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FEATURES

CHA Catholic Health Association of the United States

SAINT LOUIS UNIVERSITY

The Fifth Annual Catholic Health Care Innovation in Ethics Forum

In September 2023, Mercy hosted the fifth annual Catholic Healthcare Innovation in Ethics Forum (CHIEF) virtually. The CHIEF planning committee—made up of ethicists from Ascension, CHRISTUS Health, CommonSpirit Health, Franciscan Missionaries of Our Lady Health System, Hospital Sisters Health System, Mercy, OSF HealthCare, and Providence — affirmed the goal of CHIEF: to create an opportunity for those in Catholic healthcare to explore, present, and discuss innovative ideas in healthcare ethics.

In previous years, CHIEF solicitated talks on specific areas of interest. CHIEF 2023 welcomed all proposals topics and encouraged submissions in:

- Self-Compassion for the Ethicist
- High Reliability in Clinical Ethics
- Diversity, Equity, and Inclusion

Most of the conference presentations were "lightning talks," which consist of presentations completed in seven minutes with three slides. Presenters were grouped by subject area, and each group was followed by a 45-minute panel discussion with the presenters. CHIEF 2023 had a special 75-minute presentation dedicated to the ethical issues surrounding Thoracoabdominal Normothermic Regional Perfusion (TA-NRP) for organ donation after circulatory death. Over the two and a half days, there were seventeen presentations from fourteen ethicists on topics ranging from "Normothermic Regional Perfusion for Organ Donation after Circulatory Death" to "Clinical Ethics as a Liturgical Approach."

CHIEF 2023 conducted two workshop sessions. One workshop, "Healthcare Ethics Consultation Training - Legislative and Regulatory Advocacy" was led by Dr. Michael Redinger – Associate Professor at Western Michigan University Homer Stryker M.D. School of Medicine. The other workshop session was led by Dr. Becket Gremmels - System Vice President, Theology and Ethics of CommonSpirit Health – on "Developing a Template Curriculum for Clinical Ethics Fellowship." The interest in this workshop has led to efforts outside of CHIEF to help Catholic health systems create working templates for future clinical ethics fellowships!

One of the highlights of every CHIEF is the keynote address. In the past, CHIEF participants have benefitted from the wisdom of Dr. Ron Hamel, Dr. Carol Taylor, and other leaders with significant careers contributing to the field of Catholic healthcare ethics. This year, Fr. Thomas Kopfensteiner joined CHIEF to share his reflections and experiences as a substantial contributor to the development of the Ethical and Religious Directives for Catholic Health Care Services. In his

presentation, "The Ethical and Religious Directives: History, Content, and Adequacy," Fr. Kopfensteiner gave attendees a "behind-the-scenes" understanding of the development of the ERDs, using both humor and authentic storytelling to deepen attendees understanding of the humanness of the document.

Fr. Kopfensteiner divided his presentation into three sections, discussing the history & content, reviewing cases and key accomplishments, and reflecting on future directions. In each of the sections, he paired the sharing of history with reflection about its implications for the work today. The keynote addressed gifted participants with a deeper understanding of the developments of the ERDs and a moment for reflection on how the ERDs continue to shape and influence the work of Catholic Healthcare ethics today and into the future.

At the conclusion of every CHIEF, a survey assesses if the annual gathering has stayed true to its stated goal: to create an opportunity for those in Catholic healthcare to explore, present, and discuss innovative ideas in healthcare ethics. For 2023, CHIEF participants gave the conference an overall rating of 4.73/5 on overall quality, a score the planning committee was thrilled to see. There are two notable scores from the survey demonstrating CHIEF is achieving its stated goal:

- 72.7% are "Very Likely" or "Somewhat Likely" to make changes to the ethics services at their respective organizations.
- 81.8% believe the format of CHIEF offers more value compared to other professional events.

The continued positive results of CHIEF provide confidence and assurance to the planning committee that CHIEF continues to deliver on the purpose and goal to create a space for those serving in Catholic healthcare ethics to share and discuss, innovate, and deepen the sense of community through this crucial and meaningful work.

We hope you enjoy this issue of HCEUSA, highlighting some of the innovative work coming out of CHIEF 2023. Keep your eyes (and email) open for information about the next CHIEF in Late Summer/Fall 2024!

THERESA MCCRUDEN, JD/MA, HEC-C
Director of Ethics
Mercy Hospital
Fort Smith, Arkansas

JENNA SPECKART, DBE, MA
Vice President, Mission and Ethics Operations
Mercy
Greater St. Louis

The Clinical Ethics Consultation Benchmarking Collaborative Initial Findings

Identifying commonalities between and among ethics consultation services remains a difficult task given the lack of uniformity in data collection efforts.[1,2] Numerous studies have demonstrated the value of robust data collection, including the need for a shared set of variables[3] to assess case complexity,[4] determine volume,[5] and standardize data collection practices[6] so to make intra-institutional comparisons[7] and ultimately improve ethics consultation services in the United States.

Ethics leaders from various health systems and hospitals came together to form the Clinical Ethics Consultation Benchmarking Collaborative (CECBC) to build a broad, enduring coalition to identify, develop, and recommend metrics for a robust data set for empirical studies of ethics consultation activities across institutions and geographies. These data would include consult volume, time spent in ethics consult work, consult distribution across clinical units, as well as emerging metrics of interest to understand and improve the quality of clinical ethics consultation work.

The CECBC created an online data collection instrument which was distributed in May 2022 via a variety of clinical ethics listservs, such as the Medical College of Wisconsin's Bioethics Listserv, the Clinical Ethics Consultation Affinity Group (CECAG) of the American Society for Bioethics and Humanities (ASBH), and the ASBH general membership mailing list, as well as other email lists, requesting 2021 ethics consultation data at individual ethics services. The CECBC hypothesized that aggregated data on consult volume, distribution across units, time spent engaging in consult work, and other metrics of interest would be a valuable resource to better understand of the work of clinical ethics and improve high-quality ethics consultation practices. There were 22 variables requested with 17 coming from publicly available sources related to the composition of a particular hospital, for example, number of staffed beds, trauma designation, etc. From the collected data, the CECBC team calculated specific metrics to assess the ethics services at the hospitals and describe their activities. One calculated metric derives from a measurement created by Glover et al 2020 to describe the proportionate need (and response) of ethics consultation by licensed bed size of a facility. The consult-to-bed ratio (CBR) allows a hospital to see their relative consult volume as 'high' (CBR greater than 0.500) and 'low' (CBR less than 0.500).

Respondents from 330 hospitals within 24 health systems (3 Catholic) across 32 states provided significant insight into the ethics resources within their respective services. Close

to ten thousand (9,759) ethics consultations were conducted across 68,587 staffed beds and among 2.78M annual admissions. While the bulk of the ethics literature around ethics consultation services has been derived from academic medical centers[8,9] only 8.5% (n=28) of CECBC submissions were from academic medical centers. Close to half (45%) of the responses were from acute care general hospitals (n=148) followed closely by 28% from community hospitals (n=91), 14% critical access (n=45), and 4% specialty hospitals (n=13). Less than 2% of submissions came from children's hospitals (n=5). Close to 40% of responses (n=125) were from hospitals with 0-99 beds followed by 70 (21%) 100-199 bed hospitals, 52 (16%) 200-299 bed hospitals, 37 (11%) 300-399 bed hospitals, 20 (6%) 400-499 bed hospitals, and 27 (8%) were 500+ beds. To put this into perspective, the American Hospital Association reported 6,129 hospitals in the US in 2021.[10] Of those, 3,474 hospitals were 6-99 beds, 1,176 were 100-199 beds, 603 were 200-299 bed hospitals, 352 were 300-399 bed hospitals, 178 hospitals had 400-499 beds, and 346 hospitals had 500+ beds.

A significant finding came when the CECBC team stratified bed size by the average number of ethics consultations. Hospitals with 6-24 beds reported less than one consult per year whereas hospitals with more than 500 beds reported almost 160 average consults per year. The difference between smaller (100-199 beds) and mid-size hospitals (200-299 beds) is striking; a jump from 12 consults per year to 30 consults per year. Yet the difference between the 200-299 bed hospital and the 300-399 bed hospital is only one additional consult. Unsurprisingly, there is significant increase in volume when bed size increases with an average of 72 consults per year at 400-499 bed hospitals. Small hospitals (25-49 beds) averaged about two consults per year and hospitals with 50-99 beds reported about six consults per year.

The CECBC team calculated a mean consult-bed ratio (CBR) of 0.11 (median: 0.0395). The CBR for each of those facilities are as follows: CBR = 0.33 at academic medical centers (low volume), CBR=0.1 at acute care hospitals (low volume), CBR=0.050 at community hospitals (low volume), CBR=0.024 at critical access hospitals (low volume), CBR=0.054 at specialty hospitals (low volume), and CBR=0.108 at children's hospitals (low volume).

Despite accounting for less than ten percent of respondents, 93% of the services at academic medical centers received funding compared to 43% of acute care general hospitals, 15% of community hospitals, 41% of critical access hospitals, 31% of specialty hospitals, and 50% of children's hospitals. Just over sixty-six (66.17) full-time equivalents (FTEs) were devoted to ethics services.

This initial data collection demonstrates a novel and important starting point for ethics services across the United States. As previously argued,[11] the vast majority of ethics services provide care for patients in other-than-academic medical centers but as these findings also show, there is significantly less funding for those services than at academic medical centers. Catholic hospitals comprise 665 hospitals in the United States accounting for almost 5 million inpatient admissions[12] yet we heard from only a fraction of those facilities (about 250). Our hope in the next round of data collection that we understand more about the barriers and challenges to providing high-quality ethics consultations. The unexpectedly high number of submissions suggests a desire of many

ethicists to establish benchmarks and to better understand the field beyond one's own practice environment. For example, another metric developed by Glover et al has the same goal of the CBR but attempts to account for the fact that a hospital's licensed bed count does not always correspond to the volume of patients admitted annually. The consult-to-admission ratio (CAR) is a companion to the CBR and adds nuance. The differences between a 'high' consult volume (CAR greater than 6.00) and a 'low' consult volume (CAR less than 2.99) can be better assessed when CBR and CAR are analyzed together. This metric is currently review by the CECBC team and will be analyzed for a future publication.

The collection for 2023 data will occur later this year in 2024. We encourage all our colleagues and anyone responsible for clinical ethics consultation in Catholic healthcare to contribute to the Collaborative in future years. To find out more information, please visit the CECBC website www.cecbc.net. A larger set of data will hopefully lead to the development of normative and predictive metrics which could help support more dedicated resources to this crucial work. A strong representation of Catholic hospitals will allow us to better describe the nature of this work and promote the common good of clinical ethics across our ministry.

MARY HOMAN, DRPH, MA, MSHCE
Bioethicist and Health Services Researcher
CommonSpirit Health
Milwaukee, Wisconsin
BECKET GREMMELS, PHD
SystemVice President, Theology and Ethics
CommonSpirit Health
Dallas-Fort Worth, Texas

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High Reliability in Clinical Ethics: Creating Best Practice Criteria in Structure and Process

PROMOTING HIGHLY RELIABLE CATHOLIC MINISTRY IDENTITY

Many in healthcare, especially in the clinical realm, are familiar with what it means to be a High Reliability Organization (HRO), as defined by the Agency for Healthcare Research and Quality. High reliability is often understood as a "systems thinking" approach to evaluating and designing initiatives, structures and processes that optimize particular endpoints. Systems thinking emphasizes the relationship among a system's parts, rather than a focus only on a particular part of the system when attempting to effect change. Often persons engaged in systems thinking will start from a position of curiosity or discovery that may include an exploration of the fundamental concepts or ways of doing things that were previously thought to be true. In this way, systems thinking can offer a new perspective on the complexity of the initiative, structure or process, and in particular, on how things influence one another within the whole.

It was the idea of taking a systems thinking approach to how our ethicists in Ascension were leading their ethics programs, both in structuring Ethics Integration Committees (EICs) and the provision of clinical ethics consultation services, that led to the collaborative redesign to optimize our ethics services. In the following sections, we will explore two key initiatives as part of our systems thinking redesign: (a) the shift away from an ethics committee-centric model to an ethicist-driven model and the concurrent restructure of EICs through this lens, and (b) the optimization of clinical consultation process flows.

AN ETHICIST-DRIVEN MODEL AND ETHICS COMMITTEE REDESIGN

The Ethicist-driven model is distinguished both from the traditional Ethics Committee-centric model and the Ethicist-centric model, which views the ethicists as a "Lone Ranger" consultant. The Ethicist-driven model retains a role for Ethics Committees but the roles of those committees and their members change with the goal of facilitating access to the right level of ethics expertise in the right way at the right time and supporting the (Ethicist-driven) Ethics Programming (a systems-thinking approach to all things ethics) within the Ministry Market. The following chart (Table 1) illustrates the differences in the roles of ethics committee members in a committee-centric model vs. an ethicist-driven model. These differences in role also highlight the essential strategic, leadership and subject matter expertise the ethicist must evidence within this framework:

TABLE 1

Function	Role of Members in an Ethics Committee-centric Model	Role of Members in an Ethicist-driven Model
Consultation	Perform a large percentage of consultations	• Identify clinical ethics consult needs on the units • Escalate consults to Manager/ Director of Ethics • Support consultations by providing clinical SME and multiple perspectives to the ethicist-led consult team
Education	Provide Education (usually through an annual conference)	• Identify education needs on the units • Advise on how the ethicists can best meet those needs • Help integrate into "other people's" curricula/processes • Build support for attendance among peers
Policy Review and Development	Review and Develop policies	• Identify policies that need review • Identify issues for new policy • Provide input and recommendations on policies
Marketing the Ethics Service	None	• Educate peers regarding Ethics services • Educate other staff on when to use Ethics Services • Keep peers updated on changes to Ethics services
Member Succession Planning	None	Make recommendations to Ethicists about peers as appropriate candidates for future members and develop their interest for future membership

As Mary Homan notes in her article within this issue, many academic medical centers favor an ethicist-centric model of consultation, where the professionally trained ethicist handles all consults, and the volume of consults justifies their FTE. An ethicist-driven approach is not this, nor is it a model where the ethicist is at the service of the ethics committee or the committee chairs. An ethicist-driven approach is one where the ethicist(s), with their specific subject matter expertise, in collaboration with clinical and organizational leaders, and the EIC, set the agenda and direction for a systems-thinking based ethics program. This includes setting strategic priorities, determining optimal EIC structure and consultation processes, and aligning membership, expectations and training of members to these structures and priorities. Put simply, an ethicist-driven approach leverages the relationship among the parts within the complexity of the whole of the healthcare system to inform the right level and type of ethics service and to help ensure that ethics subject matter expertise, resources and tools are integrated into the operations of the entire health system.

As part of this work to apply systems thinking to the clinical ethics setting, in addition to revising the role of the committees themselves, we have been simultaneously redesigning the structure of the ethics committees away from the traditional model of facility-based committees. Instead, the Ministry Markets are moving to one committee that serves a specific service line or population of patients with representatives from all the facilities across the market. Within this model, for example, there may be one Women's and Perinatal Health Ethics Committee that serves the whole market, another committee that serves Pediatrics across the entire market, another that serves the adult acute care population, another that serves Behavioral Health and still another that serves the smaller community hospitals across the Ministry Market. Which service-line or population-based committees are present in which Ministry Markets will depend on the makeup of the types of facilities and service lines within those Ministry Markets. This results in both a substantial increase in member engagement (insofar as everything discussed in every meeting is relevant to everyone on the committee), and a significant increase in the ability of the Ethicist-led committee to integrate into operations in a sustainable manner, given the new membership and the roles of those members as outlined in the chart above. Systems thinking here allowed us to question whether the long-standing structure of facilities-based ethics committees is still the right structure to deliver high quality clinical ethics consultation services.

Based on anecdotal feedback, this structure provides the committee members with a greater sense of meaningful contribution to the operations, Mission and ministry identity of the organization. Insofar as the Ethicists drive, i.e., lead not just support, the work of these committees, this also results in higher quality, greater accountability and increased coordination of activities and programming (for example, education can be connected to frequent consults, and policies can be designed in response to process gaps, etc.). The "Best Practice Criteria" for Ethics Integration Committee Structure outlined below represents our ethics community's efforts to apply systems thinking to how best to integrate characteristics of high reliability into the structure and design of our Ethics Integration Committees (EICs)

across the system, while at the same time allowing for the above-mentioned variability based on Market structure and needs.

BEST PRACTICE CRITERIA FOR EIC STRUCTURE AND CONSULT PROCESS FLOW

In addition to promoting high reliability in clinical ethics as an outgrowth of our application of systems thinking to the entire body of work to improve ethics services, the development of "Best Practice Criteria" for both EIC structure and Consult Process Flow was in large part due to the need to both read and respond to the "signs of the times" and to respect the principle of subsidiarity in practice. Through the lens of systems thinking, we began to look at the way in which clinical services were realigning within Ascension. Clinical services lines were no longer operating independent of other markets or the system as a whole. Rather, they were beginning to align from the bedside to the system office. It seemed natural, therefore, to rethink EIC structures that would align in parallel to the clinical services lines rather than be locked into a structure that could not adapt. Systems thinking enabled us to view the transformation of clinical service lines as an opportunity to re-examine the traditional facility-based ethics committee structure given the importance of the relationship of the two within the complexity of healthcare delivery. Doing this effectively, however, meant attending to subsidiarity in developing the "Best Practice Criteria."

The "Best Practice" criteria came from the people closest to the work. For the EIC Redesign, we took many of the criteria from our Texas Ministry Market, where our ethicists in the market had already completely "blown up" their old structure of ethics committees to create "network" or regional specialty-focused EICs. For the Ethics Consultation Process flow, Our Ascension Indiana ethics team had already made great headway in the integration of a consult-team based approach using Voalte technology (an alert system to EIC members on the consultation subcommittee to ensure timely response from those with consultation responsibilities). So, relying heavily on these insights, we developed the following "Best Practice Criteria" and brought them to our Ethics Advisory Community for review, feedback, and refining. What you see in both Table 2 and Table 3 are the result of this process. The other key point is that the criteria are just that. They are not a "one size fits all" model. Our Ministry Market ethicists, who know their market the best, decide how to implement these criteria in their market, and what this will look like, supported by agreed upon "Standards of Performance Excellence (SOPE) for Ethics Services" data to demonstrate these, where applicable.

TABLE 2

Best Practice Criteria for Ethics Integration Committee Structure

An Ethics Integration Committee is said to be a "best practice" model when:

1. The committee structure and membership promotes and enables integration of Ethics subject matter expertise and resources into the clinical and operational processes of the organization.
2. The committee membership includes adequate numbers of influential and/or highly visible representatives from critical/high utilizer units/areas across the market, including administration, and the committee is highly visible to key utilizers not on the committee.
3. The committee has an established reporting relationship to the Mission Committee of the Board and an appropriate Clinical Leadership committee.
4. The committee provides a structured forum for training members (and others) to identify, escalate and support clinical consultation and other types of Ethics services and support (e.g., programming and integration).
5. Responsibility for supporting and participating in committee work is shared appropriately across members; all standing members are required to be active participants, with different responsibilities of ex officio members acknowledged.
6. Committee membership and operations ensure sustainable expertise (independent of any one particular individual) and diverse representation (roles as well as representative of communities served)
7. The committee structure supports and promotes ethics education throughout the institution (i.e., beyond EIC meetings)
8. The committee structure promotes quality ethics consultations and supports the Ethicists in fulfilling their Quality Assurance and Continuous Quality Improvement responsibilities.
9. The committee structure provides a foundation for a “Best Practice” consultation process.
10. The committee structure enables member engagement through highest and best use of their time.

As mentioned above, the second way that we have sought to promote high reliability as an approach to systems thinking in the clinical ethics context is by ensuring that the ethicists have appropriate involvement and oversight of all clinical ethics consultations and, when possible, the consultation process flow is integrated into and utilizes existing clinical processes. These characteristics are reflected in the Best Practice Criteria for Consultation Processes (Table 3 below). When met, these criteria ensure that the ethics consultation processes involve the appropriate expertise as enabled by the new EIC structure and member roles as well as other clinical and operational leaders in light of their own subject matter expertise. In addition, they ensure that stakeholders know when and how to access an ethics consult, and that these are responded to in a highly reliable manner.

TABLE 3

Best Practice Criteria for Ethics Consult Process Flow

An Ethics Consultation Process is said to be a "best practice" model when:

1. The process leverages the EIC Committee Structure to ensure timeliness and quality of consultation services.
2. The process has full support of clinical leaders.
3. Reliable mechanisms for providers, staff, associates, patients, and families to request ethics consultation services are established, integrated and marketed throughout the ministry market.
4. The process includes an escalation mechanism that consistently results in the right person(s) addressing the right type/level of consults.
5. The "Assess, Analyze, Act" deliberation process is utilized in addressing patient-specific care consults and retrospective case analyses.
6. The process favors an interdisciplinary team-based approach to patient-specific consults when appropriate.
7. The process allows for and promotes appropriate involvement of the Ethicist(s) for oversight of consultations, consultation trends, education needs, and quality of recommendations.
8. The process aligns with and leverages existing clinical processes and tools already utilized within the market (for example, but not limited to, Voalte as a primary means of communication).
9. The process includes appropriate follow up and communication of recommendations, including conversations with relevant staff and documentation in the EHR, per the existing ethics criteria.
10. The process promotes reliable and efficient data collection in Ascension's Ethics Integration Database.

PLANNING, PILOTING, PIVOTING

One of the most significant outcomes of this work has been the organic collaboration and sharing of "lessons learned" that has been occurring amongst our ethicists in various Ministry Markets, which has contributed to the development of education curricula designed to support our new EIC structures, as well as increased energy and engagement in this work. In light of our systems thinking approach this collaboration did not come as a surprise, but it did highlight the importance this approach places on interconnectedness and relationship when working within complex systems. Although it is early days, our initial data looks promising, and attests to this increased engagement by key stakeholders (see Table 4).

TABLE 4

Standards of Excellence for Ethics Services - Ascension

Ascension

In the chart below green indicates at or above threshold, yellow indicates slightly below threshold and red indicates significantly below threshold.

Fiscal Year FY 2023

	Performance Excellence Metric	Q1	Q2	Q3	Q4	FY
Clinical	Markets with an annual Net Patient Service Revenue (NPSR) of **greater than $2B** perform **30** or more clinical consults per quarter. Average result based on: Florida, Illinois, Indiana, Michigan, Tennessee, Texas and Wisconsin	25	26	32	38	30
	Markets with an annual Net Patient Service Revenue (NPSR) of **less than $2B** perform **15** or more clinical consults per quarter. Average result based on: Alabama, Kansas and Oklahoma	34	27	25	36	30
	Embedded Ethics Resources (EERs) are engaged in **40%** or more of Patient specific-care consultations.	46%	45%	53%	60%	52%
	At least **95%** of all Patient specific-care consultations are acknowledged within 24 hours of the request.	100%	98%	98%	100%	99%
Organizational	Total Organizational Consultations for the entire system occur at a rate of at least **115** per quarter.	167	137	182	197	171
Education	The average number of participants across all Ethics Education is **23** or greater per session.	26	37	27	26	28

As of now these standards are primarily based on volume data across the previous three years of data collection. While there is nothing inherent in these prior years of volume data that would suggest thresholds demarcating national standards in "excellence," there are in fact no "industry standards'' or even accepted metrics for measuring excellence in Ethics Services within the professional field of Bioethics, either secular or Catholic, as of yet. Thus, while merely a starting point from which to develop an understanding of what a quantitative picture of service excellence looks like, these data have and will continue to prove valuable in helping us understand the impact that our structural changes are having on the services that we provide. It is important to note that the SOPE standards themselves are not about maximizing consult volume, like in the Ethicist-centric model where the FTE is justified by volume alone, but about ensuring that we are catching all appropriate consults relative to the subject matter expertise of ethicists, and in support of high reliability. These SOPE metrics and data are reviewed on a quarterly basis with each of the in-market Ethics teams, their Chief Mission Integration Officers and leaders at the Central Ethics Unit. The chart above provides the SOPE metrics and the system-wide performance relative to those metrics for FY23.

Clearly there is more work to be done in the area of standards of excellence in the field. However, "holding tight" until the field agrees on such standards seems ill-advised. Perhaps just as important as Ascension's work on the Standards of Performance Excellence for Ethics Services is the degree to which the work served as a catalyst for systems thinking innovation. Monitoring the impact of Ascension's innovation in the area of "Best Practice Criteria" for both EIC structure and Consult Process Flow will be instrumental in ongoing transformation efforts. ✣

MATTHEW KENNY, PHD
Vice President, Ethics Integration and Education
Ascension Health
St. Louis, Missouri

MARK REPENSHEK, PHD
Vice President, Ethics and Church Relations
Ascension Health
St. Louis, Missouri

JOHN PAUL SLOSAR, PHD
Senior Vice President, Health Care Ethics
Ascension Health
St. Louis, Missouri

Training Catholic Health Care Ethicists in Legislative and Regulatory Advocacy

INTRODUCTION

Health care ethics consultation training does not include legislative and regulatory advocacy. This is despite the fact that the ASBH's Core Competencies for Healthcare Ethics Consultation recognizes that an essential competency of an ethics consultant includes "knowledge of…case law, legislation, statutes, and regulations that are intrinsic to the work of most ethics consultation services…", that a common pitfall of incompetent ethics consultants is that those "who are not intimately familiar with the legal and ethics literature may make recommendations that (at best) are not practical or (at worst) are not ethically supportable", and recommends the consultants "establish baseline knowledge regarding case law, statutes, and regulations pertinent to the area of consultation".[1]

In medicine and nursing, their respective professional societies encourage and train members of their guilds to provide competent legislative and regulatory advocacy in order to advance their interests and those of their patients. That is, the work of physicians and nurses includes not just knowledge and application of statute and regulations within the walls of the hospital or clinic but active engagement with policy makers outside of those walls to change flawed statutes and regulations in order to improve their practice and the well-being of patients. This author (a physician and ethicist deeply involved in legislative and regulatory advocacy within organized medicine at the state and national level) presented a workshop at CHIEF 2023 aimed at advancing the argument that clinical ethics expertise, particularly from a Catholic viewpoint, can likewise inform the legislative and regulatory process in order to advance the work of clinical ethics, the well-being of patients, and the interests of Catholic health care institutions. It then introduced clinical ethicists to basic political advocacy skills and allowed participants to role play these skills with their peers.

WHY ADVOCATE?

CHIEF organizers and participants have been actively involved in the emerging professionalization of clinical ethics through existing professional societies including the American Society for Bioethics and Humanities (ASBH) and the Association of Bioethics Program Directors (ABPD) as well through informal partnerships that have developed out of conferences and workgroups. While the effort to professionalize the discipline of bioethics has not been without controversy, the first step of developing a credentialing progress through ASBH's Healthcare Ethics Consultant-

Certified (HEC-C) Program has grown since its launch 5 years ago.[2,3] However, neither ASBH nor ABPD has yet developed another practice common to professional societies in health care: organized advocacy to advance the interests of clinical ethicists and to modify legislation or regulations that impact the practice of clinical ethicists or can be informed by their expertise. If so developed, clinical ethics advocacy would overlap with the advocacy efforts of other health care professionals, hospitals, and patients, but would also be distinct and separate. In addition to the advocacy programs that are likely to emerge from the ongoing professionalization of secular clinical ethics, clinical ethicists sympathetic to the Catholic tradition who are trained in advocacy would also be able to enrich the existing advocacy efforts of Catholic hospitals through their respective health systems and the Catholic Health Association.

HOW TO ADVOCATE

The workshop consisted of sharing basic advocacy tools and techniques. Participants were challenged to imagine themselves as advocates prepared to share their expertise as clinical ethicists with policy makers. Initial steps included:

- Determining the ethical issues or policy areas you're most passionate about.
- Focusing on specific areas where your expertise can make a meaningful impact.
- Conducting research to understand the current state of regulations and policies related to your chosen focus area.
- Analyzing the ethical implications of potential solutions to flawed policies.

Once a policy solution was in mind, participants were then challenged to consider which policy makers would need to be engaged to make change. Taking into consideration their knowledge of their political representatives and the political landscape, participants were encouraged to develop an engagement strategy that considered the following questions:

- Am I equipped to speak authoritatively on this issue? Can I make a succinct and compelling argument?
- Is this an issue best addressed at the national, state, or local level?
- Is this an issue that requires a legislative solution or conversation with a regulatory body?
- Who does my position align with? Can we create a coalition, or can we at least obtain their support?
- Who is going to oppose my effort and how vociferously? How can I mitigate their arguments or efforts?
- Whose interests, financial or otherwise, will be threatened by my efforts?
- Is there a solution that everyone can support?
- Is there a tangible achievement worth the political effort/capital? What are my non-negotiables and what am I willing to compromise on?

Tips and tricks about how to maximize the effectiveness of meeting with elected representatives were provided. While discussed in the workshop, these were cultivated from a number of secondary sources, the authors of which have not provided permission to republish. Therefore, they are not listed here.

CASES

Finally, the participants were then broken into small groups to consider two cases, both drawn from real-life scenarios. In the first, a state is considering taking up a potential revision to state statute defining death by neurological criteria as envisioned by proposed changes to the Uniform Determination of Death Act.[4] Whereas current model legislation for defining death by neurologic criteria requires irreversible cessation of all functions of the entire brain, including the brain stem, proposed revisions would have required:

- Permanent cessation of circulatory and respiratory functions; or
- Permanent coma, cessation of spontaneous respiratory functions, and loss of brainstem reflexes.

Participants noted that this was a challenging issue that would be difficult to easily explain to their local legislator. However, it was also recognized that Catholic clinical ethicists are likely to be best positioned to understand the potential ramifications of the proposed changes and articulate the potential treats to human dignity contained therein. Participants identified that their arguments and potential allies might vary depending on the political party of the legislator they might meet with or which party is in power in their respective locations.

The second case asked the participants to envision a scenario in which they are pulled aside by a close nursing colleague at the hospital who happens to be the Board President of the State Nursing Association. The nurse shares that the State Nursing Association is proposing legislation mandating minimum staffing ratios in hospitals. The participants are informed that the State Hospital Association, including the administration of their own Catholic health care system, is steadfastly opposed. The clinical ethicist is asked to offer their support to the nurses. In the case, the participants identified the importance of prudence in informing one's advocacy efforts. It was recognized that Catholic social teaching has a wealth of information about the rights and duties of employers and employees that can encourage the nurses and hospitals to critically reflect on their obligations to their patients and each other. However, a consensus emerged that if the clinical ethicist can be a resource to both parties, those efforts would be most effective if they take place out of the public view with an aim towards mediating the conflict internally.

CONCLUSION

To this author, the participants appeared actively engaged throughout the entire workshop. They seemed to welcome the opportunity to be introduced to basic advocacy skills and contemplate if advocacy work would align with their talents and passions. None argued that they did not see advocacy work as contrary to their role as a professional clinical ethicist and none argued that having clinical ethicists informed by the Catholic tradition would not be a valuable and important voice in the public square.

MICHAEL REDINGER, MD, MA
Associate Professor
Co-Chair, Department of Medical Ethics, Humanities, and Law
Department of Psychiatry
Western Michigan University
Homer Stryker M.D. School of Medicine
Kalamazoo, Michigan

ENDNOTES

1. American Society for Bioethics and Humanities, *Resources for Developing Advanced Skills in Ethics Consultation*. Available at https://asbh.org/uploads/publications/Resources_for_Ethics_Consultation.pdf
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3. James A. Hynds & Joseph A. Raho (2020) A Profession Without Expertise? Professionalization in Reverse. *The American Journal of Bioethics*. 20:3, 44-46.
4. Truog, R. D. (2023). The Uncertain Future of the Determination of Brain Death. *JAMA*, 329(12), 971-972

What's "Prong" with an Ethics Program's Three Functions? What's Missing? Lessons about Promotions from Latin America

CHRISTUS Health is an international Catholic health care system, with health care in Chile, Colombia, and Mexico in addition to the U.S. The organization, structure, and operation of ethics programs in CHRISTUS Health are different by country because each nation expects different things from ethics.[1] In June 2023, the large ministry in Mexico, CHRISTUS Muguerza, held a two-day ethics symposium in Monterrey, Mexico, titled Ethics and Bioethics in CHRISTUS Muguerza: Present and Future. The symposium's five modules, each with several topics or talks, contributed to the conference objective for participants to understand the importance of ethics and bioethics in daily activities. The modules were based on teamwork aimed at developing an ethical culture by continuously updating it considering medical advances that create present and future ethical challenges.

One of many insights led to a significant change in CHRISTUS Health's U.S. ethics programs. Comparing ethics' function in Mexico to ethics' function in the U.S. catalyzed and accelerated this change. In the U.S., the three-prong function of education, case consultation, policy review, and development arose in the 1980s after cases such as *In re Quinlan* and guidance such as the President's Commission's *Deciding to Forego Life-Sustaining Treatment*.[2] Mexico shares two of three prongs – education and case consultation – that assume or subsume policy review and development. Whether a third prong or part of the others, a significant ethics program function in Mexico translated to "promotions," referring to the process of how ethics program members engage, mainly internal, stakeholders about what ethics is and does.

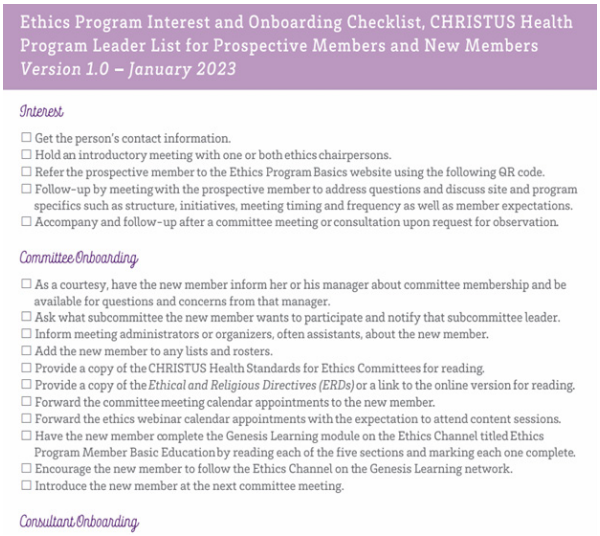
Being unintentional about promoting ethics, or sending the wrong message, can lead to disaster in my experience. Some approaches have sent those with ethics interest, but not yet in an ethics program, to the same ethics trainings or boot camps that consultants and ethics committee members attend. It's not a mystery why this generates low return, meaning few people joining ethics programs, after trying to sip from a firehose of information with little to no context. Some years ago, an associate who had interest in joining an ethics program asked a seasoned veteran with ten years as a consultant, committee member, and leader, "What do you do in ethics?" Her response was a serious, "I don't know; I'm not sure." The associate didn't join ethics.

Promotions start with the strategy that anyone

interested in ethics should know ethics programs' purpose, process, structure, and function as well as what ethics is... and is not. Interested parties should know what ethics does prior to joining a program. A tactic is to leverage CHRISTUS Health's skill and scale to centralize information shared across ethics programs while not losing the personal touch of the local program (e.g., personal invitations and onboarding from the local ethics leaders).

Three tools were developed. Intended audience members of the first tool are ethics leaders. The ethics program interest and onboarding checklist, shown in part below, is an interactive pdf, also printable, for leaders to track new member onboarding.

GRAPHIC 1



Ethics Program Interest and Onboarding Checklist, CHRISTUS Health Program Leader List for Prospective Members and New Members
Version 1.0 – January 2023

Interest

- ☐ Get the person's contact information.
- ☐ Hold an introductory meeting with one or both ethics chairpersons.
- ☐ Refer the prospective member to the Ethics Program Basics website using the following QR code.
- ☐ Follow-up by meeting with the prospective member to address questions and discuss site and program specifics such as structure, initiatives, meeting timing and frequency as well as member expectations.
- ☐ Accompany and follow-up after a committee meeting or consultation upon request for observation.

Committee Onboarding

- ☐ As a courtesy, have the new member inform her or his manager about committee membership and be available for questions and concerns from that manager.
- ☐ Ask what subcommittee the new member wants to participate and notify that subcommittee leader.
- ☐ Inform meeting administrators or organizers, often assistants, about the new member.
- ☐ Add the new member to any lists and rosters.
- ☐ Provide a copy of the CHRISTUS Health Standards for Ethics Committees for reading.
- ☐ Provide a copy of the *Ethical and Religious Directives (ERDs)* or a link to the online version for reading.
- ☐ Forward the committee meeting calendar appointments to the new member.
- ☐ Forward the ethics webinar calendar appointments with the expectation to attend content sessions.
- ☐ Have the new member complete the Genesis Learning module on the Ethics Channel titled Ethics Program Member Basic Education by reading each of the five sections and marking each one complete.
- ☐ Encourage the new member to follow the Ethics Channel on the Genesis Learning network.
- ☐ Introduce the new member at the next committee meeting.

Consultant Onboarding

Second, a recruitment "one-pager," was supplied to local ethics leaders for distributing and displaying hard copies. Two versions of the one-page brochure are almost identical – the associate-facing has a QR code for an ethics foundation site and the other, without the code, is for patients and families. Both versions have two printing options, informal for office printing or with bleeds for print shops.

The brochure outlines at a high level:

- What ethics is and its function within health care,
- Clinical and organizational differences,
- Committee and consultant descriptions,
- Five functions of ethics at CHRISTUS Health (community outreach and process improvement in addition to the three described previously),
- Ethics program member expectations,
- Additional consultant expectations,
- Committee member training, and
- Additional consultant training

Associates are extremely busy. Ethicists and ethics leaders should make every effort to minimize time burdens and maximize personal and organizational benefits for those in ethics. Communicate this in simple, understandable ways prior to them starting on the committee and/or consult team. For instance, many ethics committees meet for about an hour every other month (some quarterly). Being an ethics committee member takes less than one day per year, factoring in meeting time, homework such as reading before the meeting, and teaching between meetings. Even members of ethics committees who meet hourly once per month, only spend half a day per year in meetings. The projected time impact is also included in the brochure, (one side of the page) shown below.

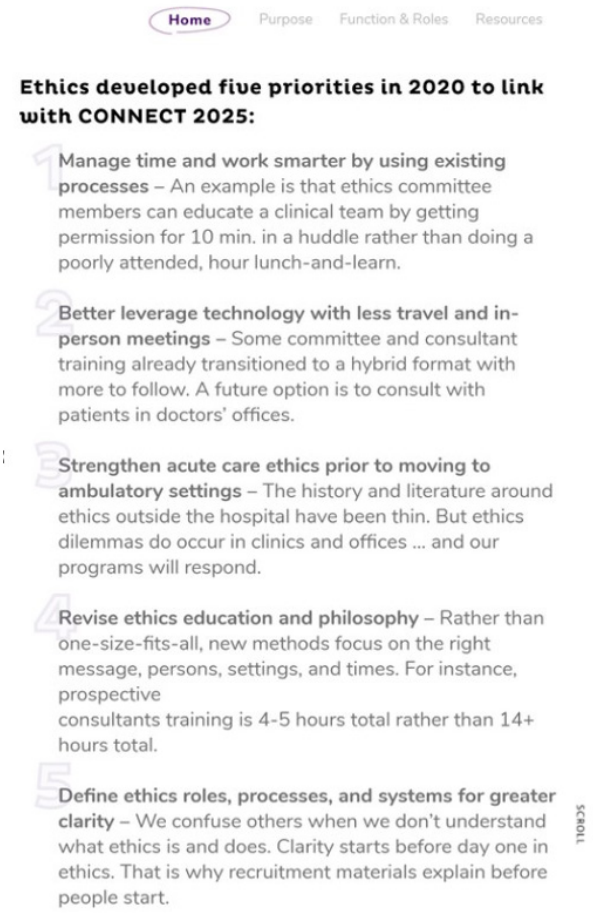
GRAPHIC 2

Third, the brochure's QR code links to a landing site called the ethics program foundation site, which includes more high-level information about ethics. A short video welcomes people. Another video gives five tips for new ethics program members. Ethics consult stats are on a page. Other modes and topics include:

- Five strategic priorities of ethics at CHRISTUS Health on the home screen (shown below);
- The purpose with the goals of ethics (e.g., "improve health care quality through the identification, analysis, and resolution of ethical questions or concerns");[3]
- Common beginning-of-life and end-of-life issues, named with little detail (e.g., prenatal testing, pregnancy and substance abuse, pregnancy complications for beginning-of-life and decision-maker discord, potentially inappropriate treatment, benefits and burdens of treatment for end-of-life);
- Expanded function of and roles with the ethics consult process and ethics committee meetings (e.g., committee meetings typically have a welcome, reflection, approval of minutes, announcements, old business, ethics consult report, new business, and close);
- Differentiating between five ethics roles – committee members, consultants, program co-chairs, program chairs, and ethicists; and
- Resources about what ethics is and is not (e.g., not to tell what is legal to do, tell another that he or she is being unethical, rubber stamp someone).

GRAPHIC 3

GRAPHIC 4



A case provides options for action and resolution that are consistent with different ethics theories and approaches, such as rule-based, consequence-based, values-based, and so on. An ethics contact list has the names of ethics program chairs by region along with email and phone number so interested parties can contact their leaders for more, site-specific information. A link takes folks who commit to being in ethics directly to the training, five modules (ethics in health care, Catholic teaching and the Ethical and Religious Directives or ERDs, common ethics issues, end-of-life ethics issues, and beginning-of-life ethics issues) in the ethics program member basic education on CHRISTUS Health's internal education platform, called Genesis. Consider resources, the ethics program foundation site for instance, as supplements to local, interpersonal interactions. The "multiplication of resources and relationships does not alter the personal character of interactions" with associates who show interest in ethics, in this case."[4] A lesson from Latin America is to treat promotions with intention, considering it part of your education plan or curriculum, irrespective of if it is a formal prong of ethics … or not.

STEVEN J. SQUIRES, PHD, MA, MED
Vice President, Ethics
CHRISTUS Health
Irving, Texas

ENDNOTES

1. For instance, ethics program members in Mexico often serve as investigators for issues such as associate behavior concerns, which go to human resources (HR) in the U.S.
2. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 671, cert. denied, 429 U.S. 922 (1976); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions* (Washington, D.C.: U.S. Government Printing Office, 1983), 162-165.
3. Anita Tarzian et al., *Core Competencies for Healthcare Ethics Consultation* (American Society for Bioethics and Humanities, 2011), 3.
4. United States Conference of Catholic Bishops, *The Ethical and Religious Directives for Catholic Health Care Services*, sixth edition (Washington, DC: United States Conference of Catholic Bishops, 2018), 13.

Clinical Ethics as Liturgical Activity

Since the inception of our field, clinical ethicists have taken different views on the appropriate methodology for clinical ethics consultation. Lively debates about how to best conduct clinical ethics consultations fill the pages of our academic journals, especially journal issues dating from the 90s and early 2000s. In recent years, however, these debates have slowed as ASBH has recommended a method they term ethics facilitation. This method of ethics facilitation closely mirrors the bioethics mediation method, one of a handful of standardized and well-known methods developed over the years that claims to ensure a responsible and reliable recommendation. Ethics facilitation is a recent but not the only method claiming to have captured the correct way doing of clinical ethics consultation.

The idea that the right method or standardized approach can ensure a reliable ethics recommendation seems to have arisen in the early 90s, which was a time when there was a great variety of educational backgrounds, religious commitments, and core disciplines among clinical ethicists. This background created a crisis of professional identity, which sparked two primary questions. First, amidst diversity, and little to no regulation, how can clinical ethicists as a group properly describe themselves and their work to others? Second, how can the public be sure the results of ethics consultation are consistent and of high quality? These questions were being pondered in the field as ASBH was getting started, and they are certainly still important today.

In a way, moves toward uniform procedures are reactions to the perceived threat of ideological diversity within our ranks. (I say "perceived threat" because there are plenty of people who don't agree that ideological diversity is a threat to ethics.) Yet because variety and diversity exist, and because professional bodies need to have some standard outcomes to point to, clinical ethics has become increasingly about homogenizing right action. Many assume that following the steps of the right method will reliably lead us to good ethical outcomes.

Certainly, the popular consultation methods, like the Four Boxes, CASES, or Clinical Pragmatism, for example, all have strengths. They each frame moral inquiry in a particular way, which structures the ethicist's reasoning and imagining so that a decision can emerge. But the strengths of these methods are perhaps also their greatest flaws. Methods frame moral inquiry, limiting the information we see as ethical in nature, potentially blinding us to idiosyncratic and vital aspects of a case. They carry us through a line of inquiry that is expected to result always in a timely answer, regardless of variation and complexity, regardless of context and culture.

My point is not to say methods are bad, or de facto illegitimate, but rather to say that clinical ethics, the search for the good of patients and their caregivers, ought never to be conflated with method deployment. Ethics cannot be circumscribed or captured by a standardized process or method. Ethics, the search for the good, is a way of life, a practice,

and an activity that should always be breaking the limits of methodological framing. Ethics is a work of conscience that moves in real time and so ethicists should always be aware of and skeptical of the blinding effects of standardizable reasoning on the vicissitudes of reality. So, I would like to suggest that clinical ethics ought to be seen (especially by Christian ethicists) as liturgical activity.

"Liturgical activity" is a way of approaching the Sacred, the Good, the Other, which is what ethicists are doing when they attempt to discern the right decision in a case. The Eucharistic liturgy, in particular, is a purposeful and ordered approach toward communion with the Sacred, but one that cannot be completed by one's own power. While it is purposeful and ordered it is also slightly different each time, according to the season, the week, the day, the people gathered, the setting, and so on. Like the Eucharistic liturgy, the "liturgical activity" of clinical ethicists is purposeful and ordered but is not controlling; it flexes to the moment and bends to the shape of the people gathered.

This "liturgical activity" of clinical ethics requires the ethicist to take a certain stance that is similar to that of a worshipper approaching the altar; humble yet bold. We do not learn this stance from methodology, because methodology's purpose is to put things in order, and as such it seeks to have mastery. Participation in the Eucharistic liturgy teaches us how to properly approach the Sacred, as well as other people and the world around us, as mysterious gifts outside our grasp. Indeed, it teaches us that we must be approached while also approaching, which should take us out of our enchantment with our own ego, a necessary precondition for good ethics consultation. While clinical ethics consultation is not itself the liturgy and is not itself worship, it can be done worshipfully: with the humble stance that the liturgy demands of us.

While space does not permit a thorough defense or examination of the features of clinical ethics consultation in a liturgical stance[1], I'd like to propose four orienting features:

1. Interruptibility: Keeping moral space and time open. Good ways of doing ethics consultation will create room for being interrupted.
2. Encounter: Attuning to the mysterious and surprising. Ethics consultation is an encounter with people and situations outside our grasp. We should attune ourselves to what we do not expect.
3. Reciprocity and Communication: Mutual participation in the Good. Ethicists participate in the activity of discernment, not as objective all-knowing observers but as human beings with our own perspectives and biases. We must involve ourselves, reflectively and responsibly, as participants in moral discernment.
4. Humility and Reflection: Self-Examination and dealing with our error. We must be willing to look at our own fallibility and the times we get it wrong. We must be professionally accountable for those times and embody the vulnerability necessary to learn from them.

Rather than entering into each consult with a prepackaged form or procedure, a liturgical stance requires us to be spiritually prepared and attuned to the moment. Great jazz artists are classically trained yet they show up on stage ready to improvise in response to their fellow musicians. Those who participate in liturgy do so according to their tradition's rubrics,

only to realize after many years that they can participate without consciously referring to the rubrics, the written pages. Likewise great clinical ethicists are well-versed in the literature, arguments, analyses, and theories that comprise academic ethics, yet they answer a consult call ready to improvise in response to the patient, family, and medical team in each unique situation and context.

Finally, seeing clinical ethics consultation as liturgical activity is not purely theoretical or metaphorical; the nature of the activity offers us practical guidelines for its structure. Rather than following a standardized method, we can engage our work according to the integrity of practical ethics itself. A few (non-exhaustive) practical guidelines that I suggest are in keeping with practical ethics are:

1. Create your own processes in your own contexts. One size does not fit all.
2. Embrace interruption in your processes, as part of the work. Reality rarely conforms to our plans. In contrast to methods which aim directly toward resolution, those in a liturgical stance will be open to inefficient, slow, and repeating parts of the process if they serve ethical inquiry and are best suited to the particular persons gathered.
3. Avoid prematurely limiting consults to "the ethics question" which can overly narrow and constrain engagement with reality and, subsequently, moral imagination.
4. Embrace your role as an active participant in moral decision-making. Standardized methods sometimes serve as ways to distance oneself from the vulnerability intrinsic to prudential judgement, which offers some emotional protection but undermines the process. Ethicists are not called to hide behind procedure for the sake of their conscience.
5. Regularly engage in self-reflection regarding the blind spots in your processes. Every process has blind spots and as we acknowledge our limited understanding of each particular situation, especially with regard to the patient and family who are usually strangers, we must be ready to revise our ethical theories as well as our processes as new features emerge.

I have often found the work of French phenomenologist Jean-Louis Chretien inspirational for my clinical ethics work as liturgical activity. In Under the Gaze of the Bible, he writes:

"For Christian wisdom does not consist in applying rules, nor in confronting what happens with the lessons of a manual, but in making our existence as disengaged, as ductile as possible, so that it tends to be nothing but an Aeolian harp on which the Spirit can improvise, according to the needs of the moment and the exigencies of such an encounter."[2]

JORDAN MASON, PHD, MDIV, HEC-C
Clinical Ethicist and Theologian
Providence
Santa Rosa, California

ENDNOTES

1. For such an analysis, see Jordan Mason, *Clinical Ethics Consultation and Liturgical Practices of Participation: A Theology of Technique for Practical Ethics*, Doctoral Dissertation, Saint Louis University, 2023.
2. Jean-Louis Chretien, *Under the Gaze of the Bible*, Translated by John Marson Dunaway, Perspectives in Continental Philosophy, Edited by John D. Caputo (New York: Fordham University Press, 2015).

Reframing the Ethics of Normothermic Regional Perfusion

Normothermic Regional Perfusion (NRP) is a category of organ preservation techniques that have been used in procurement for controlled donation after circulatory-determined death (cDCD) for more than a decade. The general concept, after removing life-sustaining treatments and technologies from a donor patient and allowing for the appropriate stand-off period to declare death, involves regionally reperfusing vital organs inside the dead donor before procurement by applying extracorporeal membrane oxygenation (ECMO). Variations according to technique and organs procured notwithstanding, NRP shows promise for increasing organ availability in the United States, particularly for livers and hearts,[1] as has been the case in other countries.[2] While patient outcomes and organ viability are important for determinations of ethical appropriateness, the field is rapidly evolving; this work addresses ethical concerns given a medical or resource allocation advantage.

There are two commonly cited ethical concerns with NRP. First, reperfusing vital organs in situ raises concerns that this method of procurement violates the Dead Donor Rule (DDR) in that circulation of oxygenated blood, previously deemed irreversibly lost, is restored to a limited number of organs by region. Second, after death has been declared and before initiating ECMO, all NRP techniques occlude potential blood flow to the brain – either singly or grouped with other organs. Some question whether this action, especially directly occluding flow to the brain only, intentionally hastens death or even creates a "brain death" situation. If even one of these concerns is validated, then NRP may be morally illicit.

This work explores both concerns by examining the actions of regional reperfusion in situ and occlusion of blood flow to the brain in the cDCD circumstance and demonstrates that NRP can be an ethical option for organ procurement; it also incorporates discussion of circumstances in the U.S. that have led to mistrust in organ procurement processes. This work relies on Entwistle's comprehensive analysis and others for technical reference and offers additional considerations for Catholic health care.[3]

CIRCUMSTANCES

The clinical circumstances leading to cDCD are generally not equivocal. Although the patient does not meet the neurologic criteria to declare death (BD/DNC), medical and ethical standards indicate that withdrawing life sustaining treatment is appropriate, and this decision is separate and distinct from the decision to move forward with organ

procurement. In addition, the patient, or the patient's surrogate decision maker, has authorized and intends to donate organs. Once the decision has been made to withdraw life-sustaining treatments, the do not resuscitate order written, and medical interventions withdrawn, reinitiating life sustaining treatments would be medically and morally inappropriate.

DETERMINATION OF DEATH

In the United States, The Uniform Determination of Death Act (UDDA)[4] stipulates that the determination of death must be made in accordance with accepted medical standards and provides two pathways for death to be determined: (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem. Debate regarding substituting the word permanent for irreversible notwithstanding, the conjunction "or" is key.

Neither pathway is prioritized over the other, and, although only one pathway must be satisfied, the whole person is dead. While much emphasis historically has been placed on the establishment of death by neurologic criteria as ethically sufficient for satisfying the DDR before organ procurement, it seems that today some ethicists prefer BD/DNC as being more morally legitimate than cDCD; but medical and legal standards say otherwise. If a person is declared dead by circulatory criteria, that person's brain is also dead by the same criteria because circulation to the whole body, including the brain, has ceased.[5,6] The person is dead. This is one of the reasons that the term "brain death" is so unfortunate – because it gives the impression that only the brain is dead when the person is dead by BD/DNC.

Within the Catholic tradition, Pope John Paul II condoned the concept of death determination by neurologic criteria, but he did not disavow death determination by cessation of circulatory and respiratory functions. Rather, he stated in the context of organ donation:

"With regard to the parameters used today for ascertaining death - whether the 'encephalic' signs or the more traditional cardio-respiratory signs - the Church does not make technical decisions… the criterion adopted in more recent times for ascertaining the fact of death, namely the complete and irreversible cessation of all brain activity, if rigorously applied, does not seem to conflict with the essential elements of a sound anthropology. Therefore a health worker professionally responsible for ascertaining death can use these criteria in each individual case as the basis for arriving at that degree of assurance in ethical judgement which moral teaching describes as 'moral certainty'".[7]

The notion that neurologic criteria of death must always be met to procure vital organs is inconsistent with the Holy See statement.

DOES OCCLUDING POTENTIAL BLOOD FLOW TO THE BRAIN AFTER A PATIENT DIES CHANGE THE KIND OF DEATH THAT HAS OCCURRED OR INTENTIONALLY CAUSE DEATH?

Some clinicians and at least one professional society[8] have advanced the notion that occluding potential blood flow to the brain after death and before ECMO essentially

converts the circulatory-determined death to death by neurologic criteria. In addition to being illogical and unnecessary, this language is unhelpful for Catholics because it makes death the goal of an action and implies that the donor may not be dead yet. Dead people cannot die. As the Holy Father stated regarding determining death with certainty:

"…the death of the person is a single event, consisting in the total disintegration of that unitary and integrated whole that is the personal self. It results from the separation of the life-principle (or soul) from the corporal reality of the person. The death of the person, understood in this primary sense, is an event which no scientific technique or empirical method can identify directly."[9]

Medical standards change over time because the profession is constantly learning. Medical professionals rely on markers of death that have been demonstrated to be reliable, if not infallible, and imprecise language decreases confidence in those standards. A dead person cannot re-die; only a living person can die. And, if death is a single event, then one person should not be considered more dead than another person who has been declared dead by generally accepted medical, moral and legal standards.

Taken to its logical end, the concern for Catholics around this language is not that resuscitation is avoided, which is consistent with stated wishes, medical standards and the Catholic moral tradition. The concern, rather, is that this language provides reason to question whether the patient, in fact, might not be dead, and occluding flow to the brain would then be killing. Imprecise language, while not necessarily indicative of truth, undermines confidence in medical standards and moral liceity of all cDCD. The whole notion smacks of conflicting interests and procurement slight-of-hand. Transparency, consistency and careful and precise language around the circumstances and process for declaring death is important.

WHY OCCLUDE FLOW TO THE BRAIN BEFORE APPLYING ECMO?

There are good reasons to occlude flow to the dead donor's brain before initiating ECMO, and they have to do with the kind of intervention ECMO is and the intentions and responsibilities of stakeholders. ECMO is generally considered a life-sustaining and even resuscitative intervention, but in NRP, ECMO is an organ preservation procedure. Circumstances matter; there is not – and should not be – any intention to resuscitate the dead donor. The intention of the medical team in occluding flow to the brain before initiating ECMO is to avoid resuscitating or even appearing to try to resuscitate the dead donor during organ preservation and testing. Procurement teams may express this in other ways, like stating that they are respecting the dead donor. It is the ethics community's job to sort through clinician's statements and meaning and offer guidance through ethical exploration and discourse.

The Permanence Principle has been utilized in countries where the definition of death following cessation of cardiorespiratory function is primarily based on brain perfusion (e.g., United Kingdom[10]), and it allows for reperfusion in situ of organs that will be procured using NRP as long as the brain is not reperfused.[11] This stipulation is logical

considering that death, so defined, has just been permitted to occur. The question is whether the same principle should apply in the U.S. or in Catholic health care, where the language defining the same reality of death is different.

Regarding circulatory death, Gardiner and colleagues note that, "The main justification for adopting permanent cessation over irreversible cessation… is that, in the great majority of cases, it is not ethically appropriate to attempt CPR or ECMO on such patients."[12] This aligns with Bernat's observation that "permanence is a perfect surrogate indicator for irreversibility" because spontaneous return of circulation will not happen and no intervention will be made to make it happen.[13]

The first and primary decision in the cDCD pathway is to withdraw treatments and technologies based on a wholistic assessment of clinical condition, standards, prognosis, treatment appropriateness and patient wishes. Although clinicians may have the technical ability to reverse the loss of cardiorespiratory function temporarily, it has already been determined that they do not have the ability to restore the patient's health. Resuscitating a person from whom life-sustaining treatments have intentionally been withdrawn in these clinical circumstances is illogical, irresponsible and possibly illegal.

The debate has been ongoing for more than fifteen years in America. The American College of Physicians approves of using "permanent" in the cDCD domain but opposes in the BD/DNC domain.[14] The American Academy of Neurology has transitioned to using the new verbiage in BD/DNC standards.[15] The USCCB and NCBC strongly stated opposition to substituting "permanent" for "irreversible" in brain death determinations, but they were less clear about their concerns in the cDCD realm, stating that this was a concern "during controlled circulatory death," rather than using the word "after."[16] It is true that occluding flow to the brain during the stand-off period could be hastening death, but the same cannot be true after death has been declared unless the whole cDCD construct is illicit.

To be clear, this work only considers the use of the word "permanent" in the cDCD domain. If removing a heart after controlled circulatory-determined death for preservation outside of the donor's body (direct procurement and perfusion) is not hastening death, then how could occluding blood vessels between the heart and brain have that result? These two actions have essentially the same effect on potential blood flow. The debate about verbiage is important and ongoing, but it should not distract from this issue; occluding blood vessels to the brain in a patient who is already dead does not hasten death.

DOES REGIONAL REPERFUSION IN SITU AFTER CIRCULATORY-DETERMINED DEATH RESTORE CIRCULATORY AND RESPIRATORY FUNCTION OF THE DEAD PERSON?

After death is determined by circulatory criteria, quickly reestablishing perfusion to the organs to be procured for transplantation optimizes future organ viability. NRP utilizes the dead donor's body as the instrument of this activity by regions, and there are specific advantages to this methodology. In the United Kingdom,

where the Permanence Rule applies, re-establishing perfusion in the body but not in the brain conforms to ethical standards because of the way death is defined. How could the definition of circulatory-determined death in the U.S. be understood in a similarly useful way?

The word "function" warrants interpretive consideration. Is respiratory function (the natural purpose of the respiratory system[17]) to move air in and out of the body, or is it to oxygenate and ventilate blood? Similarly, is circulatory function to move blood through unintegrated portions of the body, or is the natural purpose of the circulatory system to perfuse the essential organs to be alive? Can there be circulatory function without perfusing the brain? The concept of regional perfusion is important because it does not allow for integrated function of the circulatory system; that is, at least one essential organ is not being perfused. ECMO can be used to perfuse and preserve organs by body region selectively. If the heart, lungs and brain are all reperfused together, ECMO could easily qualify as a (medically and ethically inappropriate) resuscitative measure, but circulatory function is not achieved without the brain.

Another practical consideration is whether perfusing the brain would serve to meet any transplant objectives. The brain is not transplantable and will not be procured, so there is no reason to perfuse it. So, given the medical circumstances of the decision to withdraw life-sustaining treatments, the morally and legally valid declaration of death, the intentions of the patient to donate organs and the transplant team to preserve organs and not resuscitate the patient, and the absence of any future use of the brain in transplantation, there should be no moral issue with occluding flow to the brain and then initiating ECMO for organ preservation in the dead donor's body.

The concept of regional perfusion begs further analysis. The difference in perfusing the brain and the legs, for example, is that the legs do not contain vital organs, and the legs do not define death. Because the legs do not contain vital organs perfusion is not necessary to achieve the medical goals, and since they are not involved in defining death, there is greater latitude in perfusion decisions. Clinical circumstances and professional judgment determine whether to perfuse them. While techniques vary by procurement goals, donor condition, clinician training, and resources, procurement teams approach regional perfusion decisions with intention.[18] They are not applying ECMO in a manner consistent with a resuscitation of a person. See Table 1 for additional, though not comprehensive, considerations about regional perfusion.

TABLE 1: REGIONAL PERFUSION CONSIDERATIONS FOR NRP

Region	Vital Organs	Defines Death	Transplantable Vital Organs	Regional Perfusion Details	Perfusion Benefit	Recommendation
Head	Y	Y	N	Avoids donor resuscitation. Always excluded. Procedure near cannulation site prior to ECMO in TA NRP	N	Do not perfuse
Upper Extremities	N	N	N	If perfused, could result in collateral circulation to brain	N	Do not perfuse
Thorax	Y	Y	Y	Occluded for abdominal only NRP: • also occludes head/UE • additional procedure on thoracic aorta	Y	Perfuse for heart and/or lung procurement
Abdomen	Y	N	Y	Not occluded: • location of most vital organs • chemical advantage	Y	Perfuse per procurement goals and clinical circumstances

MOVING FORWARD IN CATHOLIC HEALTH CARE

Decisions to adopt clinical practices and technologies are not made in a vacuum. That is, Catholic moral reasoning is applied within the U.S. construct of health care policy and medical standards. In recent years, trust in organ procurement has deteriorated largely due to system-based challenges. It is important that Catholic hospitals recognize these challenges and engage with Organ Procurement Organizations (OPO) and policy makers to improve relationships and align work toward optimizing organ availability and resources to serve humanity.
Recent Center for Medicare and Medicaid Services (CMS) OPO certification changes have created pressure on OPOs that has led to more aggressive enforcement of first-person authorization and forced hospitals to take sides.[19] While the U.S. purports having an opt-in system, first-person authorization may be interpreted in ways that challenge whether the donor understands what their authorization means. First-person authorization has little in common with informed consent. Indicating a desire to be an organ donor in an advance medical directive, while somewhat more meaningful than checking a box while getting a driver's license, could be achieved with little or no conversation; families, who know and love the dying person, feel responsible. In these circumstances, the act of love that Catholics understand organ donation to be may even devolve into a legal battle. Considering that trust in health care is already low in America, this is not helpful.

Another issue, translation issues aside, is that different countries use different words to define death. Many authors cited in this work urge international agreement in defining death, but agreement is difficult to reach across cultural, religious and legal boundaries. At a minimum, engaging and understanding circumstances, intentions and actions with precise language in communities of practice will promote trust and alignment.

Strategy and transparency are also important to promote trust. Changing too many variables at once is not helpful because correlations and causality become unclear. At present, it is best not to shorten the stand-off period to less than five minutes in NRP. In addition, identifying, owning and communicating areas of uncertainty to the broader medical community will improve alignment. There are additional issues related to facility resource utilization and clinical accountability that significantly affect organ procurement, and OPO agreements should be reviewed and adjusted, as needed and regularly.

Organ donation has always been received with suspicion because it attempts to achieve a moral good that exists at the boundaries of anthropological and religious values. Still, much has been achieved. NRP is one procurement category that evokes many valid questions for clinicians, religious leaders, ethicists and families, and these questions should be addressed systematically and transparently. For now, moving forward is possible if all parties agree on intentions, objectives, standards and moral constraints.

KELLY STUART, MD, MPH, MTS, MSNDR
Vice President, Ethics
Bon Secours Mercy Health
Richmond, Virginia

ENDNOTES

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Thoraco-abdominal Normothermic Regional Perfusion (TA-NRP) Resuscitates Moral Doubts about Donation after Circulatory Death (DCD)

Modern transplant medicine continues to innovate techniques that Catholic health care can adopt as more effective ways to honor the charity of those donating their vital organs upon death. Yet by creatively extending principles from accepted techniques into controversial territory, transplant innovations can also reveal that those previously accepted procedures themselves were adopted on less than morally sure grounds. Thoraco-abdominal normothermic regional perfusion (TA-NRP) is an innovation for improved heart transplantation that promises to increase the number and quality of heart transplants in a cost-effect manner and already in practice in Europe and the United States.[1] It extends the principles of donation after circulatory determination of death (DCD), itself an innovation that has grown more than ten-fold in two decades.[2] In the last five years, the number of DCD heart transplants has exploded from only 7 in 2019 to 612 in 2023, many of these likely done by TA-NRP.[3] This new procedure has not been without controversy in the general medical literature and now in Catholic bioethics in particular.[4]

Certain features of TA-NRP, raise the question of whether DCD donors are actually dead when their vital organs are explanted. Arguments in favor of TA-NRP often avoid this question by a legalistic focus on the co-validity of the neurological and the circulatory-respiratory criteria for declaring death in federal and state law. If the patient is legally dead, so it goes, the patient just is dead. In opposition, if DCD and TA-NRP patients are not known with strict moral certainty to be dead after five-minute waiting periods after asystole, then Catholic health care should reject both TA-NRP and DCD donation. Instead, physicians, mission leaders, ethicists, and bishops should reassess every non-brain-death donation technique that involves a waiting period from asystole to vital organ harvesting of less than twenty minutes. I fall among those who hold that DCD and TA-NRP are continuous in principle, but that therefore both are evil as currently practiced. Ironically, I am in a sense closer in argument to those who hold both are permissible and furthest from those who accept DCD but reject TA-NRP.[5]

TA-NRP is best described as a modification of a controlled DCD procedure. Common to both transplantation techniques is the removal of life support from a critically injured donor whose death is ethically accepted. Asystole occurs, then a "hands-off period" of five minutes, and next a declaration of death by the circulatory-respiratory criteria by the attending physician.[6] Only then does the transplant team initiate organ explantation. Where TA-NRP differs from cDCD is in the transplant team's actions to improve heart transplantation following access to the thoracic cavity: the team resuscitates the donor's heart in situ by canulation and ECMO, perfusing the heart with warm, oxygenated blood ("normothermic"), both to reduce damage from warm ischemia and also to assess heart function. This perfusion is kept "regional," however, by the ligation of the cervical vessels which could carry blood to the donor's brain, typically by clamping or exposing the vessels to atmosphere. The intention is to avoid the resuscitation of brain function. Proponents differ in their explanation of the necessity of this step. Some argue that the patient is legally dead by virtue of irreversible loss of respiratory-circulatory function, so allowing general circulation would negate the basis of the declaration of death. Other speak of "switching the patient over" to the brain death criterion, the loss of brain function now made irreversible by occluding circulation, in order to restore legally the circulatory function of the heart. Yet others speak of ensuring that the donor, legally dead, may not experience any pain from the process of organ retrieval. Apart from a shared concern to fulfill at least one legal criterion for death, these justifications are contradictory with each other and even with themselves. The donor is dead, yet the transplant team must do something to protect the donor from becoming undead in some way.[7]

We can at least say that TA-NRP by design eliminates the risk of resuscitating the donor's brain function, but by this very aspect the procedure reveals that no moral certitude exists that the donors are dead when the typical five-minute or less waiting period after asystole is observed. Rather, the fact that their brain functions can be resuscitated technically raises a genuine doubt that they have experienced the definitive separation of body and soul required in any Catholic account of death. This lack of moral certainty with a mere five-minute waiting period that the donor is dead before vital organ explantation proves that both TA-NRP and cDCD are morally unacceptable. St. John Paul II came to accept vital organ donation in cases of brain death only if the neurological criteria gave strict moral certainty that the donor was in fact dead.[8] The same standard of moral certainty of the donor's death must also apply to DCD and TA-NRP.

The risk of brain function revival with TA-NRP is real. A recent porcine study of TA-NRP indicates that, when nothing is done to prevent blood flow to the brain, the donation procedure revives brain function, including the drive to breath, cortical signals, and sensation.[9] The researchers performed TA-NRP on two pig groups in which they induced asystole with an extended hands-off time of eight minutes. One of the groups had cervical vessel occlusion by clamping and another did not. In the clamped group, TA-NRP induced no cortical electrical activity nor somatosensory evoked potentials (SSEP) nor agonal breathing. In other words, clamping prevented any resurgence of brain activity, from cortex to brain stem. There was

some concern prior to this experiment that ligation would be insufficient to ensure that no brain functions were revived through collateral circulation. After this porcine experiment and empirical investigation of human TA-NRP donations, ligation does appear sufficient to prevent brain function revival.[10] Yet the absence of a function does not entail by itself an organism's lack of ability to perform a function. What happened to the non-clamp group?

In the non-clamp group, all eight pigs either had a revival of cortical electrical activity (EEG) or EEG plus SSEP upon normothermic perfusion. Furthermore, six of the eight pigs in this non-clamp group began agonal breathing. Admittedly the study is an imperfect analogue to human cases, for they induced cardiac death in otherwise healthy pigs, whereas the human donors in cDCD and TA-NRP cases are very severely injured. What the study does show, however, is that the respiratory-circulatory criterion of death can be fulfilled while the organism still has the potential for brain function resuscitation, a reversible absence of activity. In the current state of medical technology and knowledge, one can no longer claim that the respiratory-circulatory criterion for death declaration, based as it is on a mere five-minute waiting period, is a sufficient medical sign that a patient has died. What one should say is that an organism meeting the respiratory-circulatory criterion will inevitably die by the death of the brain that will follow.

The need to ligate the cervical vessels of donors in TA-NRP to prevent brain function revival confirms the doubt that some Catholic ethicists had earlier expressed about whether a mere five-minute waiting period in DCD would be sufficient to guarantee the actual death of the donor prior to vital organ explantation.[11] Now the principles underlying both techniques appear identical and in fact I agree with those who claim that TA-NRP is simply an extension of DCD. If DCD were morally acceptable, then TA-NRP should be, as well. Those who hold that there is a significant physical or moral distinction between these techniques are mistaken.[12] Both techniques understand the irreversible loss of either brain or circulatory function as "permanent," taken in the sense that the patient cannot for himself or herself revive those functions and not that they are unrevivable. Both techniques at their best are based ethically on the idea that, with the consent of the donor whose own body cannot long remain informed by the soul, the vital organs are no longer of the patient nor for the patient. With the appropriate isolation of the heart's function as described above, there is no real ethical difference between in situ reperfusion in TA-NRP and removing the heart for reperfusion ex situ in DCD.[13] Yet this similarity is the very reason why both should be rejected until a waiting period is established that truly ensures an irreversible loss of brain function. Indeed, both cDCD and TA-NRP cause the irreversible loss of brain and circulatory-respiratory function by the removal of the heart in the former or the isolation of the heart's function in the latter.[14] The loss of the capacity for auto-resuscitation is not identical to the irreversible loss of vital functioning or the loss of life. Double effect would not apply to such an act, for the saving of the organ recipients is mediated by causing the irreversible loss of vital function by either regional isolation (TA-NRP) or vital organ removal (DCD).

I must relegate to another piece my full argument from the metaphysics of death and the priority of the neurological signs of death over the circulatory-respiratory criteria. Neither do I presume here that skepticism about the validity of the neurological criteria of death would require agreement with my case.[15] TA-NRP exploits the legal co-validity of the two death criteria that was established before the innovation of TA-NRP itself. If a donor's vegetative and sensitive functions at least could be revived by perfusion of the brain, as TA-NRP with a short hands-off period intrinsically risks, then that donor still retains an active potentiality for such functions and is therefore not dead. Indeed, we all know that such a donor may have cardiac function revived by attempts at resuscitation for a prolongation of life, even if it would be immoral to so attempt resuscitation when contrary to the patient's reasonable will. Again, the patient is not "ethically" dead nor really dead, but dying.

The practical implication of TA-NRP revealing that DCD patients are not known to be dead with a mere five-minute waiting period is that Catholic hospitals and health systems should cease cooperation with all DCD and TA-NRP protocols to preserve their witness to the dignity of all human life.[16] Even if done for a good intention (e.g., increasing the number of vital organ transplants), these procedures perpetrate grave moral evil due to the lack of moral certainty that the donor has died. For the same reason that euthanasia of a patient with five minutes to live remains a direct killing, so the direct elimination of vital organ functioning, even if only the active potentiality for such functioning, in a dying patient is homicide. As Jonah Rubin, MD, a critical care physician and ethicist with Massachusetts General and Harvard Medical School, says of TA-NRP, "Ultimately, the cause of death is either the cerebral artery clamping-inducing presumed—not proven—brain death or vital organ explantation, both by direct surgical intervention. This is euthanasia, if not simply killing, even if voluntary."[17] Rubin then draws the same illation I have been arguing: "Indeed, this raises questions even about classical cDCD. A condition is reversible if it can be reversed, even when it is not. NRP has proven what we already know—irreversible cessation of circulatory function occurs after the commonly accepted waiting period after cardiac arrest."[18]

On the other hand, DCD or TA-NRP with a "hands off" period long enough to ensure brain death along with pre-mortem injection of anticoagulants and vasodilators prior to death may be an ethical alternative for cardiac recovery. How long would such a waiting period have to be for ethical validity? Twenty minutes has been suggested by some moral theologians who do not assume that a lack of cardiac auto-resuscitation equates to death.[19] The validity of such a period would need confirmation in conversation with neurologists. In the meantime, Catholic hospitals may not need to give up all cooperation with OPOs but should continue to support vital organ donation by strict protocols for determining death by "whole brain death" neurological criteria.[20] As DCD and now TA-NRP rapidly increase in their proportion of donations done in the United States, the task of discernment and moral renovation will be difficult. The pressures from CMS, OPOs, and from the genuine desire to help those who organs are failing are great. Yet transplantation medicine is full of dedicated people who can innovate

within ethical boundaries set by Catholic health care institutions. Even if not, one must not do evil to bring about good. The reward of an evangelical witness to life leading to ethical innovation consistent with that witness would be increased public trust in the U. S. transplant system and a greater sense of the dignity of human existence, even unto the moment of death. ✠

BARRETT H. TURNER, PHD, MDIV
Associate Professor of Theology
Mount St. Mary's University
Emmitsburg, Maryland

ENDNOTES

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2. According to the data from the Organ Procurement and Transplantation Network, DCD donations have grown from 757 in 2004 to 9963 in 2023 (https://optn.transplant.hrsa.gov/data/). There is another form of NRP that just perfuses the organs of the abdominal cavity (abdominal or A-NRP). I'm concerned in this paper with TA-NRP because it threatens brain reoxygenation and restarts cardiac activity. For A-NPR in particular, see A. L. Dalle Ave, D. M. Shaw, and J. L. Bernat, "Ethical Issues in the Use of Extracorporeal Membrane Oxygenation in Controlled Donation after Circulatory Determination of Death," *Am. J. Transplantation* 16 (2016): 2293-2299.
3. OPTN does not have a separate code for TA-NRP donations and codes these as DCD donations, but the advent of TA-NRP's use in the United States and the explosion of heart transplants from DCD donors correlates well. Contributing to the rise are *ex situ* machine perfusion techniques, which are more expensive.
4. American College of Physicians, "Ethics, Determination of Death, and Organ Transplantation in Normothermic Regional Perfusion (NRP) with Controlled Donation after Circulatory Determination of Death (cDCD): American College of Physicians Statement of Concern," April 17, 2021; Brendan Parent, Arthur Caplan, Nader Moazami, and Robert A. Montgomery, "Response to American College of Physician's statement on the ethics of transplant after normothermic regional perfusion," *Am. J. Transplant*. 22 (2022): 1307-1310; see also debates in recent issues of Chest (August 2022) and *American Journal of Bioethics* (February 2023), the latter of which with a focus on whether TA-NRP can sidestep the ethical pitfalls of DCD; Robert D. Truog, Andrew Flescher, and Keren Ladin, "Normothermic Regional Perfusion—the Next Frontier in Organ Transplants?" JAMA 329.24 (June 27, 2023): 2123-2124.
5. For similar positions that entail doubting the moral liceity of both cDCD and TA-NRP, see: Kyle Karches, Erica K. Salter, Jason T. Eberl, and Patrick McCruden, "Dead Enough? NRP-cDCD and Remaining Questions for the Ethics of DCD Protocols," *Am. J. Bioethics* 23.2 (2023): 41-43; L. Syd M. Johnson, "DCD Donors are Dying, but Not Dead," *Am. J. Bioethics* 23.2 (2023): 28-29; and Stephen Napier, "The Dead Donor Rule is Not Morally Sufficient," *Am. J. Bioethics* 23.2 (2023): 57-59. For those who see both DCD and TA-NRP as licit, see: Anji Wall and Giuliano Testa, "Defining the Cause of Death and Vitality of Organs in the Ethical Analysis of Controlled Donation after Circulatory Death Procedures," *Am. J. Bioethics* 23.2 (2023): 35-38; James L. Bernat et al., "Understanding the Brain-based Determination of Death When Organ Recovery Is Performed With DCDD In Situ Normothermic Regional Perfusion," *Transplantation* (2023); Christos Lazaridis, "Normothermic regional perfusion: Ethically not merely permissible but recommended," *Am. J. Transplant*. 22 (2022): 2285-2286; Les James, Brendan Parent, Nader Noazami, and Deane E. Smith, "Does Normothermic Regional Perfusion Violate the Ethical Principles Underlying Organ Procurement? No," *Chest* 162.2 (2022): 290-292. For those who hold that cDCD is permissible but TA-NRP is not, see: Anne L. Dalle Ave and Daniel P. Sulmasy, "Death Lost in Translation," *Am. J. Bioethics* 23.2 (2023): 17-19; Lainie Ross, "The Dead Donor Rule Does Require that the Donor is Dead," *Am. J. Bioethics* 23.2 (2023): 12-14; Alexandra K. Glazier and Alexander M. Capron, "Normothermic regional perfusion and US legal standards for determining death are not aligned," *Am. J. Transplant.* 22 (2022): 1289-1290; ACP Board of Regents, "Statement of Concern," April 17, 2021..
6. The five-minute threshold has been justified by the fact that the donor's heart function will not revive on its own. See S. Dhanani et al., "Resumption of Cardiac Activity

after Withdrawal of Life-Sustaining Measures, "*NEJM* 384.4 (2021): 345-352. Whether lack of ability to auto-resuscitate is a sufficient for vital organ transplantation to occur is a distinct question, one that I answer in the negative. Still, the assumption that auto-resuscitation is sufficient for vital organ removal is commonly assumed, e.g., Michael A. DeVita, "The Death Watch: Certifying Death Using Cardiac Criteria," *Progress in Transplantation* 11 (2001): 58-62; Stephen Napier, "Out of the Frying Pan and Into the Fire," *American Journal of Bioethics* 11.8 (August 2011): 60-61.

7. An exception to these lines of argument is Nicanor Pier Giorgio Austriaco's position that the non-heart-beating donor remains alive after asystole but that the heart is at that point no longer a vital organ, thereby permitting explantation (*Biomedicine and Beatitude*, 2nd ed. [Washington, DC: Catholic University of America Press, 2021], 302).

8. John Paul II, "Address to the 18th International Congress of the Transplantation Society," August 29, 2000: "Acknowledgement of the unique dignity of the human person has a further underlying consequence: vital organs which occur singly in the body can be removed only after death, that is from the body of someone who is certainly dead. This requirement is self-evident, since to act otherwise would mean intentionally to cause the death of the donor in disposing of his organs … The death of the person is a single event, consisting in the total disintegration of that unitary and integrated whole that is the personal self. It results from the separation of the life-principle (or soul) from the corporal reality of the person … Here it can be said that the criterion adopted in more recent times for ascertaining the fact of death, namely the complete and irreversible cessation of all brain activity, if rigorously applied, does not seem to conflict with the essential elements of a sound anthropology. Therefore a health-worker professionally responsible for ascertaining death can use these criteria in each individual case as the basis for arriving at that degree of assurance in ethical judgement which moral teaching describes as 'moral certainty'. This moral certainty is considered the necessary and sufficient basis for an ethically correct course of action" (emphasis original).

9. Frederick F. Dalsgaard et al., "Clamping of the Aortic Arch Vessels during Normothermic Regional Perfusion after Circulatory Death Prevents the Return of Brain Activity in a Porcine Model," *Transplantation* 106.9 (2022): 1763-1769.

10. Alex Manara et al., "Maintaining the permanence principle for death during in situ normothermic regional perfusion for donation after circulatory death organ recovery: A United Kingdom and Canadian proposal," *Am. J. Transplant*. 20 (2020): 2017-2025; Jennifer A. Frontera et al., "Thoracoabdominal normothermic regional perfusion in donation after circulatory death does not restore brain blood flow," *J. Heart and Lung Transplantation* 42.9 (2023): 1161-1165.

11. Don Marquis, "Are DCD Donors Dead?", *Hastings Center Report* (May-June 2010), 24-31; Christopher Kaczor, "Organ Donation following Cardiac Death: Conflicts of Interest, Ante Mortem Interventions, and Determinations of Death," in *The Ethics of Organ Transplantation,* ed. Steven J. Jensen (Washington, DC: Catholic University of America Press, 2011), 111; Gina Sanchez, "Objections to Donation after Cardiac Death: A Violation of Human Dignity," *National Catholic Bioethics Quarterly* (Spring 2012): 55-65; Matthew T. Warnez, BH, "The Ethics of Donation after Cardiac Death," *National Catholic Bioethics Quarterly* (Winter 2020): 745-758.

12. For example, James DuBois, "Determining Death," in *Catholic Health Care Ethics*, ed. Edward J. Furton (Philadelphia: National Catholic Bioethics Center, 2020), 18.9: "in establishing an irreversible loss of circulatory-respiratory functions, one does not need to consider the possibilities of modern resuscitative medicine, but rather the parameters for spontaneous recovery set by nature." While DuBois's conclusion is very common in both non-Catholic and Catholic bioethics, the argument moves invalidly from the true premise that one ought not revive the dying against informed consent to the assumption that irreversibility is fulfilled with passing the point of spontaneous revival of function and that such a point is identical with death. For the same critique of DuBois, see Jason T. Eberl, *Thomistic Principles and Bioethics* (Routledge, 2006), 124. Likewise erroneously assuming that DCD and TA-NRP are in principle ethically different, see the recent, "Submission fo the NCBC and USCCB to the Uniform Determination of Death Committee of the Uniform Law Commission," July 12, 2023.

13. While disagreeing with their approval of TA-NRP, I agree in this specific point with Angi E. Wall et al., "Applying the ethical framework for donation after circulatory death to thoracic normothermic regional perfusion procedures," *Am. J. Transplant*. 22 (2022): 1314a: "When a standard cardiac DCD procedure is performed, the heart is removed from the body and put on a machine, restarted and circulates blood and perfusate through the machine. While there is an optical difference between the circulatory function of the heart being restored within the corpse rather than outside of the body, there is no ethical difference." So long as we state the obvious point with Austriaco, that the donor remains alive at this moment (see n. 7 above), those who embrace DCD and TA-NRP together seem the most logically consistent to me.

14. To express this more metaphysically, both DCD and TA-NRP must assume that "irreversible" or "permanent" mean the loss of an active "capacity in hand". Yet these techniques can violate the other active capacity, the "natural potentiality", which can remain in severely injured and dying people. For the distinction between

potentialities, see Jason T. Eberl, *The Nature of Human Person: Metaphysics and Bioethics* (Notre Dame, IN: University of Notre Dame Press, 2020), 149-150.

15. Indeed, some skeptical of the neurological criteria nevertheless argue for retaining DCD and other vital organ transplantation procedures (Austriaco, OP, *Biomedicine and Beatitude,* 301-303; Charles C. Camosy and Joseph Vukov, "Double Effect Donation," *Linacre Quarterly* 88.2 [2021]: 149-162)

16. USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: USCCB, 2018), nn. 63, 70, 71.

17. "The Irreversible Cannot Be Reversed: Normothermic Regional Perfusion is Euthanasia," *J. Cardiothoracic and Vascular Anesthesia* 38 (2024): 608-609, at 608b.

18. Rubin, "Irreversible cannot be Reversed," 608b-609a, emphasis added.

19. Kaczor, "Organ Donation following Cardiac Death," 111: "twenty to thirty minutes"; Jason T. Eberl, *Thomistic Principles and Bioethics*, 126: "at least ten to fifteen minutes". Kevin J. Clarke, SJ, offers an analysis seemingly based on proportionalist reasoning, yet still recommends at least a ten-minute hands-off period ("A Catholic Perspective on Organ Donation After Cardiac Death," in *Contemporary Controversies in Catholic Bioethics*, ed. Jason T. Eberl [Springer, 2017], 499-515).

20. Whether the revised American Academy of Neurology guidelines are strict enough for moral certainty is a separate question. Compare David M. Greer et al., "Pediatric and Adult Brain Death/Death by Neurologic Criteria Consensus Guideline: Report of the AAN Guidelines Subcommittee, AAP, CNS, and SCCM," *Neurology* 101.24 (December 2023): 1112-1132, against Michael Nair-Collins & Ari R. Joffe, "Frequent Preservation of Neurologic Function in Brain Death and Brainstem Death Entails False-Positive Misdiagnosis and Cerebral Perfusion," *AJOB Neuroscience* 14.3 (2023): 255-268.

Problems, Mysteries, and Frustrating Cases: How Narrative Competence at the Bedside Can Improve Patient Care

Imagine cases like the following:

Worried about liability for assault, a doctor calls the ethicist after a patient refuses to allow removal of a Foley.

A patient-appointed surrogate refuses a safe discharge to SNF, while the patient's estranged daughter agrees with the care team's discharge plan.

Members of the care team experience moral distress as a patient in a long recovery from brain surgery undergoes painful multi-hour dressing changes without a prognosis of clear benefit.

Cases like these frustrate everyone involved, not because they indicate complicated ethical dilemmas, but because they center on conflicts between plans of action that are mutually unintelligible to each of the parties involved. In the first case, for example, the medical team simply cannot understand why the patient would compromise his safety by refusing the removal of a source of infection when the catheter is no longer providing medical benefit. Likewise, it seems equally obvious to the patient that removal is not worth considering. The conflict prevents both the patient and the medical team from achieving their preferred goals; and so their frustration mounts, their appraisals of the other's motives darken, and their thoughts turn to litigation. What should have been a routine interaction becomes a threat to patient care and to the professional-patient alliance.

Rita Charon's exploration of narrative competence, combined with Gabriel Marcel's distinction between problems and mysteries, offers a path out of this clinical dead end. Together, Charon's and Marcel's insights provide a fresh perspective for cases like these and demonstrate how approaching care with narrative skills can improve clinical outcomes at the bedside.

In her landmark work Narrative Medicine, Charon defines "narrative competence" as the possession of "skills of recognizing, absorbing, interpreting, and being moved by the stories of illness."[1] Narrative competence, then, is a multi-dimensional skill set and requires the development of an array of cognitive and emotional abilities. Charon's reference to interpretation is of particular importance with respect to the frustrating cases we're considering. Including that skill within

narrative competence suggests that our attention to the stories of illness our patients bring and enact is always a kind of seeing-as.

If Charon is right, how we see our patients and interpret their suffering matters. We can describe two opposed hermeneutical stances with categories provided by the French Catholic philosopher Gabriel Marcel. In several of his texts, Marcel distinguishes between problems and mysteries.[2] Understanding that distinction can help to clarify the demands of narrative competence in patient encounters.

When I interpret a situation as a problem, in Marcel's term of art, I construe it as fundamentally an object of manipulation. It doesn't directly involve me; I am not a participant but an observer, even if one with ambitions to change the situation for the better. A problem can be solved with the right resources and techniques. Anyone with the requisite skill set should be able to address it effectively. So, a problem calls for cleverness, technical know-how, or expertise. If I am confronted with a problem, I will focus my response on answering how questions; that is to say, I will concern myself with inquiring into the most effective and efficient means for manipulating the parts of the whole to obtain a given, "successful" result.

If my computer crashes, for example, I find myself confronting a problem. Though I depend on the computer in numerous ways and find my activity hindered when it fails, I have not crashed with the computer. The problem remains external to me, and I look for an effective technique to manipulate hardware and software to reverse the failure and prevent it from recurring. If I can just learn how to wield the right method, I can control the situation and remove the obstacles to my action.

But even in solving problems, method is rarely enough. Complex problems in information technology, plumbing, or car repair call for sophisticated knowledge, trained perception, and finely honed intuitions. Solving medical problems is even more demanding, and the technical skills that make it possible, correspondingly admirable. Nevertheless, the ability to solve medical problems is not enough to empower practitioners of the art of medicine to reach the ends of their practice by their means alone. In the medical context, the limitations of interpreting patient encounters solely as technical problems become readily apparent.

For example, a problem that cannot be solved becomes fertile soil for the growth of cynicism. The limits of my IT problem-solving abilities make me much more cynical about computers than my engineering-student son. This phenomenon is sadly familiar to most of us who work in health care. The patient whose problems resist our best techniques is the patient who is also most likely to become the object of cynical and exasperated comments.

For such a patient, another hermeneutical stance is necessary, and Marcel's description of mystery provides an apt alternative. When I interpret a situation as a mystery, it doesn't manifest itself as an object of technical manipulation. It cannot be held at a distance because it evokes personal attitudes such as wonder or hope. Consequently, it involves me in a way that goes beyond an acquired skill set, enlisting me as a participant rather than a mere observer. Simone Weil's reflections

on the power of attention suggest another way to characterize the hermeneutical stance that correlates with mystery: to interpret a situation as a mystery rather than a problem is to respond to it with attentive presence before attempting to solve it with technique.[3]

One's own suffering is a clear case of a phenomenon best approached as mystery. John Donne, reflecting on his life-threatening illness, wrote, "As sickness is the greatest misery, so the greatest misery of sickness is solitude."[4] But isolation is not amenable to technique or expertise; it invites one, not to cleverness, but to hope—or despair. I cannot hold it out at a distance, mastering it as an object of observation or manipulation, and it makes me long for the attentive presence of another.

The suffering of others calls for interpretation as mystery as much as our own. Kenneth Gallagher, commenting on Marcel, insists, "only one who participates with me in my suffering has the right to interpret it for me."[5] Those of us caring for patients cannot avoid interpreting their suffering; so, if Charon and Marcel are right, then we must earn that right by finding a way to enter into their suffering. The questions suggested when we take a patient's illness as a problem offers no path to that goal, but rather sets the suffering at a distance and attempts to control it by asking how we can resolve it and what techniques will allow us to do so. A hermeneutical stance of mystery invites different sorts of questions. For example, when faced with resistance to our technical skills, the question why, asked with openness and a wondering curiosity, brings us into the complex of ends and purposes that constitute the intelligibility of a human life. Likewise, engaging such patients with the question what does it mean to you can manifest the forms of attention and perception in which the patients themselves become aware of their suffering. We can then join them in their vulnerability, their unwilling openness to a world of pain and solitude.

Because it concerns human suffering, then, narratively competent medicine must begin with attentive presence to mystery; and those acts of attention will often reveal problems suitable for medical skills. Mystery does not displace problems but contextualizes them. Beginning with attentive presence to a patient's story of illness can bring to the surface problems that medical skills can then appropriately address. Or perhaps we might better say that our problem-solving can, at its best, become an instrument of our attentive presence, rather than a replacement for it. Ultimately, problems are solved for the sake of entering into the mystery, which is why Our Lord insisted on a personal encounter with the woman who suffered from a hemorrhage, even after she had already experienced the resolution of her problem through the touch of his hem.[6] We need both stances of problem and mystery to serve our patients; but we must have them in the right order.

A shift from prioritizing problem to foregrounding mystery led to resolutions in each of those frustrating cases which we began with. In each case, attempts to move beyond technical problem-solving to some participation in the patient's own encounter with suffering brought to light the latent intelligibility in otherwise frustrating forms of resistance that had stymied technical problem-solving.

In the first case, pursuing those questions that

can open to mystery revealed something new. When the team finally asked why the patient was refusing the removal of the Foley catheter, they learned that what it meant to him diverged decisively from what it meant to them. Rather than focusing on the catheter as a dangerous source of infection, the patient saw its removal as a threat to his dignity and comfort, since he could not effectively use a urinal. An offer of absorbent undergarments resolved the stand-off.

Similarly, in the second case, deeper conversation surfaced the surrogate's picture of the rejected discharge option—a picture of his friend wasting away in a wheelchair in some institutional hallway, with an afghan blanket thrown over his knees. When the team acknowledged the force of that framing and provided the surrogate with another, more accurate picture, a path opened for mutually intelligible decision-making.

Finally, in the third case, the plastic surgeon continued to cheerfully predict that success was almost at hand, through surgery after painful surgery and multi-hour wound changes with heavy pain medication—for a patient whose other comorbidities were themselves significant. Empowering the patient's family to present their concerns frankly to the surgeon helped him to re-direct his attention from the technical problems of reconstructive surgery to the patient's and family's hopes and fears. The surgeon quickly saw that re-contextualizing his technically proficient surgical problem-solving as an instrument for encountering the mystery of the patient's suffering—rather than as the goal of the patient encounter—required a re-evaluation of the treatment plan and a transition for the patient to another level of care.

In all these cases, then, narrative competence at the bedside, understood as the ability and disposition to ground interventions in an attentive presence to the mystery of the patient's suffering, proved the key to achieving the clinical outcomes most appropriate for the patients. Renewed attention to developing the skills of narrative competence promises, in many situations, both to improve the care of patients and to address some of the frustrations of their caregivers. ✠

RANDY COLTON, PHD, HEC-C
Director, Ethics
Mercy Northwest Arkansas
Rogers, Arkansas

ENDNOTES

1. Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (NY: Oxford University Press, 2006), 3.
2. For one important example, among others, see Gabriel Marcel, *Being and Having*, trans. Katharine Farrer (Glasgow: The University Press, 1949; repr. Westminster, Dacre Press), 116-121.
3. See especially Simone Weil, *Waiting for God*, trans. Emma Craufurd (NY: Harper and Row, 1973).
4. John Donne, *Devotions Upon Emergent Occasions and Death's Duel* (NY: Random House, 1999), 26.
5. Kenneth Gallagher, *The Philosophy of Gabriel Marcel* (NY: Fordham University Press, 1962; repr. Barakaldo Books, 2020), 64.
6. Luke 8:40-48.

Narrative Respect and SOGI Data Collection: How Patients' Charts Can Tell Their Stories

Across the health care industry, new requirements and initiatives for collecting data about patients' sexual orientation and gender identity (SOGI) have increased over the last few years. Clinical needs, concerns about patient safety, epidemiological and population health efforts, and regulatory demands have all contributed to these new developments. Many Catholic health care ministries have already found ways to respond to this environment, and others are discerning their own path forward.

Mercy has recently charted its own course through these waters and found them, perhaps predictably, somewhat tumultuous. We began the process with a long questionnaire covering SOGI data thoroughly and including questions about sexual orientation, an organ inventory, and so on. One plan suggested that this questionnaire be incorporated into the electronic medical records system and administered to every patient who came into our care. Concerns soon arose about this approach. Some co-workers and clinicians felt that they were being pressed into taking sides in polarizing cultural conflicts; others wondered how it all intersected with our Catholic identity; and still others worried that the questionnaire was too invasive and would make many patients uncomfortable, especially since some of the data points didn't seem to align directly with clinical needs.

In response to these concerns, we shifted course and found a way that works for us to address the fundamental concerns driving these SOGI data collection initiatives, while taking the concerns of our co-workers and clinicians into account. The ethical heart of this approach centers on the demands of what one could call narrative respect. In this essay, I will explain that concept, drawing on Wayne C. Booth's ethics of fiction; indicate how we applied it to the issue of SOGI data collection; and briefly summarize the benefits of that approach.

Each patient's chart tells a story. It includes the essential elements that narrative theorists have identified as definitive of a narrative: a teller and a tale.[1] The tale is sometimes front and center; consider all the notes that include a "History of the Present Illness." Even beyond those histories, the chart as a whole is an ongoing presentation of the patient's course through disease processes, recoveries, efforts at health maintenance, and so on, all made intelligible through their linking in a narrative moving from beginning to middle to eventual end.[2]

The mark distinguishing a narrative from a drama is its indirect presentation of the actions and events through the perspective of a teller.[3]

A patient's chart, along with its tale, features a plethora of tellers, as each clinician presents the narrative from a particular professional and personal perspective; and, if clinicians are sufficiently attentive, the patient's own telling will be represented in the chart as well. If a robust alliance has formed between the patient and the caregivers, one might even find that the tale is ultimately told by a team whose contributions achieve some unity of perspective. But in any event, the chart offers its readers a narrative representation of the patient's experience.[4]

The literary scholar Wayne C. Booth draws readers' attention to a feature of stories that suggested a path forward for our SOGI data collection initiative. Booth points out that every story presents the reader or auditor with a set of fixed norms, "beliefs on which the narrative depends for its effect but which are also by implication applicable in the 'real' world."[5] For example, writes Booth, "The Goose that Laid the Golden Egg" suggests many 'nonce beliefs,' only to be accepted as obtaining in the world of the story—such as that geese can lay golden eggs—but also many fixed norms, such as "Greed is self-destructive."

Careful readers can identify a story's fixed norms and understanding them is crucial to a full appreciation of a narrative. The effort to understand a narrative in terms of its own fixed norms, however, does not necessarily entail the reader's own endorsement of that norm as applying in both the world internal to the narrative and the world external to it. For example, a riveting piece of sports journalism may imply the norm that athletic excellence is a preeminent human good, and a reader may understand the story in those terms, without agreeing that, in the "real" world, athletic excellence is so central to human flourishing.

Different tales and different tellers structure their stories according to different fixed norms, and this applies to patients and their charts as well. Some fixed norms are common across almost all patients' stories—such as that health is generally preferable to illness—but others are less universal. In the present case, for example, the stories that some patients tell about themselves include fixed norms that present the relation between gender identity and biological sex as accidental; but other patients structure their narratives around opposing fixed norms. Attempts to standardize the narratives contained in patient charts, beyond the scope of those very general and nearly universal fixed norms, present the danger of imposing on all patients the fixed norms that belong only to some patients' telling of their stories.

Recognizing this reality allows one to frame the difficulty of SOGI data collection in a new way. The problem is how to elicit every patient's story in the chart, as each would tell it, without imposing controversial fixed norms on any patient, at least as far as possible. From this perspective, it becomes apparent that the misgivings co-workers expressed about our original process reflected a reasonable intuition: that requiring all patients' charts to identify them in categories such as "transgender" or "cisgender" represented a kind of narrative imperialism, forcing patients to tell stories in accord with fixed norms that they would themselves reject. In that case, their charts would stifle their own telling of their stories rather than giving them an honored place.

This form of imperialism acts on the

assumption that local or individual differences are not relevant and that authority—in this case, narrative authority—must ultimately rest in a higher, more expert perspective. What we needed to counteract that narrative imperialism was an attitude of narrative respect. Narrative respect requires care teams to recognize patients' authority to tell their own story by making place for the telling of their stories in their charts and by avoiding, as far as possible, the imposition of controversial fixed norms that the patients may not endorse. Without this kind of respect, caregivers will often find themselves unable to discern the coherence of patient narratives, because they will lack access to the fixed norms that underpin their intelligibility.[6] However, the fact that caregivers exercising narrative respect will engage a variety of patient stories with diverse and conflicting fixed norms raises another perplexity. It suggests a kind of incoherence in their own perspectives with caregivers careening from one fixed norm to a contrary one in the course of a few minutes with the electronic medical record (EMR).

But Booth's reflections again suggest a way out. He writes, "[W]e may finally, on reflection, reject even the fixed norms: that is precisely what much ethical criticism does."[7] Narrative respect does not require careful readers to endorse the fixed norms in the stories they encounter, but only to recognize them and consider how they provide the structure for the meaning the teller finds in the tale. Clinicians experience this kind of tension in many different circumstances. Consider the expectant mother whose birth plans strike the caregiver as excessively risky but also as understandable in terms of fixed norms rooted in holistic approaches to health or cultural mores. Or think of those types of counseling in which the therapist helps clients to uncover unrealized fixed norms in their own stories and reflectively evaluate them.

In some cases, a patient's chart will remain a site of tension, because the multiple tellers of the tale it contains will not share important fixed norms, even if each can understand the others' stories in terms of their respective commitments. Not every chart attains that unity of perspective that comes from integrating telling of the tale that are distinct and yet share central fixed norms. Narrative respect does not require every teller of the tale in the chart to endorse the same fixed norms, but it does require a place for those diverse tellings to be heard and the effort to understand them in their own terms.

The applications of this understanding of the patient's chart as a story turned out to be fairly straightforward. SOGI data collection that requires every patient to declare a gender identity arguably imposes fixed norms about the relation between gender and biological sex on all patients—and perhaps on the providers as well, who must present the questions, with their implied narratives, as if their fixed norms were universal. A promising alternative is to focus instead on open-ended, clinically focused questions. Providers might ask, "is there anything about your gender identity or sexual orientation that you would like us to know as your health care provider?" Or, more specifically but still without assuming the patient endorses any particular fixed norm, "Have you ever received, or do you plan to receive, hormonal or surgical treatment for gender incongruence or dysphoria?" Affirmative answers to inquiries like these would trigger a question set in the EMR that

drills down into further details, allowing patients who endorse fixed norms affirming the accidental relation between sex and gender to have narratives that make sense to them represented in the chart—and ensuring that information important for patient safety is included. Negative answers would result in the interview continuing without demanding that the patient's narrative conform to fixed norms alien to that patient. In each case, the provider would remain a careful witness to the stories patients want to tell but would not be committed to endorse every fixed norm they entail.

We eventually moved in this direction, working with a version of those sorts of open-ended questions. We believe the benefits are significant. It allows all patients to tell their stories according to fixed norms they endorse. It lowers hurdles for providers reluctant to engage these conversations, because it provides a way for them to be respectful while not committing them to endorsing, or appearing to endorse, controversial fixed norms. For the same reason, it is consistent with our Catholic identity. It does not assume any fixed norm that may be in conflict with those implicit in a Catholic anthropology;[8] and, at the same time, it compassionately welcomes patients to tell their stories their way, as Our Lord did in conversation with the woman at the well.[9] Finally, while achieving all these benefits, it also procures the relevant clinical, epidemiological, and population health data and meets regulatory requirements. Using open-ended questions to express narrative respect for our patients in these fraught conversations, then, is an approach that we believe deserves wider consideration. ✣

RANDY COLTON, PHD, HEC-C
Director, Ethics
Mercy Northwest Arkansas
Rogers, Arkansas

ENDNOTES

1. Robert Scholes, James Phelan, and Robert Kellogg, *The Nature of Narrative*, 40th anniversary ed., rev. and exp. (New York: Oxford University Press, 2006), 4.
2. Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 2nd ed. (Notre Dame, IN: University of Notre Dame Press, 1984), 205.
3. Scholes and Kellogg, 4. See also Randall G. Colton, *Repetition and the Fullness of Time: Gift, Task, and Narrative in Kierkegaard's Upbuilding Ethics* (Macon, GA: Mercer University Press, 2013), 73.
4. See Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (NY: Oxford University Press, 2006), 146-148.
5. Wayne C. Booth, *The Company We Keep: An Ethics of Fiction* (Los Angeles: University of California Press, 1988), 142-143.
6. See Booth, *The Company We Keep*, 149: "In whatever form we take the story, as long as it is intelligible to us we will have seen it in a matrix of its fixed norms."
7. Booth, *The Company We Keep*, 143.
8. See the United States Conference of Catholic Bishop's "Doctrinal Note on the Moral Limits to the Technological Manipulation of the Human Body," March 20, 2023 (https://www.usccb.org/resources/Doctrinal%20Note%202023-03-20.pdf).
9. John 4:1-26.

Ethics Tea Time

In the post-COVID era, there seems to be an increased promotion of self-care amidst the staffing challenges of "doing more with less." This is true for not only frontline clinical staff, but also for all members of the care team, including ethicists.

Mercy's Ethics Council of eleven people, scattered throughout the ministry, consists primarily of Directors of Ethics throughout the system in all the major markets, but also includes the Executive Director of Ethics at the ministry office and a couple mission leaders who have backgrounds in ethics. They convene weekly to discuss and collaborate on various needs throughout the ministry. In the years 2022 and 2023, the group was composed of a nice mix of veteran ethicists and those who had been in the role 2 years or less. However, due to the nature of those regular meetings, there was not ample opportunity for the newer ethicists to glean wisdom from the more senior members of the group. At that time, it also became apparent that the group needed space for respite from the pressures that come from the nature of their work.

Setting the Table

The Mercy Ethics Council was inspired by the work of Steven Squires and Andrea Thornton in their article, "Jacks and Jills of All Trades, Experts of Some: Process Skills Training for Ethics Programs" (HCEUSA, Fall 2022).[1] In discussing the article, the group felt that it would be to beneficial to grow in some of the skills discussed by Squires and Thornton. Of particular interest to the group was the idea of verbatims—a tool used to train chaplains in Clinical Pastoral Education (CPE).[2] Squires and Thornton describe the verbatim and its usefulness for ethicists:

> A verbatim includes a transcript of a consult (from memory) with notes on context, nonverbal communication, the consultant's mood, the consultant's read on the interlocutor(s)' mood(s), and interpersonal dynamics. The verbatim allows for reflection on one's own performance, including the micro-politics and emotional factors that influence analysis and communication. These reflections are not simply private writing experiences; they are presented before a group of peers for discussion and evaluation. They invite others to broaden the consultant's self-awareness, bringing attention to habits or styles of communication that may not serve the goals of the consultation. Implementing the verbatim in the training of ethics consultants will address the gaps in process learning that the profession currently experiences to improve ethics quality.[3]

Mercy's Ethics Council members were interested in the prospect of developing these process skills and learning from the wisdom of the group through the sharing and discussing of cases using verbatims. Initially, the group agreed to do this at a meeting that would be separate from the weekly Ethics Council meetings. This time together was dubbed Ethics Tea Time as a nod to Mercy's tradition surrounding the "comfortable cup of tea" that Catherine McAuley encouraged the sisters to

share together upon her passing.[4]

Something's Brewing…

Having gone through a unit of CPE myself, I felt comfortable leading the charge. I created a template to be used (included below) that was based off the verbatim template that was supplied for me when I did my unit of CPE. I also set up a rotating schedule of who would be tasked to 'present.'

The following is the initial Mercy Ethics Council Verbatim template:

ETHICS COUNCIL VERBATIM TEMPLATE

Instructions: The purpose of these verbatims is manifold. The hope is that the writer would get out of the verbatims whatever it is that they felt they needed. This format is merely a suggested format based off a CPE template. As the writer of the verbatim, please include whatever details you feel are necessary in order that you and the group may get the most out of our time together (this, of course, may vary from following the template exactly to a product that's more of a stream of consciousness with thoughts and questions at the end).

Ethicist's Name		Date Written:
Patient's Initials:	Age	Gender:
Ethnicity:	Faith Tradition:	Patient's Location:
Family Present:	Patient's Vocation:	
Admission Date:	Date of Visit:	Length of Visit:
Current Medical Problem:		Prognosis:
Reason for Visit:	Referred? Yes / No	Who Referred?

1. Summary of the case:
2. Description of Patient as a Person: what does the patient's (and/or family/care team member's) appearance, gender, race, diagnosis, language, etc. tell you about him or her? Track your reactions to any of the above here.
3. Verbatim Dialogue (if you feel inclined to recount, verbatim, part of the consult, you may do so here)[5]

Dialogue goes here	Ethicist's thoughts on this side
Patient said…	
Ethicist said…	
Care team member said… (etc.)	

4. Competence: Reflect on the ethics "interventions" (logic-related or as a facilitator) you used. How were they guided by your interior process? What pastoral skills did you use? Mention specific areas of challenge by letter and number (like C2, etc.) if you chose to include a verbatim.
5. What are some things you want to get out of the group discussion of this verbatim (e.g., help with skills, answering specific questions, feedback, group case discussion, rapport building with the ethics group)?
6. Answer this question: "What do I want to learn from this verbatim?" Please do not ask the group to tell you what you did well or did poorly. Explore those here for discussion with the group.

ADJUSTING THE RECIPE… ADDING MILK & SUGAR

Fairly quickly, there was a need to change. The verbatim became just another thing to do for our busy ethicists. There was near-unanimous agreement that the time it would take to engage in a verbatim with the accuracy and intention that the exercise intends, and that the group wanted to give, would not be possible. The move was then made away from assigned, formatted verbatims to maintaining a regular time for general case discussion that was optional to attend. At times when no one had a case to present, the time together was oriented towards fellowship and enjoying the company of peers. Currently, Ethics Tea Time has a spot on everyone's calendar every week. On even weeks, it is held in the morning, and occurs in the afternoon on odd weeks. Both instances of Tea Time take place on different days of the week to maximize the possibility that one might work with people's schedules.

FINDING THAT COMFORTABLE CUP OF TEA

The Mercy Ethics Council is still working to find a version of Ethics Tea Time that suits the needs of the group. Feedback about the time together has been overwhelmingly positive as it has been an opportunity for many to enjoy fellowship with those who can intimately relate to the challenges and opportunities that come with the role. One of the main opportunities moving forward for Teat Time is to find the balance between the original intention of growing in those process skills that are critical to the role and not making the event an onerous one, all the while creating an opportunity for fellowship. The future goal for Ethics Tea Time is that it can continue to adapt to suit the group's changing needs and fill the Mercy ethicists' cups.

ADDISON S. TENORIO, PHD(C)
Executive Director of Mission
Mercy Hospital Ardmore
Ardmore, Oklahoma

ENDNOTES

1. Jacks and Jills of All Trades, Experts of Some: Process Skills Training for Ethics Programs (chausa.org)
2. Ibid., pg. 15.
3. Ibid.
4. For more on the tradition surrounding the "comfortable cup of tea": The Power of Tea - Sisters of Mercy.
5. Of note, this chart is small simply to demonstrate the format. A verbatim is typically the recounting of a whole or part of a conversation. Therefore, it has many back-and-forth interactions (often, between multiple people).

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