bed ratio)	n > 0.50
CAR (annual ethics consult to admissions ratio)	n > 5.00 per 1000
CiBR (annual ethics consult to ICU bed ratio)	n > 1.05

Table 1A

OR Any combination of two or more of the following:	
Average Daily Census of any hospital in market	n > 250
Licensed Bed Count of any hospital in market	n > 300
ICU Licensed Beds in any hospital in market (excluding NICU)	n > 50
Trauma (any hospital in market)	Level 1
Case Mix Index (CMI) of any hospital in market	n > 1.7
Deliveries	n > 5000
Clinical Research	n > 150 protocols open annually in > 3 specialties

Table 1A also accounts for a combination of criteria that serve as a proxy where clinical ethics consultation volume alone may not warrant a required FTE in clinical ethics. In other words, despite the fact that a facility may be 200+ beds or maintain a 50+ bed ICU, for whatever reason it may not experience a significant volume of clinical ethics consultation.[5] In the absence of this volume, the first six criteria suggest that the size of the facility or number and acuity of patients cared for, in my experience, warrants a required FTE in clinical ethics. Gremmels has made a similar argument citing the incidence rates of preeclampsia, premature rupture of membranes, and other causes of induction which often result in complex clinical ethics consultation[6] thus establishing a threshold for number of deliveries. He also uses Trauma Levels[7] and Case Mix Index[8], but does so across differing recommendation levels and thus does not allow for comparison between categories based on similar criteria.

The last criteria represent an attempt to expand beyond metrics related directly to clinical care. Again, based largely on professional experience, human subjects research programs that have more than 150 open protocols tend to include some Phase I and Phase II studies which may reflect the integration of both safety and efficacy studies, respectively, into clinical service lines. These phases of human subject research may present significant issues related to informed consent,[9] vulnerability of human subjects,[10] and therapeutic misconception[11] which, in tandem with another criterion related to clinical care, warrants a FTE in clinical ethics.Tables 2 and 2A illustrate consistency in the use of the criteria from Tables 1 and 1A while adjusting the metrics to account for the shift from "Required FTE" to "Strongly Recommend FTE."

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

To account for the shift, Table 2 decreases the range in volume for all three metrics while Table 2A accounts for shifts in patient acuity and the magnitude of human subject research

Table 2

STRONGLY RECOMMENDED FTE, Clinical Ethicist	
Any one of the following:	
CBR (annual ethics consult to bed ratio)	0.50 > n > 0.20
CAR (annual ethics consult to admissions ratio)	5.00 > n > 3.00 per 1000
CiBR (annual ethics consult to ICU bed ratio)	1.05 > n > 0.80

Table 2A

OR Any combination of two or more of the following:	
Average Daily Census of any hospital in market	250 > n > 150
Licensed Bed Count of any hospital in market	300 > n > 200
ICU Licensed Beds in any hospital in market (excluding NICU)	50 > n > 30
Trauma (any hospital in market)	Level 2
Case Mix Index (CMI) of any hospital in market	1.7 > n > 1.45
Deliveries	5000 > n > 3000 per year
Clinical Research	150 > n > 100 protocols open annually in > 3 specialties

Finally, Table 3 adjusts to account for a shift from "Strongly Recommended" to "Recommended" by further decreasing volume metrics associated with clinical ethics consultation, while Table 3A does so by both removing criteria found in Tables 1A and 2A and decreasing the size of the facility or number and acuity of patients cared for.

Table 3

RECOMMENDED FTE, Clinical Ethicist	
Any one of the following:	
CBR (annual ethics consult to bed ratio)	n < 0.20
CAR (annual ethics consult to admissions ratio)	n < 3.00 per 1000
CiBR (annual ethics consult to ICU bed ratio)	n < 0.80

Table 3A

OR Any combination of two or more of the following:	
Average Daily Census of any hospital in market	150 > n > 100
Licensed Bed Count of any hospital in market	200 > n > 100
ICU Licensed Beds in any hospital in market (excluding NICU)	30 > n > 15
Trauma (any hospital in market)	Level 3 or below

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Although the criteria and structure may differ from that proposed by Gremmels in 2020, the similarities are important to note in that it may represent some emerging consensus in the field. I am not suggesting that two opinions constitute consensus in the field, especially given our prior collaboration on the topic. However, given the years of experience and number of clinical consultations that both Gremmels and I have participated in over the past 20 years, these models can certainly serve as a starting point for consideration of an FTE in clinical ethics for healthcare facilities and/or systems that heretofore have had few resources to which to turn.

MARK REPENSHEK, PH.D.
Vice President, Ethics and Church Relations
Ascension
Mark.repenshek@ascension.org

ENDNOTES

1. Gremmels, B. "When to Hire a Clinical Ethicist." *HCEUSA* 28(1) (Winter-Spring 2020): 16-18.
2. A.C. Glover, T.V. Cunningham, E.W. Sterling and J. Leandrini, "How much volume should healthcare ethics consult services have?" *The Journal of Clinical Ethics* 31, no. 2 (Summer 2020): 158-72. Use of the CiBR ratio was developed by S.L. Feldman, S.H. Riaz, J.S. Crites, J.Jankowski, and Paul J. Ford, on behalf of Cleveland Clinical HCEC Service, "Answering the Call for Standardized Reporting of Clinical Ethics Consultation Data," *The Journal of Clinical Ethics* 31, no. 2 (Summer 2020): 173-7.
3. American Society of Bioethics and the Humanities, see: https://asbh.org/uploads/ASBH_Code_of_Ethics.pdf, accessed on December 31, 2020.
4. The Catholic Health Association see: https://www.chausa.org/ethics/overview accessed on December 31, 2020.
5. Fox, E., S. Myers, and R. A. Pearlman. "Ethics Consultation in United States Hospitals: A National Survey." American Journal of Bioethics 7, no. 2 (Feb 2007): 13-25.
6. Gremmels, B. "When to Hire a Clinical Ethicist." *HCEUSA* 28(1) (Winter-Spring 2020): 16-18.
7. American Trauma Society, https://www.amtrauma.org/page/traumalevels accessed on January 5, 2021 and J. MacKenzie et al., "National Inventory of Hospital Trauma Centers" *JAMA* 289(12) (March 26, 2003): 1566-7. For more specific delineation of Trauma Levels relative to qualifying criteria, see: Committee on Trauma. American College of Surgeons. "Optimal Care of the Injured Patient 2014". (Chicago:Il, 2014): 17-18 accessed on January 5, 2021.
8. Although Case Mix Index (CMI) is used by the Centers for Medicare and Medicaid Services to determine funding allocation for Medicare and Medicaid beneficiaries in hospitals and other care facilities, CMI does reflect the diversity, clinical complexity, and resource needs for a particular facility. As such, a higher CMI tends to indicate more complex and resource-intensive case load. See: C Mendez, D Harrington, P Christensen and B Spellberg, "Impact of Hospital Variables on Case Mix Index as a Marker of Disease Severity." *Population Health Management* 17(1) (2014): 28-34.
9. C Grady, "Enduring and Emerging Challenges of Informed Consent," *NEJM* 372 (February 26, 2015): 855-862.
10. M Biros, "Capacity, Vulnerability, and Informed Consent for Research," *The Journal of Law, Medicine & Ethics* 46(1) (March 27, 2018): 72-78.
11. P Appelbaum, "Therapeutic Misconception in Clinical Research: Frequency and Risk Factors." *IRB Ethics and Human Research* 26(2) (2004): 1-8.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Shared Ethics Call: Responding to the Needs of the Organization and the Health of Its Ethicists

Jenna Speckart, D.Be., M.A.

Even the most proactive and high-functioning ethics consultation programs have a need for quick access to expert ethicists when emergent and sensitive issues arise in the field. To respond to clinical ethics concerns quickly and with the right level of expertise, ethicists frequently make themselves available around the clock.

However, for a multi-facility health care system, there is an opportunity to coordinate response efforts to increase work-life balance for the team of ethicists and meet the demand for expertise in addressing time-sensitive clinical ethics issues. The solution for Mercy was the creation of one shared call number, accessible for all facilities, for ethics support during weekend and holiday hours. This seemingly simple transition changed the way the team of ethicists engaged, increased teamwork across facilities, solidified continuous learning opportunities and created a healthier work-life balance for the individual ethicists.

Prior to moving to shared ethics call coverage, the team of ethicists individually covered their facilities or geographic areas. This approach worked well because it allowed for easy *navigation through the challenges of different state laws and reinforced well-established* relationships with the facility's resident ethicist. However, this approach also perpetuated an "always on" mentality for our clinical ethicists, making personal time away an illusion versus a reality. In order to meet the needs of both the organization and the well-being of the ethicists, Mercy transitioned to a call model where ethicists rotate coverage for weekend and holiday call across the entire organization. In addition to increasing work-life balance, the new shared call solution created standardized processes for responding to consultation requests across all facilities and facilitated the collection and cataloging of local resources and contacts.

In order to make the transition from facility or geographic coverage to shared ministry-wide coverage, seven critical steps needed to occur. The first five steps were accomplished before the switch to the new shared call model, and the last two continue to occur to this day.

1. **One shared phone line –** The ability to rotate call between several ethicists using one consistent phone line

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

required the use of telecom technology[1] to set up a unique number that could be "publicly" shared across all facilities. This shared number prevented the inevitable challenges that come with rotating coverage when phone numbers are unique to the individual providing coverage (e.g., communicating last minute schedule changes). With the use of the technology, calls are forwarded to the personal line of the ethicist on call, and changing those personal lines is accomplished on the back end with no disruption to the publicized shared call line number.

2. **Share and access resources –** To ensure all ethicists had readily-available access to specific information about the local facilities (e.g., contacts, call schedules, policies), a website-based collaboration system[2] is used to house and share all resources. All ethicists have the access to share and pull information from the system as needed.
3. **Scheduling –** The shared call schedule covers all weekends and holidays. The start and end times are defined on the schedule for ease of educating and disseminating the appropriate contact for ethics consultation depending on the time. For weekends, call begins at 4:00 p.m. on Friday and ends at 8:00 a.m. the following Monday. Holidays follow a similar time structure and are either an extension of the weekend or stand-alone depending on the day of the week. Ethicists equally share number of holidays and weekends throughout the year.
4. **Education on local laws, procedures and cultures –** To prepare for the switch to shared call coverage, intentional education and conversation about local laws, procedures and cultures were crucial. While each ethicist had access to information regarding these local details, education sessions allowed all ethicists to dive into the nuances of state laws or local cultures.
5. **Socialization to the process –** The transition was a big change, not only for the ethicists, but also for the facilities who were very comfortable knowing whom to call for emergent ethics consultation needs. For the transition to be successful, each local ethicist had to educate, advertise and make resources available for the clinical teams to readily access the new shared call number. Each local ethicist was charged with ensuring the right teams had the correct contact information and understood the new process in preparation for the switch to the shared call model.
6. **Proactive prevention and "Heads Up" –** As each weekend or holiday approaches, the team sets the weekend call ethicist up for success in two ways. First, the local ethicist seeks to resolve or stabilize any ongoing ethics concerns before the start of the call time. Second, the local ethicist provides the on-call ethicist with information regarding any lingering or potential ethics challenges that could surface over the shared call time. The ethics "heads up" allows for continuity in response between the start and close of the consultation regardless of the ethicist responding.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

7. **Ongoing process improvement –** This final step is one of the most important as it allows the team to continue to develop the best possible ethics support over time. Each Monday, the team of ethicists meets and discusses the ethics concerns addressed over the weekend/holiday. These discussions allow for faster recognition and response to growing organizational concerns, enable continuous learning in clinical ethics consultation across different states, and provide a quick assessment of the ethics consultation activity throughout the organization.

Each health care organization has a slightly different structure and process for addressing emergent ethics consultation needs. However, even with these differences, the task of ensuring the right level of expertise is available at the right moment remains a responsibility for all health care ethicists. The shared call model represents one possibility for extending the reach of ethics expertise throughout the organization and contributes to efforts to create healthy balance for the scarce resource of highly trained and skilled ethicists.

JENNA SPECKART, D.BE., M.A.
Vice President, Mission & Ethics
Mercy
Jenna.speckart@mercy.net

ENDNOTES

1. Technology platform is Cisco's *Unified Communications Self Care Portal*
2. Initially, SharePoint was the platform used for collecting and sharing resources, but the team later migrated content to Microsoft Teams. Both platforms work well for storage but migrating to Microsoft Teams made the resources a little easier to access and edit.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Integrating Formative Practices into Ethics Education

Emily Trancik, Ph.D.

Traditionally, "ethics education" tends to focus on training participants in ethical principles and applications to case-based scenarios. This type of education is oriented to the intellectual aspects of ethics, and it is critical to ensuring clinicians have the tools they need for moral decision-making. However, incorporating formative elements into ethics programming is also valuable. Doing so connects the textbook learning, which is oriented to the mind, with a reflective holistic approach, which is oriented to the heart, to deepen the way individuals personally connect to ethics, mission, and ministry identity.

The disciplines of ethics and formation have always had significant areas of overlap, especially in understanding the meaning of our identity as a ministry of the Catholic Church, and in promoting human dignity and the common good. Where ethics may focus on principles of Catholic health care ethics, Catholic Social Teaching, clinical ethics best practices, and the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), formation emphasizes reflection on identity and connection to self, others, world and God, and on strengthening a sense of calling to vocation, community, and ministry.[1] The work of both ethics and formation is strengthened by the other, although they may be siloed in the creation of educational content.

Making ethics training more formative has several benefits. First, formative content encourages participants to think about the underlying reasons why ethics is so important, not just about the content of ethics norms and analyses. Such reflection promotes commitment to ethics both personally and on behalf of the ministry. Second, formation has greatly improved the ability for leaders and clinicians to enter into ethical discourse. For example, leaders who have participated in formation programs tend to be well equipped to consider how decisions affect poor and vulnerable populations, and they are comfortable raising critical ethical questions. They understand how essential ensuring that vulnerable people have access to health care is to the mission, and therefore are able to promote good ethics decision-making. Third, formative approaches to ethics honor the virtue ethics tradition and pursuit of human flourishing. While no overview of the "landscape" of ethics would be complete without education on virtue ethics theory, less attention is given in practice to educating and growing in virtue. Yet, even

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

if someone cognitively understands ethical principles, if they are not motivated to change what they do or have a reason to commit to ethical practice, it matters little what they theoretically know about ethics.

In what follows, I will share key learnings from my experience introducing formative elements into ethics education.

First, in planning education, be intentional about objectives. For a typical ethics education session, an objective might use words like "understand the way in which the principle of double effect applies to the distinction between direct and indirect abortion…" or "develop skills for clinical ethics consultation." Consider the following, contrasting objective: "*Commit* professionally to the healing ministry and mission of Jesus with special attention to and solidarity with those who are poor and vulnerable." The distinction between these two kinds of objectives is between conceptually understanding with the mind and personally committing with the heart. Ethics education needs to get at both to influence practice, and a formative objective sets the tone for creating and delivering content to meet that goal.

Second, find ways to incorporate art into education. This idea is nothing revolutionary, as engaging with art naturally lends itself to formative experiences. For example, use imagery to assist in an opening reflection related to the theme of the activity. I often invite participants to reflect on the Conclusion of the ERDs before discussing human dignity. That text references the Parable of the Great Banquet, so I share art[2] depicting invitations to "the poor, crippled, the lame, the blind" (Luke 14:13) and invite participants to notice something about the imagery, which might help them connect in a deeper, more lasting way. I also incorporate short films to help participants enter into the experience of those who are impacted by the ethics topic being discussed. The encounter through film engages people more holistically; their senses and emotions enrich what is otherwise a solely intellectual experience. Anecdotally, one individual has provided feedback saying that for the first time, they really understood the purpose of the ERDs after connecting with ERD 3 in the context of a short film about food insecurity.[3]

A third way to be formative in ethics is to create space for reflection on personal experience and institutional identity, in circumstances where time permits. For example, to begin a lecture on ethical theories I asked participants to write a few sentences about a time in their life when they had a true ethical dilemma. Then, we talked about moral theories and processes for ethical decision-making. At the end, I gave them time to revisit their own personal experience and think about how a consequentialist, deontologist or a virtue ethicist might have responded to their circumstance, and how having a process for ethical decision-making may have helped them work through their dilemma. Connecting to their own lives, they could better appreciate the value of applying ethical theories.

As I continue to develop formative ethics education, I am still considering the best way to invite feedback and measure success in such an endeavor. The transformation of hearts that

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

is intended with this kind of education does not lend itself well to quantitative metrics. Anecdotal qualitative evidence and continued engagement with this type of education can indicate that it is enriching the experience of ethics education, and perhaps is cultivating deeper commitments to mission and ethics.

EMILY TRANCIK, PH.D.
Director of Ethics Integration
Ascension Tennessee
Emily.trancik@ascension.org

ENDNOTES

1. Ascension. "Spiritual and Theological Formation," accessed January 7, 2021, https://ascension.org/our-mission/spiritual-and-theological-formation.
2. For example, Copping, Herald. "Parable of the Great Supper," accessed January 7, 2021, https://www.doctrinalhomilyoutlines.com/wp-content/uploads/2014/10/harold-copping-parable-of-the-great-supper-400x546-219x300.jpg.
3. See "Inherit the Earth," https://vimeo.com/350027983.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

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.P.H. anticipated 2023) and Darian Diepholz M.B.A., M.P.H., (J.D. anticipated 2022).

FLORIDA TELEMARKETER CONVICTED IN GENETIC TESTING FRAUD SCHEME

A telemarketing call center owner in Florida was convicted after his agency made fraudulent calls to Medicare beneficiaries, claiming Medicare covered genetic testing to detect cancer risk. Ivan A. Scott, who owned Scott Global, was convicted January 8 on counts of conspiracy, health-care fraud, and paying and receiving kickbacks, the Department of Justice said, for his involvement in the $2.8 million scam. After Medicare beneficiaries agreed to genetic testing, Scott sent bribes and kickbacks to telemedicine doctors who authorized tests for patients they never treated. Scott then sent doctors' orders disguised as marketing services to laboratories, also in exchange for kickbacks. Labs submitted $2.8 million in fraudulent Medicare claims between November 2018 and May 2019, of which Medicare reimbursed more than $880,000. Scott pocketed $180,000. Genetic testing, which can cost up to $6,000, is generally only reimbursed by Medicare for patients with a history of cancer.

Christopher Brown, *Bloomberg Law News*, Jan. 11, 2021, https://www.bloomberglaw.com/document/XDDQCOBS000000?bna_news_filter=health-law-and-business&jcsearch=BNA%252000000176f33ad345a777f33a32bf0001#jcite

SOME COVID SURVIVORS HAUNTED BY LOSS OF SMELL AND TASTE

Some COVID-19 survivors lose their senses of smell and taste. For a portion of those patients, those senses have yet to return. A *New York Times* piece on January 2, 2021 chronicled the struggles of some patients with anosmia, the scientific term for loss of smell, who are hindered from partaking in daily activities. Katherine Hansen, a Seattle, Wash. realtor, lost her sense of smell and taste in March, at the beginning of the pandemic, and still can't even bear the feeling of chewing food. Others like her have consequently worsening mental health, reporting diminished quality of life due to an inability to enjoy food and related pleasure, along with feelings of isolation, anxiety and depression. A short-term side effect may be nutritional deficiency and weight loss. Still others have experienced unpleasant phantom smells. Until COVID-19 started impacting olfactory senses, research in the field received little attention. Now, scientists are struggling to cure anosmia in COVID-19 patients and worry some may lose their senses of smell and taste permanently.

Rony Caryn Rabin, *The New York Times*, Jan. 2, 2021 https://www.nytimes.com/2021/01/02/health/coronavirus-smell-taste.html

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

IN MINORITY COMMUNITIES, DOCTORS ARE CHANGING MINDS ABOUT VACCINATION

Among those most resistant to the COVID-19 vaccine are Black and Hispanic Americans, who are also hardest hit by the pandemic. To help persuade them to vaccinate when the time comes, Black and Hispanic doctors are educating their families, friends and communities about the benefits of vaccination and dispelling myths. Dr. Zanthia Wiley, an infectious disease expert at Emory University in Atlanta, has traveled to her Alabama hometown to sit down with community members and discuss vaccination with those who worry vaccine efforts may be borne out of the government's historical experimentation on Black people. Wiley, however, says Black Americans like her should be among the first to receive vaccination. In addition to her hometown visits, Wiley is sharing messages on social media and through video chat. Dr. Valeria Daniela Lucio Cantos, also an infectious disease specialist at Emory, conducts virtual town halls, which she thinks are effective not just because she speaks Spanish, but because she is an immigrant. "Culturally, they have someone they can relate to," Cantos told the *New York Times*. Along with dispelling myths and misinformation, doctors are explaining the importance of vaccination on returning to normal living. Wiley said she believes conversations with experts may be key in shifting away from vaccination hesitancy among Black and Hispanic Americans.

Gina Kolata*, The New York Times*, Dec. 31, 2020,
https://www.nytimes.com/2020/12/31/health/coronavirus-black-hispanic-vaccination.html

WHY THE AMAZON, JPMORGAN CHASE, BERKSHIRE VENTURE COLLAPSED: "HEALTH CARE WAS TOO BIG A PROBLEM"

A joint health care venture between Amazon.com Inc., JPMorgan Chase & Co., and Berkshire Hathaway, Inc. will end February after three years of challenges. Named Haven, the joint venture sought to reduce health care costs for the three companies' combined 1.5 million employees. However, the $100 million project struggled from the start with obtaining data and battled staff turnover and competition. For example, Haven struggled to estimate and establish explanations for their employees' medical costs, a major roadblock and one not unfamiliar in health care. A person from within Haven told *The Wall Street Journal* that "health care was too big a problem for us to solve." Others from within Haven said the three companies realized their goals would be better managed internally than through a partnership unless more companies or government agencies cooperated with the venture's goals. The venture also lacked bargaining power with health insurers and providers. JPMorgan CEO Jamie Dimon, whose idea it was to embark on the joint venture, was reported to be the only executive who actively participated in projects. While Haven employees worked to establish the venture, including setting up a virtual primary care service called Starfield, it faced competition from its own partners -- namely, Amazon set up a similar service called AmazonCare for its Seattle employees. Haven eventually shut down Starfield, the venture's head and Harvard University professor Dr. Atul Gawande stepped down. Lacking direction, Haven employees left their jobs or were laid off. Ultimately, industry experts and former staff say the three

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

companies, with their sprawling geographical reach and disparate corporate structures, were "an odd fit."

Sebastian Herrera and David Benoit, *The Wall Street Journal*, Jan. 7, 2021, https://www.wsj.com/articles/why-the-amazon-jpmorgan-berkshire-venture-collapsed-health-care-was-too-big-a-problem-11610039485

ILLINOIS IS FIRST IN THE NATION TO EXTEND HEALTH COVERAGE TO UNDOCUMENTED SENIORS

Illinois will allow low-income, noncitizen seniors to access publicly provided health insurance, the first state in the nation to offer public health insurance to undocumented seniors. Experts are hopeful Illinois' decision will set the stage for other states to follow suit. The move is especially important during the COVID-19 pandemic, as uninsured immigrants often forgo health care for lack of coverage. The newly insured include undocumented legal permanent residents -- people who have had green cards for less than five years, who are typically left out of health insurance programs. Those recipients must fall below the federal poverty line and must be over 65. Illinois already covers organ transplants for undocumented immigrants and covers undocumented children, while California covers undocumented, low-income people 26 and younger. Federal law prohibits Medicare, nonemergency Medicaid, and Affordable Care Act marketplace coverage for undocumented people; states with coverage for the undocumented must cover services using state funding. The Illinois Department of Healthcare and Family Services estimates up to 4,600 seniors will gain coverage under the expansion.

Giles Bruce, *Kaiser Health News*, Jan. 7, 2021, https://khn.org/news/article/illinois-is-first-in-the-nation-to-extend-health-coverage-to-undocumented-seniors/

HOW MIGHT A MASK MANDATE PLAY OUT? LOOK TO THE BATTLE OVER SEAT BELT LAWS

Advocates for mask mandates are looking to the past battles over seat belt and helmet laws, as well as failed mask mandates to decide how to move forward during the COVID-19 pandemic. In the 1950s, campaigns began for the U.S. to adopt legislation to enforce seat belt usage. Seat belt advocates were met with pushback from the car industry, who did not wish to have people focus on issues of safety in their products, and from fellow citizens who claimed these laws were attempting to "nanny" the people of the U.S. It took years of advocating before President Johnson signed legislation in 1966 to require seat belts in passenger cars. Beginning in 1984, states began passing seat belt mandates and the federal government provided extra highway funding to those with strict laws. Since then, seat belt usage has risen to 91% nationally as of 2019. The U.S. tried a similar route with motorcycle helmet laws, by requiring helmets in order to receive federal highway construction funds. However, in 1976 Congress dropped the requirement to receive funding and half the states reversed their helmet laws. Even with striking research on the benefits to safety, still only half of the U.S. have helmet mandates. These factors play into how the U.S. may attempt to create a mask mandate. In 1918, there was a mask mandate during the influenza epidemic, but with little research on its protective qualities, the mandate failed. Now, research shows masks reduce transmission of the virus. Currently, 33 states and D.C.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

have mandates, but there is slow progress for mandates in other states that believe it is a personal responsibility and should not be a law. President-elect Joe Biden has spoken of his plan to speak with each state's officials about creating mask mandates, but researchers wonder if an act by Congress to regulate funds like the passing of seat belt laws will be needed. A study projected universal mask-wearing could save 130,000 lives in the U.S. by the end of February, showing the importance masks bring.

Joanne Silberner, *STAT,* Nov. 10, 2020,
https://www.statnews.com/2020/11/10/covid19-masks-mandate-seatbelt-laws/?fbclid=IwAR1eBCt9ZBsDzbS9C30uOBYK8RCVQ5wZTq2r4o8K_JP2fYAJRmBeQdmy-iw

"EVERY DAY IS AN EMERGENCY": THE PANDEMIC IS WORSENING PSYCHIATRIC BED SHORTAGES NATIONWIDE

In the U.S., 40% of adults have mental health conditions. A study completed in June 2020 found nearly 11% of adults surveyed had considered suicide in the last 30 days. Even with these numbers, the COVID-19 pandemic has decreased the availability of inpatient psychiatric beds across the country as facilities comply with social distancing or use beds for COVID-19 patients. States do not have the beds to help all those in need. Over the years, funding and beds have slowly decreased. A CEO for a Massachusetts behavioral network estimated the state had lost 300 psychiatric beds this past year. COVID-19 has only worsened the mental health problems already occurring. For example, governors are stopping admission to psychiatric hospitals, temporarily shutting them down when an employee tests positive for COVID-19. In addition, many hospitals have had to shut down their inpatient mental health units due to financial loss. This backup has led to prolonged stays in the emergency room while staff attempt to place a patient in a psychiatric bed, some staying for longer than three days. Beyond beds, state governments have considered cutting mental health budgets during the pandemic, but the public's disapproval has halted any progress thus far. Researchers state many legislators are only looking at the virus and should pay attention to the mental health problems increasing during the pandemic that could cause major long-term effects. These researchers suggest this rise in mental health conditions should be treated as a part of the response to the COVID-19 pandemic and receive better funding for more beds and facilities to stay open.

Roger Rapoport, *STAT*, Dec. 23, 2020,
https://www.statnews.com/2020/12/23/mental-health-covid19-psychiatric-beds/

CHANNEL TO RESOLVE DRUG DISCOUNT DISPUTES UNDER EXECUTIVE REVIEW

Low-income health centers often rely on the federal drug discount program, 340B, to continue providing affordable health care to their patients. Under 340B, drug companies have to sell discounted products to these centers or be at risk for fines or their product being pulled from Medicare and Medicaid programs. However, 340B does not allow centers to sue companies if they feel they have been overcharged. Plus, companies state under the current rule they are not required to give discounts to pharmacies that are partnered with the centers. Now, there is a rule up for review with the White House's Office of Management and Budget that would provide a formal channel for centers to challenge drug charges. This rule was created after legal

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

demands from health centers were taken against the Department of Health and Human Services (HHS) for neglecting to add a dispute process to 340B. The issue is how to create a remedy. In 2016, HHS published a rule for a dispute process but was pulled after complaints it wasn't fair to companies. Thus, simply reviving the old proposal would not work. Further, another suit has been filed requesting that 340B entities be allowed to buy and distribute 340B drugs through their chosen pharmacies to settle the issue with companies not providing discounts to pharmacies associated with health centers. Thus, the dispute rule currently up for review is a good start to addressing the discount program, but it is unknown how this will affect the current lawsuits and address issues health centers are facing.

Jacquie Lee, *Bloomberg Law News,* Nov. 18, 2020, https://www.bloomberglaw.com/product/health/document/XFR0CR6G000000?criteria_id=d7733c3ad614beb9ced66554d13b2b68&searchGuid=73610411-641b-4adf-b320-a23138320918&bna_news_filter=health-law-and-business

PURDUE WINS APPROVAL OF $8.3 BILLION U.S. OPIOID SETTLEMENT

In November 2020, a bankruptcy judge approved the settlement between Purdue Pharma and the Justice Department for $8.34 billion. The settlement required Purdue to plead guilty to three felonies over their marketing and distribution of OxyContin. The judge also approved a $225 million payment to the Justice Department from the Sackler Family, who owns Purdue, for civil charges. This settlement was opposed by many, including almost 24 states. The judge urged Purdue and states that opposed to go through mediation for the next month to resolve any open issues over Purdue's claims against the Sacklers and Purdue's plans for restructuring once the company emerges from Chapter 11. Purdue's intent is to come out a public-benefit company, including a resolution from the case that ensures Purdue takes action towards combating the opioid crisis. Purdue will end up only paying a fraction of the $8 billion settlement, with fines and penalties being paid off at less than 1 cent on the dollar. At the hearing, the federal government agreed to a substantial discount, meaning states and local governments throughout the country will be able to get a bulk of Purdue's assets instead of the Justice Department. Purdue is currently trying for a broad framework that will settle thousands of claims from states and more for their role in fueling the opioid crisis. The Sacklers have offered to cede the company to creditors while paying another $3 billion. This proposal requires court approval.

Jonathan Randles, *The Wall Street Journal,* Nov. 17, 2020, https://www.wsj.com/articles/purdue-gets-chapter-11-approval-of-justice-department-opioid-settlement-11605655666

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Literature Review:
Navigating Hesitancy and Resistance: Conscience Concerns Regarding the COVID-19 Vaccine

Addison S. Tenorio

BACKGROUND

The Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU), "COVID-19 Dashboard," https://coronavirus.jhu.edu/map.html; Liz Hamel, et al. "KFF COVID-19 Vaccine Monitor: December 2020," Dec. 15, 2020. https://www.kff.org/coronavirus-covid-19/report/kff-covid-19-vaccine-monitor-december-2020/.

In the wake of political discord and death tolls surpassing 400,000,[1] the United States is ramping up efforts to vaccinate the population and move closer towards herd immunity. People are raising concerns about whether or not they will actually get vaccinated when their turn arises. The Kaiser Family Foundation's *COVID-19 Vaccine Monitor* reports: "About a quarter (27%) of the public remains vaccine hesitant, saying they probably or definitely would not get a COVID-19 vaccine even if it were available for free and deemed safe by scientists. Vaccine hesitancy is highest among Republicans (42%), those between ages 30-49 (36%), and rural residents (35%)." Respondents cite a number of reasons for their vaccine hesitancy. Principal among these are concerns about side effects (59% cite this as a major reason). Other reasons include lack of trust in the government's ability to ensure the safety of vaccines (55%), concerns regarding the newness of the vaccine and a desire to "wait and see" what happens to others who are vaccinated (53%), and other concerns regarding the role of politics in the vaccine's development (51%). Only 34% of those interviewed want to get vaccinated "as soon as possible," while 39% belong to the "wait and see" group. Nine percent of those interviewed said they would get vaccinated "only if required," and 15% would "definitely not" get vaccinated. KFF did not gather data surrounding the religious convictions of its respondents.

SOME CHRISTIAN SENTIMENTS TOWARDS VACCINATION

Andrew L. Whitehead and Samuel L. Perry, "How Culture Wars Delay Herd Immunity: Christian Nationalism and Anti-vaccine Attitudes," *Socius: Sociological Research for a Dynamic World* 6: 1-12.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

Neither Kaiser nor the Pew Research Center has data on the religious affiliations of people associated with their willingness to be vaccinated. Other researchers have collected data on this information. The collection and dissemination of this information tends to be politicized, however, taking shape in articles with witty titles showcasing their author's agendas (e.g., "Religious Nationalism and the Coronavirus Pandemic: Soul-Sucking Evangelicals and Branch Covidians Make America Sick Again"[2]). Similarly, but less acerbically, Whitehead and Perry use a nationally representative sample that contains questions regarding people's views on vaccines. They connect religious/Christian nationalism—characterized as being typically white, native born, politically and religiously conservative—with the growing numbers of people who are vaccine hesitant or resistant. Authors, like Whitehead and Perry, have found that this group is united in their desire to not be vaccinated after controlling for race, education, political party, or religiosity.[3] Many have reported that Christian nationalism is associated with mistrust of science, not following COVID-19 public health guidelines, and support for politicians who align with Christian nationalist views.

Reports like these, however, seem to miss the mark as far as many Christians are concerned—failing to acknowledge the *why* behind these nicely distilled characteristics. Preferring, instead, to report the information that is controversial, "newsworthy," and that easily feeds into partisan politics. Nevertheless, this research is growing in popularity, and has been cited by major news outlets, like *NBC*.

RESPONSE FROM THE CATHOLIC CHURCH

Holy See Press Office, "Note of the Congregation for the Doctrine of the Faith on the morality of using some anti-COVID-19 Vaccines, 21.12.2020," https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2020/12/21/201221c.html; Chairmen of the Committee on Doctrine and the Committee on Pro-Life Activities United States Conference of Catholic Bishops, "Moral Considerations Regarding The New COVID-19 Vaccines," Dec. 11, 2020. https://www.usccb.org/resources/moral-considerations-covid-vaccines.pdf.

Both the United States Conference of Catholic Bishops (USCCB) and the Congregation for the Doctrine of the Faith (CDF) have made statements regarding the liceity of the COVID-19 vaccine. There has been concern from ethicists due to the connection between some of the vaccines and morally tainted cell lines—those that have connections to aborted fetuses.

Both the CDF and the USCCB offer lessons on cooperation in their statements, acknowledging that "there exist differing degrees of responsibility" between the concerned citizen seeking to do their part in working towards herd immunity, and those who decided to use these morally compromised cell lines in the development of the vaccine.[4] The type of cooperation involved in being vaccinated with these compromised cells is identified as *remote passive material cooperation.* This means that the person being vaccinated does not morally

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

approve of the immoral action in question (abortion), but they participate in the result of that action (vaccination) for other reasons (herd immunity, love of neighbor, etc.). The person's decision to be vaccinated exists many degrees of separation apart from the original moral evil of abortion. The CDF is clear that "*it is morally acceptable to receive Covid-19 vaccines that have used cell lines from aborted fetuses in their research and production process*," but cautions against complacency towards abortion that may come with the use of the HEK293, and similar, cell lines. The HEK293 cell line is derived from fetal kidney cells obtained through an abortion that occurred in the Netherlands in 1972; it is the second most commonly used cell line in cell biology and biotechnology only to the HeLa line. Both the USCCB and the CDF take time to speak about the gravity of the sin of abortion, and caution that the successful use of the HEK293 cell line in the various stages of the COVID-19 vaccine development should not be seen as license to further research of this kind. Both offer the rubella vaccine as an example. This vaccine was also derived from aborted fetal cells. However, it is the only known vaccine for the rubella virus in existence. By vaccinating oneself and one's children, one prevents the transmission of rubella to pregnant women and their unborn children, thus, preventing the harms of congenital rubella syndrome, which causes miscarriages and a variety of birth defects (many of which are severe). While the development of the rubella vaccine does not require more abortions to occur in order for it to continue to be produced, there is still proportionate reason to justify cooperation with the use of these morally compromised cell lines.

The USCCB offers a thorough analysis and goes one-by-one through some of the major vaccines in production, including those by Pfizer, Moderna, and AstraZeneca, and assesses the connection of each to compromised cell lines, and thus, to abortion. Moderna and Pfizer's vaccines both involve the use of the morally compromised cell line HEK293 to perform a confirmatory test on the vaccine to verify its efficacy (5). Whereas, the AstraZeneca vaccine uses the HEK293 cell line in the "the design, development, and production stages of that vaccine, as well as for confirmatory testing" (5). In light of this, the AstraZeneca vaccine should be avoided in the face of available alternatives; however, the bishops acknowledge that it might not be possible for someone to seek out an alternative for moral reasons.

RECOGNIZING LEGAL CLAIMS TO VACCINE EXEMPTION

Cameo C. Anders, "Individual and Institutional Religious Exemptions from Vaccines: Federal Law and Catholic Teaching," *National Catholic Bioethics Quarterly* 20, no. 3 (2020): 501-523.

In light of not only the concerns voiced by the general public and articulated by Church leaders, the issue of conscientious objection/religious exemption from vaccines must be addressed. A variety of Supreme Court cases has solidified the First Amendment right that provides for the free exercise of religion, which allows people to claim religious exemption when it comes to being vaccinated. Federal law holds that individual exemption from vaccination is valid "when it is based on subjective, sincere beliefs rooted in religion

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

but not dependent on the existence, veracity, or accurate understanding or application of denominational tenets or doctrines" (501). Like the state, institutions may override an otherwise valid application of the law if it has a compelling reason to do so, which entails an institutional religious exemption. These institutional religious exemptions are not dependent simply on matters of sincerely held beliefs, but "matters of church government as well as those of faith and doctrine."[5] Individual religious exemptions, if otherwise valid, that infringe on these matters of governance, faith or doctrine may prompt an institution to claim a religious exemption of its own. Both the institution and the individual rights to claim religious exemption have the same origin, the First Amendment. Anders is quick to emphasize that the institution's failure to acknowledge the individual's right to religious exemption causes its own ability to act similarly to be at risk. Therefore, the institution's first concern should be to act to protect the individual's right.

Anders points to the important fact that institutions need to note is not whether they should hold as valid individuals' claims to religious exemptions under the law, but rather whether there is a basis for overriding individual exemptions "within the institution's government, faith, or doctrine" (509). For example, Anders offers the case of *Flynn v. Estevez* (2017). Here, a father, Patrick Flynn appealed that since a Catholic school received federal funding, it was required to acknowledge his appeal to a religious exemption from vaccination; thus, admitting his son to the school without being vaccinated. However, Flynn's state-based right was overridden by the school's federally granted right to deny such individual exemptions based on governance and the doctrine of the common good.

Besides *Flynn*, there are a number of cases that undergird a person's right to refuse vaccination. These include cases that address individual and institutional right to free exercise, and the state's compelling interest to mandate vaccination. Using these cases, Anders proposes policy guidelines. He concludes:

> A policy would not be legally sound if it required more than merely subjective, sincere religious beliefs when following state law; if it did not apply the policy uniformly; if it required proof of the religious belief via clergy or another third party; and if it did not employ the least restrictive means possible. A policy would not be doctrinally sound if it asserted the common good without respecting the right of the individual to object on the basis of a well-formed conscience; if it did not assert the sacred duty of all to protect the well-being, including the health, of the group; and if it did not harmonize the rights and duties of individuals and society in a morally acceptable and least restrictive manner. (523)

Crucial to this policy recommendation is the harmonization of the legal and theological obligations that religious organizations have to their group members.

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

SUPPORTING CONSCIENCE DEVELOPMENT

Many people have voiced concerns about the COVID-19 vaccine, be they Christians or not. Unfortunately, there has been a great deal of misinformation surrounding the vaccine, which public health officials have had to combat. In order to best support people who might have concerns about the vaccine, whether it be about issues of cooperation with the issue of abortion, or others. Institutions, like the Mayo and Cleveland Clinics, have put together resources dispelling what they think are other common myths surrounding the vaccine (these are not specifically tailored to a Christian audience). They address concerns about whether it will change a person's DNA; involve a microchip or some other surveillance device; is safe because of the speed with which it was developed; has severe side effects (perhaps worse than if one were to contract the virus itself); causes infertility, and among others.[6] Catholic health care should parallel these efforts to address misinformation surrounding the vaccine. Likewise, it should be concerned with matters of conscience and help people to form their consciences so that they can make decisions about vaccination. Catholic theology and the law concur that people should follow their consciences, even when they are in error.[7] Still, continued efforts—such as CHA's "Love Thy Neighbor" wear a mask campaign—can help spark consciences and should be encouraged.

ADDISON S. TENORIO
Teaching Assistant
Health Care Ethics M.A./Ph.D. Program
Albert Gnaegi Center for Healthcare Ethics
Saint Louis University
addison.tenorio@slu.edu

ENDNOTES

1. Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU), "COVID-19 Dashboard," https://coronavirus.jhu.edu/map.html.
2. Peter McLaren, "Religious Nationalism and the Coronavirus Pandemic: Soul-Sucking Evangelicals and Branch Covidians Make America Sick Again," *Postdigital Science and Education* 2 (2020):700–721.
3. Andrew L. Whitehead, "Christian Nationalism's Covid Vaccine Doubt Threatens America's Herd Immunity," *NBC News,* January 2, 2021. https://www.nbcnews.com/think/opinion/christian-nationalism-s-covid-vaccine-doubt-threatens-america-s-herd-ncna1252515.
4. Here, the CDF is quoting *Dignitas Personae* (n. 35).
5. *Kedroff v. St. Nicholas Cathedral*, 344 U.S. 94 (1952) at 116. Cf. Anders, 509.
6. COVID-19 Vaccine Myths Debunked," *Mayo Clinic Health System*. https://www.mayoclinichealthsystem.org/hometown-health/featured-topic/covid-19-vaccine-myths-debunked; "9 Common COVID-19 Vaccine Myths Explained," *Cleveland Clinic*, December 23, 2020. https://health.clevelandclinic.org/8-common-covid-19-vaccine-myths-explained/.
7. St. Thomas Aquinas in the *Summa* writes, "In like manner if a man were to know that human reason was dictating something contrary to God's commandment, he would not be bound to abide by reason: but then reason would not be entirely erroneous. But when erring reason proposes something as being commanded by God, then to scorn the dictate of reason is to scorn the commandment of God" (ST I-II 19, 5); cf. *Farina v. The Board of Education* (2000).

Copyright © 2021 CHA. Permission granted to CHA-member organizations and Saint Louis University to copy and distribute for educational purposes.

HCEUSA | A Quarterly Resource for the Catholic Health Ministry

Health Care Ethics USA © 2021 is published quarterly by the Catholic Health Association of the United States (CHA) and the Albert Gnaegi Center for Health Care Ethics (CHCE) at Saint Louis University.

Subscriptions to *Health Care Ethics USA* are free to members of CHA and the Catholic health ministry.

EXECUTIVE EDITOR
Brian M. Kane, Ph.D., CHA senior director, ethics

ASSOCIATE EDITORS
Tobias Winright, Ph.D., Hubert Mader Chair of Health Care Ethics, Albert Gnaegi Center for Health Care and Ethics, Saint Louis University, and Nathaniel Blanton Hibner, Ph.D., CHA director, ethics

MANAGING EDITOR
Ellen B. Schlanker, CHA director, communications and marketing

LAYOUT DESIGNER
Dottie Martin, CHA digital media project coordinator

LEGAL LENS CONTRIBUTOR
Amy N. Sanders, associate director, Center for Health Law Studies, Saint Louis University School of Law

PERIODICAL REVIEW EDITOR
Lori Ashmore-Ruppel, CHA director, sponsor services

TALK TO US!

We want to hear from you!
If you have questions, comments or topics you would like discussed, please contact the *Health Care Ethics USA* team:

hceusaeditor@chausa.org

CHAUSA.ORG

WE ARE CALLED TO CONFRONT RACISM BY ACHIEVING HEALTH EQUITY. TOGETHER, AS CATHOLIC HEALTH CARE, COMMIT WITH US TO IMMEDIATELY ADDRESS DISPARITIES IN COVID-19 TESTING AND TREATMENT, AND TO SWEEPING MEASURES TO END DISPARITIES. FATHER BRYAN MASSINGALE, A CATHOLIC THEOLOGIAN, REMINDS US THAT THIS IS ABOUT OUR VERY INTEGRITY. "... THE IMPACT OF RACISM HAS GOT TO BECOME R... WE HAVE A STAKE AND INVESTMENT IN OVERCOMING. IT CAN'T JUST AF... HOW IT AFFECTS ME AND MY INTEGRITY." BUT WHEN WE SAY ... SYSTEMIC RACISM, WHAT ARE WE TALKING ABOUT? HEALTH EQUIT... AND JUST OPPORTUNITY TO BE AS HEALTHY AS POSSIBLE. IT'S DIFFERENT THAN EQUAL SINCE NO TWO PEOPLE NEED THE EXACT SAME THINGS TO BE AS HEALTHY AS EACH CAN BE. SO, SAYING WE WANT TO ACHIEVE HEALTH EQUITY MEANS THAT WE NOT ONLY HAVE TO ENSURE ACCESS TO QUALITY HEALTH CARE SERVICES BUT WE HAVE TO

We are Called

TO HEAL. TO UNITE. TO JUSTICE.

Join us in confronting racism by achieving health equity

WeAreCalled.org