VOLUME 20, NUMBER 1
2026

HCEUSA

Health Care Ethics USA

A resource for the Catholic Health Ministry

2026

 ISSN 2372-7683

CHA Catholic Health Association of the United States

SAINT LOUIS UNIVERSITY

Preface and Introduction

BACKGROUND AND CONCEPT

Those who study and do the work of ethics may notice a tension within health care. The signs are everywhere. They are in comments from health care colleagues such as, "things work differently out here in the field," "ethics articles and literature are way too theoretical," and even "the home office doesn't understand the other ministries." Attending to these responses demands active listening, facilitating, and resolving each issue. Using data-driven or reactive-proactive ethics methods, we can treat such comments as being disconnected or as evidence of a deeper wound or tension.

A possibility is that ethics has a town-gown dichotomy or distinction. The Cambridge Advanced Learner's Dictionary & Thesaurus defines town and gown as "the university and the local people of a city, considered together … posed in opposition to one another." In its most pure or absolute form, people at the university or gown, on one side, view those in the town as unable to understand nuance and distinctions, unsophisticated, and undereducated. Those in the town view those in the university as being out-of-touch, too theoretical, and therefore impractical.

Ethics is not the only field to experience this disconnect. Universities and the hard sciences have worked to create alignment between communities and higher education. It is a continuous work in progress involving presence, listening to understand, and adaptive communication. For instance, a tour of a Big Ten university's labs in the early 2000s described the labs' work in terms that only a physicist would understand. The explanation stuck when described in layperson's terms - the labs were trying to develop advanced scanning technology machines and microchips that could detect hazardous chemicals quickly and cheaply. Bottom line, these advancements could save many lives, town and gown.

The ideal state is to treat town and gown as a false dichotomy. Universities' community grants, community relations boards, community partnerships, and institutional research may not blur the lines but create more opportunities for dialogue and interaction. The model of the reclusive academic banished to gothic buildings on the edge of town seems antiquated. Universities along with their faculty and staff members are much more in the town than ever before.

What does this mean for ethics? On the heels of Pope Francis' death, we need to remember his advice and great commission from over a decade ago. He said that the Church must be a field hospital after a battle in America magazine.[1] While it's true this pertains to our patients and communities, it also refers to being open to our own collective wisdom, whether in the field or behind a desk. After listening, communication must happen in a way that the person receiving a comment understands it, similar to a clinician assessing and using the knowledge and language of the patient during

the informed consent dialogue. Or else, what good is communication? What is the point of talking past one another?

One of our professors once said, "describing nuance matters because ethics is a field of nuance." Former Speaker of the House, Nancy Pelosi combined two moral axioms when she remarked that "the devil and the angels are in the details."[2] Perhaps the focus of those with formal ethics education, much less anyone communicating ethics, should be that God is in the process or, as Pope Francis said, the encounter. Communication plays an inherent role in the three-legged stool of clinical ethics - education, case consultation, and policy review.

FORMAT AND CONTENT

This special edition of Health Care Ethics USA addresses various models and modes for transmitting ethics education. While all scholarship (including this) attempts to be pragmatic, this issue does not heavily rely on academic sources, nor does it need to be read cover-to-cover or initial header to final footer in this electronic journal. Readers should find the sections that resonate most with them (virtue ethic approach) or will result in the most good for your organization or ministry (consequence-based ethic approach).

The content's sequence begins with the responses from three universities that were invited to contribute. Universities make tough decisions, both in general and with respect to forming a bioethics curriculum. Imagine having to choose the components of a core curriculum and, if applicable, electives for a certificate, masters, or doctorate program. Would a public health course benefit students more than a family dynamics or counseling course? What about process improvement or strategic planning courses? On the one hand, what education and training would help to feature ethics on the global stage? On the other hand, what would help health care clinicians or ethicists focus on the most vulnerable, whether among us or in our communities?

In this section, professors and students respond to some of these questions. The trend of ethicists going into mission roles is a topic. Over the years, ethics colleagues have shared the reasons for seeking mission roles, including some health systems combining mission and ethics roles into one, mission having "better job security" than ethics, and mission roles are "easier" than ethics roles. A program administrator comments that ethics teaches a skill set that may apply to any number of roles.

While it is true, mission and ethics are separate yet overlapping fields. It takes a special ethicist and skillset to be a Catholic healthcare mission leader (not all ethicists make good mission leaders), just as a mission leader needs special training and skillsets to be an ethicist. The idea that mission and ethics are completely interchangeable skill sets seems grounded in a fundamental misunderstanding of the practice of both fields. We hope that this is just the beginning of a discussion that is too big to happen in this issue and setting.

If ethics theory is a language and practice is another, then ethics practica, fellowships, and internships are the translators between the two. The middle segment begins with a history of COPACET, which will formalize, and hopefully reimburse, ethics internships.

It continues with a template for a Catholic health care fellowship curriculum developed by a working group that originated from a CHIEF meeting.

The final section is about methods used to teach clinicians and other health care professionals about ethics. Both curriculum and pedagogy have academic connotations. However, all these terms mean is to have an intentional education plan and method, respectively, which are hardly bad things. The methods here shift traditional curricula and pedagogies for ethics education and dialogue in ways that benefit stakeholders. Articles address coaching as a mode or pedagogy, using behavioral health content in education, and an education plan tailored to clinicians, particularly nurses.

Enjoy and let's make these conversations so that we keep going into the future.

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ENDNOTES

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2. "US Increases Fiscal-Stimulus Offer to $1.8 Trillion to Fight Covid-19: Report," Mint, October 9, 2020, https://www.livemint.com/news/world/us-increases-fiscal-stimulus-offer-to-1-8-trillion-to-fight-covid-19-report-11602260810732.html.

Ethics in Higher Education

Three institutions of higher education responded to special edition editors' request of programs respected for their scholarship and graduating ethicists into notable roles, particularly within Catholic health care. Programs were given the choice to respond to three prompt questions or feature a part of their curriculum that addresses educational needs or gaps in unique ways. Their responses are in alphabetical order by university. Duquesne University and Saint Louis University responded to the prompts about educating ethicists, which reads in an interview style. Loyola University Chicago featured the new disability elective for medical students at the Stritch School of Medicine, which reads as a short essay.

DUQUESNE UNIVERSITY, CENTER FOR GLOBAL ETHICS

JORIS GIELEN, PHD
Center Director and Associate Professor

What are some historic and current (Catholic) health care challenges that may necessitate future curricular development?

In our programs, we emphasize global health. It is very important that healthcare ethicists are aware of global healthcare connections. This includes connections at an international level, but, also, connections between local communities, diverse social, racial, ethnic groups, and the environment. This global health emphasis aligns with the Catholic mission of Duquesne University and is a great fit for our graduate programs that focus on Catholic healthcare ethics. While we already pay attention to global health in our programs, I listed this for future curricular development because it is something that is tremendously important to us and that we continuously aim to develop further.

What are some gaps remaining after comprehensive ethics academic programs and fellowships?

Academic programs and fellowships are, of course, very different and, in a way, complement each other. Moving from an academic program into clinical practice will always remain a significant step and we should aim to support future clinical ethics leaders so that that transition is as smooth as possible. Fellowships have an essential function there, while graduate degrees offer more scope to train in ethical theory and methods.

What do you think of the practice of educated ethicists going into, sometimes immediately, other Catholic health care careers?

You could think of this in a negative way, of course, as ethics expertise that is being lost or a "brain drain" from ethics, but this isn't the

right way to look at the issue. Students learn a skill set. Our graduate programs aim for this skill set to form our students to become ethics leaders. An ethics leader can be in any number of different positions. Alumni integrate their ethics expertise in whatever position they accept after graduation, be it clinical ethicist, academia, or administrative leadership roles.

LOYOLA UNIVERSITY CHICAGO, NEISWANGER INSTITUTE FOR BIOETHICS AND HEALTHCARE LEADERSHIP

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Educating Medical Students on Disability Health: Development and Implementation of a New Disability Healthcare Elective at Loyola University Chicago Stritch School of Medicine

People with intellectual and developmental disabilities (IDD) comprise one of the most neglected groups in healthcare. Although they have lower life expectancy and higher prevalence of chronic medical conditions, their health needs are often unmet due to insufficient resources, support, and healthcare provider training. The Liaison Committee on Medical Education (LCME) Standards do not currently require exposure to disability healthcare in medical school, which may contribute to poorer health outcomes for patients in this population. The mandate to better educate medical students on disability has been issued. Specifically, the Hastings Center issued a brief on March 13, 2024 that outlined a series of recommendations for medical educators to improve disability education. The recommendations consist of the following:

- Curricular components with learning goals tied to the Alliance for Disability in Health Care Education (ADHCE) and National Council on Disability (NCD) Core Competencies
- A procedure for identifying and removing curricular components that perpetuate harmful, outdated, or inaccurate understandings of disability
- A biopsychosocial approach to teaching about disability across the curriculum with an explicit focus on the relationship between ableism and health disparities
- Opportunities for learners to engage with disability culture in ways that model flourishing and challenge preconceived notions about quality of life
- Relationships with disability community groups and individuals who are acknowledged and compensated as expert educators
- Professional development opportunities for faculty and staff to incorporate a disability lens into their teaching
- Classroom and clinical environments built using Universal Design for Learning (note not in the original - UDL is a framework that promotes the development of flexible learning spaces to accommodate different learning styles)

The barriers and inequities that result from a lack of curricular attention to meeting the needs of patients with IDD led to a student-developed and student-run Disability Healthcare Elective at Loyola University Chicago Stritch School of Medicine. The course has now been successfully offered three

times over the past few years. The course was developed by students with the inclusion of two faculty advisors from the Neiswanger Institute for Bioethics at Loyola and the Program Director of the Combined Internal Medicine & Pediatrics Residency Program at Loyola. The course was created to reduce the gap that exists in medical education regarding healthcare for patients with IDD and the disparities they often face. Individuals with disabilities engage with many specialties and aspects of healthcare; therefore, educating trainees on disability health is a crucial step in producing clinicians who are more comfortable and competent in treating these patients effectively and equitably. Considering the disability motto "Nothing About Us, Without Us," the course invited local members of the disability community to participate in clinical simulations. Moreover, leaders in the disability field presented on a variety of topics related to disability health with the ultimate goal of improving care and health outcomes for this patient population. The development and implementation of the course fit squarely within the Mission of Loyola University Chicago Stritch School of Medicine:

> *Loyola University Chicago Stritch School of Medicine (Stritch) is committed to scholarship and the education of medical professionals and biomedical scientists. Our faculty, trainees, students, and staff, are called to go beyond facts, experimentation, and treatment of disease to prepare people to lead extraordinary lives and treat the human spirit in an environment that encourages innovation, embraces diversity, respects life, and values human dignity.*

While the Disability Healthcare Elective is not a bioethics course, per se, the curriculum presented and the skills gained by students are focused on professional identity formation, development of shared decision-making skills, social justice, and the importance of narrative in gaining a better understanding of patients' needs, concerns, goals, and values. In addition to the knowledge and skills that the students gained, community members gained a deeper understanding of what to expect in a clinical encounter, ways they might choose to effectively engage and advocate for their own healthcare, and the importance of developing a trusting therapeutic alliance between patient and provider.

What was gained by both students and participants illustrates the interplay between mission and ethics and how this collaboration can foster education, community engagement, and professional development. From the student perspective, the course:

- Helped to fill the gap that currently exists in medical education regarding how to interact with and care for diverse patient populations, including patients with IDD
- Ignited a passion for disability advocacy within healthcare
- Exemplified the struggles that individuals with disabilities continue to overcome in everyday life that make seeking adequate healthcare difficult
- Increased confidence and comfort in interacting with people with IDD and encouraged continued learning and adapting care for patients with IDD
- Exemplified the importance of both being aware of one's own choice of language and the idea that genuine curiosity and humility may sometimes be more important than a "perfect" vocabulary

- Highlighted that the current healthcare system is not suitable for all, and that intentional preparation is needed to best care for individuals with IDD
- Introduced them to alternative methods of taking histories to better accommodate individuals with IDD
- Helped them realize it is not a physician's job to protect an individual with disabilities from making a seemingly "wrong" healthcare decision, but rather to ensure they have the tools needed to make an informed decision for themselves
- Accentuated the value of patient narratives and lived experience
- Encouraged them to cultivate a mindset that embraces diversity, fosters empathy, and champions the provision of equitable healthcare for all

From the community perspective, the course:

- Allowed them to feel included and integral to the process of better understanding the needs of patients with disabilities
- Felt like an important step in training healthcare professionals to gain skills for improved interaction with disabled patients
- Promoted confidence in the patient-physician relationship to hopefully allow other patients with IDD to feel more comfortable in future healthcare encounters

The reciprocity and inclusivity in the course reinforced the social contract between physicians and the range of communities they serve. Integrating ethical awareness throughout the development and execution of the course has contributed to not only its success but also underscores the value of integrating bioethics in healthcare more broadly.

SAINT LOUIS UNIVERSITY (SLU), THE ALBERT GNAEGI CENTER FOR HEALTH CARE ETHICS

JASON EBERL, PHD
Center Director

ERICA K. SALTER, PHD
Department Chair

What are some historic and current (Catholic) health care challenges that may necessitate future curricular development?

Whatever the challenges faced by Catholic health care now or in the future requires forming ethicists who can adaptively respond in creative ways to those challenges, with the capacity to critically examine them through multiple lenses. A primary way in which such formation can occur is through education in not just the practical aspects of clinical ethics, but in the foundational methodologies of disciplines such as philosophy, theology, and the social sciences. To cite one historical example, when developing or evaluating crisis standards of care policies, ethicists are needed to provide expert consultation on questions such as whether it is fair to unilaterally withdraw life-sustaining treatment from a patient in order to make such treatment available for another patient during a surge, or whether certain conditions – e.g., cystic fibrosis – may be taken into account when triaging patients during a pandemic involving respiratory disease. Engaging these questions requires ethicists to be conversant not only with the ethical literature on distributive justice, utility, and double-effect but also property, disability, and even just war as evinced in the literature debating these topics. An additional

example that has emerged as a pressing post-pandemic problem is the trend of increased moral distress, moral injury, and burnout among health care professionals. While not a traditional focus of clinical ethics education, ethicists may be called on more frequently to attend to the social, emotional, and spiritual needs of providers through strategies like moral distress rounds, incident debriefings, and targeted ethics education. Finally, we have seen an increase in ethics consults related to safe discharge planning which reveals the many barriers that exist beyond the acute care setting, like a lack of post-acute care options, limited community resources, and financial constraints. Thus, ethicists must learn how to navigate not only the organizational systems that construct the health care institution, but also the larger social systems that construct the environment into which patients are discharged.

What are some gaps remaining after comprehensive ethics academic programs and fellowships?

Depending on how comprehensive a particular ethics academic program or clinical ethics fellowship is, gaps may persist at either the theoretical or practical levels. With respect to the theoretical level, even students who enter a doctoral program with a bachelor's or master's degree in philosophy, theology, or a social science discipline would benefit from greater interdisciplinary formation. Thus, the SLU doctoral program in health care ethics includes required courses in philosophical, religious, and interdisciplinary methodologies in order to provide a more well-rounded theoretical foundation, and dual-PhD degrees with philosophy or theology for those who seek more in-depth formation. At the practical level, skill development in communication techniques, conflict management/mediation, and pedagogy would enhance one's capacities as both an ethics consultant and educator; the SLU program provides formation in the last of these by providing students with opportunities to teach undergraduate courses. Finally, there is increasing awareness that clinical ethics intersects consistently with organizational ethics; thus, some of SLU's doctoral students have taken an elective in health administration. Given the constraints of a doctoral curriculum involving 36-48 credit-hours of coursework, addressing some of the more practical gaps would best fit within a fellowship curriculum, while the doctoral program maintains its primary focus on the theoretical dimension with baseline clinical ethics skills developed through a required practicum (150 hours) and an elective advanced practicum (300 hours).

What do you think of the practice of educated ethicists going into, sometimes immediately, other Catholic health care careers?

Those formed by SLU's doctoral program are for the most part oriented toward either an academic career track, a professional career as a health lawyer or physician, or a career as a clinical ethicist within a Catholic or secular health care setting. However, there are sometimes more employment opportunities available in complementary areas such as mission integration or, if they have the appropriate background, pastoral care. It is not evident whether those who enter into one of these alternative career tracks do so because they perceive it to be easier than working as a clinical ethicist, or whether it is the case that there is simply more demand for theologically-formed graduates in these areas. If, for example,

qualifying for an ethics position requires a postdoctoral fellowship or extensive clinical experience, whereas the requirements of a mission position are less demanding on the practical side and the applicant's theological formation is more pertinent, then the market will naturally shift in that direction. ✣

Clinical Ethics Fellowships

PREFACE

Historic developments are happening with the professionalization of the bioethics field. Hundreds of ethicists have health care ethics certification. Legendary bioethicist Ellen Fox introduces COPACET, the accreditation of clinical ethics fellowship programs, and differentiates accreditation from certification. Then, a workgroup emanating from the 2023 Catholic Healthcare Innovation in Ethics Forum (CHIEF) conference shares the resources they developed after nearly a year of meetings. Readers can use this to create or refine their own fellowships, hopefully, to become accredited later. In times of diminishing finances, accreditation represents a way to add financially efficient bench strength to clinical ethics programs.

COPACET AND THE FUTURE OF CLINICAL ETHICS ACCREDITATION

ELLEN FOX, MD, HEC-C
President
COPACET

Over the past two decades, clinical ethicists have become integral to healthcare teams across the United States and Canada. These professionals bring expertise in navigating complex ethical dilemmas, supporting patients, families, and clinical teams during moments of deep uncertainty. As this role has grown in visibility and importance, so too has the need for consistent, high-quality training for those entering the field.

That is the driving force behind **COPACET (the Council on Program Accreditation for Clinical Ethicist Training)**. This new nonprofit organization is dedicated to promoting ethics excellence in health care by developing an accreditation process for **Clinical Ethicist Training Programs (CETPs)**. COPACET was founded to help ensure that clinical ethicists are consistently well-prepared for their critical role in healthcare organizations, and well trained to practice with the competence, clarity, and compassion that high-stakes ethical situations demand.

WHY ACCREDITATION MATTERS

Unlike licensure, certification, and credentialing, which apply to individuals, accreditation applies to educational institutions and programs. The purpose of accreditation is twofold: to ensure quality and promote continuous improvement. For CETPs, accreditation represents a public commitment to high educational standards. For prospective trainees, it offers transparency and accountability. And for hospitals and health systems, it provides assurance that the clinical ethicists they employ have been trained to

nationally recognized standards.

This is especially important in a field where training varies widely. In a recent empirical study of CETPs, Fox and Wasserman[1] found significant differences across programs in many areas, including program goals, expectations, and core components. While variation may be expected in an evolving discipline, the lack of consistency poses real risks to care quality, workforce preparedness, and public trust. Recognizing these concerns, nearly 80% of CETP directors surveyed said they would likely seek accreditation if it were available.[2] COPACET is now making that possible.

By establishing clear expectations for program outcomes, COPACET seeks to improve the quality and consistency of CETPs and the availability of well-trained ethicists, thereby elevating clinical ethics across healthcare systems. For Catholic hospitals and other mission-driven organizations, this work builds on long-standing commitments to human dignity, compassionate care, and moral leadership. COPACET offers a path for religious and secular institutions alike to advance clinical ethics training nationally.

Importantly, COPACET's work also supports the Agency for Healthcare Research and Quality (AHRQ)'s vision for high-reliability healthcare – systems that consistently minimize harm while promoting safety, effectiveness, and responsiveness. By fostering shared standards, strengthening accountability, and embedding continuous learning into clinical ethics practice, accreditation reinforces the foundational elements of high-reliability organizations. In doing so, it helps ensure that clinical ethicists are prepared to contribute meaningfully to the broader pursuit of safe, effective, and trustworthy healthcare systems.

ACCREDITATION THAT SUPPORTS GROWTH AND SUSTAINABILITY

In addition to enhancing quality and consistency, COPACET accreditation offers an important **secondary benefit**: the potential for **federal reimbursement of training costs** by the Centers for Medicare and Medicaid Services (CMS).

Through what is known as "pass-through funding," CMS provides reimbursement to hospitals for the costs of operating approved clinical training programs in dozens of health professions—from nursing and pharmacy to chaplaincy and occupational therapy. Until now, CETPs have not qualified for this support because there has been no national accreditation mechanism available. COPACET aims to change that. Once CETPs are accredited based on COPACET standards, they will be eligible to apply for CMS pass-through funding under federal regulations (42 CFR § 413.85).

While funding is not the primary motivation for accreditation, it can significantly impact a hospital's ability to sustain and grow CETPs. For institutions that have long wanted to invest in ethics training but lacked resources, CMS funding could provide the means to do so—thereby helping to build a stronger pipeline of well-trained clinical ethicists.

FROM VISION TO INFRASTRUCTURE: COPACET'S RAPID PROGRESS

The idea for COPACET began to coalesce at the 2022 Clinical Ethics UnConference in Atlanta, where ten clinical ethicists formed a workgroup to explore the feasibility of accrediting CETPs. Over the following 18 months, the workgroup commissioned a study of CETPs in the U.S. and Canada, examined CMS funding eligibility, and explored potential accreditation pathways.

The workgroup ultimately partnered with the Commission on Accreditation of Allied Health Education Programs (CAAHEP), the nation's largest accreditor of healthcare training programs. CAAHEP oversees over 2,500 accredited programs in 32 health science fields, ranging from surgical technology to diagnostic medical sonography. By affiliating with CAAHEP, COPACET gained access to a well-established accreditation infrastructure with proven processes and external legitimacy.

Before applying to CAAHEP, the workgroup secured sponsorship from two national organizations: the Catholic Health Association (CHA) and the Association of Bioethics Program Directors (ABPD), bringing together both mission-based and scholarly leadership.

In early 2024, a Steering Committee developed COPACET's governance structure and selected its name—a nod to the word copacetic, which conveys that things are "as they should be." While COPACET's initial accreditation program will focus on clinical ethics fellowship programs, COPACET's name refers to CETPs more broadly (Council on Program Accreditation for Clinical Ethicist Training) since COPACET's accreditation program might someday expand to include other types of CETPs.

A national call for Board Member nominations yielded 38 exceptional candidates, of whom 13 were selected to serve. By the fall of 2024, COPACET had incorporated as a nonprofit public charity, gained CAAHEP approval as a Committee on Accreditation, and received 501(c)(3) recognition from the IRS.

BUILDING ACCREDITATION STANDARDS WITH THE FIELD, FOR THE FIELD

COPACET's work continues to progress quickly. At its inaugural Board meeting in January, three committees were launched:

- The **Curriculum Committee** is defining specific learning outcomes that all accredited clinical ethics fellowship programs will be required to meet.
- The **Policies and Procedures Committee** is drafting essential CAAHEP-required documents: accreditation standards and guidelines, program review policies, and a self-study template.
- The **Governance Committee** is focusing on financial sustainability, Board membership, and community engagement.

Stakeholder input has been a key part of this development process. COPACET has already conducted a series of focus groups with members of the clinical ethics community and released draft standards for public comment in October 2025.

WHAT WILL THE STANDARDS LOOK LIKE?

COPACET's standards must align with CAAHEP's required framework. This includes requirements for fair practices, outcome

measures, ethical standards, and program transparency. CETPs must also demonstrate that graduates achieve profession-specific learning outcomes, but programs will be free to determine how those outcomes are achieved. Instead of prescribing a rigid curriculum, COPACET standards will support curricular innovation, enabling programs to tailor their instructional methods to local strengths and resources.

COMPLEMENTARY TO THE HEC-C CREDENTIAL

Some may ask how COPACET accreditation relates to the **Healthcare Ethics Consultant-Certified (HEC-C)** program. In brief, the two are distinct but complementary.
The HEC-C program certifies individuals—specifically, it validates an individual's knowledge and skills in healthcare ethics consultation. Those who hold this credential are not necessarily professional clinical ethicists. Instead, they may be clinicians who serve on ethics consultation teams in a volunteer capacity, for whom clinical ethics is not their primary professional role.

COPACET, by contrast, accredits programs that specifically prepare trainees for a paid job as a clinical ethicist – a professional role with a scope of practice that extends far beyond ethics consultation. In addition to serving as an ethics consultant, the clinical ethicist serves as an ethics leader in a healthcare organization by, for example, assisting healthcare executives with organizational ethics issues, designing and delivering education for multiple healthcare audiences, developing and implementing clinical ethics policy, and carrying out systems-level ethics initiatives.

Together, HEC-C and COPACET provide complementary tools for strengthening the field—one by credentialing individuals in ethics consultation, the other by accrediting training programs that prepare trainees to be professional clinical ethicists.

SUPPORTING COPACET'S MISSION

COPACET has accomplished a great deal already by transforming a shared vision into an operational infrastructure with legal status, institutional backing, and a national platform. Now the real work begins: defining standards and designing and implementing the accreditation process.

On behalf of COPACET's Board of Directors, I invite you to contribute to this important new effort. During this critical formative phase, broad input and participation from the clinical ethics community will be vital to the initiative's success.

Establishing an accreditation process that is robust, evidence-based, fair, transparent, and stakeholder-informed will require countless hours of research, consultation, and collaboration from experts across the country. While our team is dedicated and passionate, the financial burden of this endeavor is significant. COPACET is currently tax-deductible donations from individuals and organizations to support its work. We also need volunteers to assist with our work, especially those who can help with administrative support, fundraising, and website design.

ADVANCING ETHICS IN HEALTHCARE, TOGETHER

COPACET is more than a new accreditation body. At its heart, it represents a shared commitment to excellence and accountability for the field of clinical ethics. Now is the time for educators, institutions, and ethics professionals to help position clinical ethics as a nationally recognized and rigorously trained profession. COPACET offers a unique and powerful opportunity to shape the future of clinical ethics—and health care delivery—for generations to come.

To find out more about how you can support COPACET, visit https://copacet.org or email us at support@copacet.org.

ENDNOTES

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Template Clinical Ethics Fellowship Curriculum

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Clinical ethics fellowship programs serve a key function in training ethicists. They provide unique opportunities for experiential learning from an experienced practitioner that complements academic coursework, similar to preceptorships or residencies in many other healthcare professions. However, there has been little work done to formalize the structure or expectations of what ethics fellowships offer. Ellen Fox describes some attempts at such formalization elsewhere in this issue. We offer here a template curriculum for clinical ethics fellowships as one more piece of this effort to provide more rigor in practical training for ethicists.

This project grew out of a workshop at the Catholic Healthcare Innovation in Ethics Forum (CHIEF) in 2023. Participants were divided into three breakout groups to brainstorm specific elements of a fellowship curriculum: key observational opportunities, essential literature, and professions to learn about. Over the next 9 months, we met every other week to flesh out the results of that workshop into a functional template curriculum.

Clinical ethics fellows in Catholic healthcare have opportunities to serve a range of communities and expand their ethical framework and toolkit. Catholic healthcare offers unique clinical ethics fellowship experiences because of its mission and identity. Mission and Catholic identity animate a distinctive type of calling and service. These fellows benefit from the unique vocation of Catholic healthcare, even if they are uncertain about staying in Catholic healthcare.
The Mission of Catholic healthcare is advanced by professionals of a diverse array of religious and faith backgrounds; it is ecumenical by nature. The communities served by many Catholic healthcare systems are pluralistic and often are not predominately Catholic. Those

who work in Catholic health care embrace and celebrate these differences, exemplified in part by Directive 11 of the Ethical and Religious Directives for Catholic Health Care Services (ERDs) about responding appropriately to persons' religious beliefs or affiliation. They also draw from the strengths of these diverse life experiences to further Catholic health care's commitment to promote and protect the dignity of all, especially the most vulnerable. Ethics fellows benefit from a focus on theological understanding of clinical ethics issues. Fellows can help make and draw out connections between faith traditions or provide alternative perspectives in the absence of faith traditions. Certainly, in maintaining its religious and moral commitments, Catholic healthcare benefits from having ethicists with both fellowship experience and academic training in theology and ethics who are already formed in the intellectual tradition. Secular health care systems also benefit from fellows formed in the Catholic tradition. As one in five Americans identify as Catholic, ethics fellows from Catholic healthcare are better equipped to respond to needs of Catholic patients, families, and clinicians.

Ethics seeks to identify, unpack, and navigate values. Ethicists in Catholic health care have additional layers of moral analysis to consider, given the theological and social commitments derived from Church teaching. Fellows in Catholic health care will become adept at applying the ERDs and other Catholic teaching to individual cases. Fellows will be required to learn the ethical standards of practice, general moral norms, relevant laws and regulations which would apply in any health care context. Most healthcare facilities are not academic medical centers, yet most clinical ethics fellowships currently exist in this setting. Catholic healthcare is more representative of the diversity of care settings across the care continuum, especially community hospitals, ambulatory care, and safety net healthcare settings. While the Ethics Consultant (EC) practitioners who designed ASBH's improvement projects generally work in large teaching hospitals with high-volume Ethics Consultation Services (ECSs) (Bruce et al. 2018; Fox 2016), most general hospitals in the U.S. are quite small (50.1% have <100 beds and 71.3% have <200 beds), have no academic affiliation (61.5% are nonteaching hospitals and only 6.1% are major teaching hospitals), and perform between zero and three ECs per year (Fox et al. 2021).

Catholic health care also provides a unique setting to train ethics fellows. Catholic health care goes beyond physiological treatment by treating the whole person, with mind-body-spirit care. It creates a welcoming environment that encourages employees to be their authentic selves, including their religious beliefs, and considers how one can maintain personal, professional, and organizational integrity. Fellows contribute to the mission, formation programs, and even assessment programs like the Ministry Identity Assessment from the Catholic Health Association, which has ethics components and is unique to Catholic healthcare. Given Catholic healthcare's commitments to the poor and underserved, fellows can better experience and engage with the needs of communities.

Finally, Catholic health care offers a formational opportunity to train ethicists through clinical ethics fellowships. This is a needed pipeline not only to help form ethicists

for Catholic healthcare, but also to train ethicists who might work outside Catholic healthcare to help them understand the important nuance that religious beliefs bring to medical decision making. Given the size of Catholic healthcare in the United States, there is also a potential for more fellowships than currently exist in primarily academic medical centers. Catholic health care has a great ability to contribute to this growing area of health care education.

This template is written as one example for fellowship programs to adapt as needed. Not all elements will apply to all fellowships, and not all suggestions will be feasible in all hospitals. More work also needs to be done in clinical ethics fellowships, in particular a formal assessment process to evaluate the progress of fellows towards functioning as independent ethicists after completion. We reference such an assessment but do not address it in detail as this project focused on the curriculum itself. Even still, we believe this template curriculum will help fellowship program directors in Catholic hospitals and non-Catholic hospitals as they create and revise their own curricula.

Purpose:

This one-year Clinical Ethics Fellowship is designed to provide fellows practical experience in daily clinical ethics work, including consultation services, ethics education, policy review, and ethics rounds. This program gives fellows exposure to clinical and organizational elements of healthcare. Fellows are expected to work collaboratively with Mission Integration and spiritual care while cultivating an understanding of Catholic healthcare.

Eligibility:

To be eligible to apply, prospective fellows must have a masters or doctorate degree in bioethics, theology, philosophy, or a related field.

Outcome:

The goal of the Clinical Ethics Fellowship is to provide the training and experience necessary to develop the knowledge, skills, ability, and character one should possess before entering the clinical ethics profession. Fellowship training will emphasize developing ethics consultation skills sufficient to perform independent clinical ethics consultation in acute care settings, with a focus on Catholic health care settings.

Competencies:

This fellowship is a competency-based program, organized around the following competencies:

- Knowledge
  - Be conversant in basic concepts in healthcare finance, reimbursement, and payer strategy
- Skills and Abilities
  - Consultation
  - Policy Development
  - Policy Review
- Character Development and Spiritual Formation
  - Leadership
  - Ways to integrate work as a clinical ethicist and prayer life
- Systems-Based Practice
- Education and Scholarship
- Presentation skills and engagement with the literature

Opportunities and Experiences:

Clinical

- Fellows will have exposure to and integration into clinical areas to understand how clinical care works and the ethics needs of patients, clinicians, and their families.
- The following areas are required for fellows to have exposure to. Each area can be done all at once (e.g. one week at a time) or periodically over the fellowship (one or two days a month or weekly rounds). If an area is not available at a hospital or health system, the fellow should spend time at another local hospital that offers the service.
    - Critical Care
    - Emergency department
    - Med-Surg
    - Cardiology
    - Oncology
    - Labor and delivery
    - NICU
    - Ambulatory care
    - Operating room
- The following areas are encouraged if available, but not required if unavailable.
    - Pediatrics
    - PICU
    - Behavioral health
    - Skilled nursing facility
    - Home health
    - Hospice
    - Palliative care
    - Transplant
    - Nephrology
    - Advance care planning
- In addition to clinical areas, fellows will shadow members of the following professions or roles for at least one day.
    - Case manager
    - Nurse (direct caregiver)
    - House supervisor
    - Social worker
    - Palliative care team
    - Chaplain
    - Physician
    - Medical resident

Organizational

- Fellows will have exposure to and integration into organizational areas to understand how healthcare leaders work and their ethics needs.
- The following areas and meetings are required for the fellow to attend.
    - Safety huddle (hospital wide)
    - Quality committee
    - Medical executive committee
- The following areas are encouraged if available, but not required if unavailable.
    - Schwartz rounds or similar event focusing on emotional support for clinicians
    - Leadership meeting with the Mission leader
    - IRB
    - Tumor board
    - Morbidity and mortality review
- Fellows will become familiar with the health system's discernment process and participate in a discernment process if available
- Fellows will earn how to cultivate relationships and when to contact key partner groups including: Mission integration, legal, risk management, patient experience, communications, etc.
- Fellows will have opportunities to become familiar with hospital operations and various leadership roles including the following.

- Shadow members of the following professions or roles as available.
  - COO
  - CMO
  - CNO
  - CFO
  - Director of case management
  - Nursing unit manager (critical care and med/surg)
  - Director of a service line such as cardiology, oncology, nephrology, etc.
  - Clinic director
  - Mission leader
- Conduct information interviews to get to know members of hospital senior leadership, their role, and how they
- Attend leadership meetings or create 1:1 opportunities to gain knowledge and familiarity with:
  - Basic concepts in healthcare finance, reimbursement, and payer strategy
    - For example, CHA's Mission Leader Seminar on Finance for Mission Leaders
  - Audits or reviews like TJC, internal ethics audits, CMS, or other regulatory agencies

- Fellows will get exposure to meeting with bishops or diocesan healthcare liaisons
- The fellow should attend meetings and shadow areas related to Mission Integration in order to be familiar with the work of a Mission leader. Examples may include:
  - Market or Region Mission Leadership meetings
  - Spiritual care rounds, including Clinical Pastoral Education (CPE) program verbatim if available
  - Formation sessions, if available
  - Community Health meetings to review the Community Health Needs Assessment (CHNA) and ongoing community health projects
  - Faith Community Nursing
  - Community Benefit program, if available

<u>Policies</u>

- The fellow will become familiar with policy review and development, including the following experiences:
  - Learn how to access policies
  - Assist in ongoing policy development and revisions:
    - Revising policies in light of individual cases
    - Conducting literature reviews to identify best practices and evolving policy standards
    - Identifying stakeholders and gathering stakeholder input/ feedback
    - Review, revise, edit, or develop at least one policy and shepherd it through the approval process.

<u>Ethics</u>

- Fellows will have exposure to clinical ethics experiences to develop and grow skills related to clinical ethics.
- The opportunities required for fellows include:
  - Clinical ethics consultation
    - The following definition of clinical ethics consultation is used for this document: "Clinical ethics consultation is a service provided in response to a question (or questions) from a patient, family

member, surrogate decision-maker, healthcare professional, administrator, or other involved party who seeks to resolve uncertainty or conflict regarding value-laden concerns." (Core Competencies, 2025, p 3-4)

- Observe at least 100 hours of consultation performed by an ethicist.
- Perform at least 100 hours of consultation while being observed by an ethicist.
- Perform at least 100 hours of consultation independently.
- At least 15 hours of consults in each category must include face to face interaction with a combination of the following in order to build and practice ethics facilitation skills: the patient, legally authorized decision maker, family members or loved ones, and the care team.
- Activities that count towards the required hours include: speaking to the person who requested the consult to clarify the request, speaking to members of the care team or other ethics colleagues about the consult, speaking to the patient or their family, meeting with stakeholders, searching the literature, reviewing the chart, and writing a note in the patient's chart.
    - If the volume of ethics consults does not allow for the number of hours to be met, it can be supplemented with palliative care family meetings.
- Participate in ethics on-call consultation service.
    - Consultation experience should vary by topic to include issues at the end of life, beginning of life, and in various departments and health disciplines.
    - Work with local ethicist on consultations regarding matters related to the ERDs, including
        - Identifying relevant Directives in particular consults
        - Discussing when the Directives might establish boundaries that may be different in non-Catholic hospitals
        - Demonstrating a working knowledge of how the Principle of Cooperation applies to commonly encountered issues
- Regularly attend Ethics Committee meetings
- Documentation
    - Grow from observing an ethicist document a consult in the patient's medical record, to writing a note after a consult to be reviewed with faculty and not placed in the patient's record, to documenting in the patient's record independently with later review by faculty.
    - Learn how to access and navigate the Electronic Medical Record (EMR)
    - Write one verbatim monthly from an ethics consultation or ICU rounds and debrief with faculty.
- Conduct ethics rounds together with hospital's primary ethicist or hospital leaders to identify potential ethics needs, and grow to be able to conduct ethics rounds independently
- Attend regular Ethics Leadership meetings
- Attend ongoing ethics education, such as

CHA webinars, external ethics education, or HEC-C training sessions
- Attend regular Ethics Committee meetings and grow to lead or co-plan one
- Regular meeting with VP of ethics or market ethics lead to debrief
- Participate in employee orientation and relevant orientation for new clinicians
- Work closely with Advance Care Planning Coordinator
- Prepare report and analysis on ethics metrics, especially related to consultation

Education

- Attend CHA Theology and Ethics Colloquium, CHA Assembly, or CHA Foundations for Ethicists
- Participate in monthly CHA Ethics Webinars
- Attend one clinical ethics conference
  - ASBH, CHIEF, APPE, Clinical Ethics Unconference, etc.
- Provide a presentation to faculty on a research paper or a topic from academic work
- Offer ethics education to a medical staff or department meeting
- Dedicate 5 hours weekly to personal research and writing for academic work, as applicable (Comprehensive Exams, Dissertation, Preparation for Ethics Consultation Certification by ASBH, etc.)

Scholarship

- Fellows will have opportunities to write and publish on topics related to clinical ethics
  - For fellows who are doctoral candidates, this could include flexibility for conducting dissertation work.

Assessment and Mentorship:

Faculty will use the following methods to assess the fellow's progress towards developing the five competencies described above. Assessments will occur periodically throughout the fellowship, including an initial and a final assessment.

- Routine one-on-one meetings with a faculty member to discuss:
  - Overall experience
  - Clinical ethics cases
  - Feedback on professional and interpersonal skills: composure, behavior, comportment, implicit bias, ability to develop and maintain relationships with colleagues, etc.
  - Any concerns or obstacles for the fellow to meet the expectations of a fellowship graduate should be surfaced early and directly to provide the fellow the best opportunity for growth
- Self-reflection and self-evaluation
  - This should be a somewhat formal or guided process to provide the fellow with a structure for continued reflection and self-care. For example, a fellowship program could adapt CHA's Mission Leader Examen to be used for ethicists. (Available at https://www.chausa.org/docs/default-source/prayers/cha_missionleaderexamen-8-5x11_hr.pdf?sfvrsn=f510cbf2_0)
- Documentation of activities regularly reviewed by preceptor/fellowship director
- Mentorship of clinical consultation skills by preceptors for clinical consultation skills, executive presence, leadership, and teaching abilities as well as feedback from the fellow

- Clinical ethics consultation skills will be assessed according to a formal set of criteria, for example ACES, Core Competencies, the literature, or a combination of these sources. A formal assessment of the fellow's progress will occur quarterly throughout the fellowship including at the end of the fellowship
    - Assess the ability to respond to and incorporate constructive feedback

APPENDIX 1: CORE KNOWLEDGE TOPICS

The following are core topics that clinical ethics fellowship programs should focus on for improving fellows' competency.

- End of life or severe/chronic illness issues
    - Proportionate and disproportionate means
    - Advance directives and advanced care planning
    - Brain death and working with Organ Procurement Organizations
    - Understanding palliative care and hospice
- Reproductive issues
    - Ectopic pregnancy debate (May vs Moraczewski)
    - Direct vs. indirect abortion and the principle of double effect
- Patient-provider relationship issues
    - Decision making capacity
    - Identifying the appropriate surrogate, including working knowledge of state law
    - Unrepresented patients
    - Informed consent
    - Shared decision making
    - Pediatric decision making; parental authority and limitations
    - General psychology around grief and trauma
- How healthcare works
    - The role of the Ethics Committee
    - Knowing what the role of ethics is and is not
    - Professional boundaries (when you stop and someone else takes over; when to escalate)
    - Basic understanding of hospital structure (e.g. Med Exec Committee)
    - Medical and nursing training; roles in the hospital; what is a med resident
    - Basic understanding of ethics codes in other disciplines
    - HIPAA
    - Policies and procedures – how to find existing policies, skills for writing policies
    - Knowledge of Joint Commission/ Regulatory
- Values integration
    - Catholic social teaching
    - Cooperation issues excluding M&A
- Clinical ethics facilitation skills and tools
    - Mediation skills (e.g. Nancy Dubler and Carol Liebman)
    - Strategies for difficult and complex conversations
    - Group facilitation skills
    - Meeting management for an EC
    - Moral distress and resilience
    - EMR Documentation
    - Common pedagogy for teaching ethics relative to setting and participants
    - Self-awareness of biases
- Vulnerable populations
    - Behavioral health
    - People who are incarcerated or formerly incarcerated

    - People experiencing homelessness
    - Minors
    - Unrepresented
    - Immigrants and persons who are undocumented
    - Self-pay, those without insurance
    - Cultural and religious issues
    - Common faith norms of religious and cultural groups.
- Research ethics
    - Research vs experimentation
    - Optimism bias
- Key legal cases
    - Dax Cowart
    - Henrietta Lacks
    - Nancy Cruzan
    - Jahi McMath
    - Other issues unique to the legal jurisdiction of the fellowship program
- Additional Topics

APPENDIX 2: LIST OF CURRICULUM DOCUMENTS

The following is a list of core articles and literature to review with clinical ethics fellows during their fellowship. These are the references that fellows would be expected to be generally familiar with, or would be helpful for faculty to refer to while teaching the core knowledge topics. A fellow would not necessarily be expected to thoroughly read every item on this list during the fellowship. This list is not comprehensive; other sources may be needed and used. They are grouped by category but are not listed in order of importance.

<u>Key articles and literature</u>

Magisterial Teaching

- *Ethical and Religious Directives for Catholic Healthcare Services* (ERDs), United States Conference of Catholic Bishops, 7th Edition, 2025.
- Address of His Holiness John Paul II to the Leaders in Catholic Health Care (September 14, 1987) in Phoenix
- Note on the Morality of Some Anti-Covid-19 Vaccines (December 21, 2020) Congregation for the Doctrine of the Faith
- *Dignitas personae* (June 20, 2008) Congregation for the Doctrine of the Faith
- Responses to Certain Questions of the United States Conference of Catholic Bishops concerning Artificial Nutrition and Hydration, with Commentary (August 1, 2007) Congregation for the Doctrine of the Faith
    - Congregation for the Doctrine of the Faith Commentary
- Address to the Participants in the International Congress on Life-Sustaining Treatments and the Vegetative State: Scientific Advances and Ethical Dilemmas (March 20, 2004) Pope John Paul II
- Address to the Eighteenth International Congress of the Transplantation Society (August 29, 2000) Pope John Paul II
- Moral Principles concerning Infants with Anencephaly (September 19, 1996) Committee on Doctrine National Conference of Catholic Bishops (U.S.)
- *Evangelium vitae, "The Gospel of Life,"* (March 25, 1995) Pope John Paul II
- Responses to Questions Proposed concerning "Uterine Isolation" and Related Matters (July 31, 1993) Congregation for the Doctrine of the Faith
- Nutrition and Hydration: Moral and Pastoral Reflections (1992) Committee for Pro-Life Activities National Conference of

Catholic Bishops (U.S.)

- *Donum vitae, Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation* (February 22, 1987) Congregation for the Doctrine of the Faith
- Declaration on Euthanasia (May 5, 1980) Congregation for the Doctrine of the Faith
- *Quaecumque sterilizatio, Responses on Sterilization in Catholic Hospitals* (March 13, 1975) Congregation for the Doctrine of the Faith
- Declaration on Procured Abortion (November 18, 1974) Congregation for the Doctrine of the Faith
- *Humanae vitae* (July 25, 1968) Pope Paul VI
- "The Prolongation of Life," Address to an International Congress of Anesthesiologists (November 24, 1957) Pope Pius XII
- *Dignitas infinita*, 2024 CDF
- *Samaritanus bonus*, 2020, CDF
- *Veritatis splendor*, Pope St. John Paul II
- USCCB Doctrinal Note on transgender issues
- The New Charter for Healthcare Workers, *Pontifical Council for Health Care Workers*, 2016

Catholic Bioethics

- Striving for Excellence in Ethics, *Catholic Health Association*, 2014.
- Pope Francis and the Transformation of Health Care Ethics
- Contemporary Catholic Health Care Ethics, 2nd edition
- Catholic Bioethics and the Gift of Human Life by William May
- Hamel, Ron. Early Pregnancy Complications and the ERDs. *Health Care Ethics USA*. 2014, 22:1.
- Lysaught, M. Therese. Respect: Or, How Respect for Persons Became Respect for Autonomy. *Journal of Medicine and Philosophy*. 2006, 29:6.
- Moraczewski, Albert. Ectopic Pregnancy Revisited. *Ethics & Medics,* 1998, 23:3.
- Derse, Arthur R., David Schiedermayer. Practical Ethics for Students, Interns, and Residents. 4th edition, 2017.
- Family dynamics – L. Maitland, "Taking Families Seriously in Patient Care," Trinity Health Ethics Institute, 2012, available because of permission from Trinity Health and L. Maitland's next-of-kin; Psychology Today Staff, "Understanding Family Dynamics," available at https://www.psychologytoday.com/us/basics/family-dynamics.
- Negotiation literature (in addition to Getting to Yes) – D. Shapiro, *Negotiating the Nonnegotiable*, reprint ed., New York, NY: Penguin Books, 2017; C. Voss, *Never Split the Difference: Negotiating as if Your Life Depended on It,* Harper Business, 2016; S. Finder and M. Bilton, eds., *Peer Review, Peer Education, and Modeling in the Practice of Clinical Ethics Consultation: The Zadeh Project*, Springer Cham, 2018.
- Health care continuum of care, finance, and operations – sources (an operations coach?) L. Shi and D. Singh, *Delivering Health Care in America*, 8th ed., Burlington, MA: Jones & Bartlett Learning, 2022; E. Askin and N. Moore, *The Health Care Handbook: A Clear and Concise Guide to the United States Health Care System*, St. Louis, MO: Washington University in St. Louis, 2012; R. Pearl, *Uncaring: How the Culture of Medicine Kills Doctors & Patients*, New York, NY: PublicAffairs, 2021; J. Wolff, *Ethics and Public Policy: A Philosophical Inquiry*,

2nd ed., New York, NY: Routledge, 2020.

- J. Glaser, "Catholic Health Ministry: Fruit on the Diseased Tree of U.S. Health Care," *Health Care Ethics USA* 15, no. 1.
- M. McDonough, *Can a Health Care Market be Moral? A Catholic Vision*, Washington, D.C.: Georgetown University Press, 2007
- J. Renken, *Church Property: A Commentary on Canon Law Governing Temporal Goods in the United States and Canada*, Staten Island, NY: Alba Hourse, 2009.
- Moral distress and moral injury – C. Rushton, *Moral Resilience: Transforming Moral Suffering in Healthcare*, New York, NY: Oxford University Press, 2018; E. Nagoski and A. Nagoski, *Burnout – The Secret to Unlocking the Stress Cycle*, New York, NY: Ballantine Books, 2019.
- Leadership and leadership training – R. Jones, "The Family Dynamics We Grew Up with Shape How We Work," Harvard Business Review, available at https://hbr.org/2016/07/the-family-dynamics-we-grew-up-with-shape-how-we-work.
- Organizational ethics (business ethics) – K. Goodpaster, "Business Ethics and Stakeholder Analysis," *Business Ethics Quarterly* 1, no. 1; G. Magill, "Organizational Ethics in Catholic Health Care: Honoring Stewardship and the Work Environment," *Christian Bioethics* 7, no.1; Markkula Center for Applied Ethics at Santa Clara University, Business and Organizational Ethics webpage, available at https://www.scu.edu/ethics/focus-areas/business-ethics/resources/articles/.
- Organizational dynamics, politics, and behaviors – GreggU, "Organizational Behavior," YouTube, available at https://youtu.be/QJAv6674_Sw?si=NzHLDFBpYq0ldS-P; GreggU, "Organizational Dynamics and Behavior," YouTube, available at https://youtu.be/AU1PMNPy_vI?si=IP2JEIkYHeGe3TtR;
- Basic medical terms and language – American Institute of Medical Science and Education, "All Essential Medical Terms in One Place," 2022, available at https://aimseducation.edu/blog/all-essential-medical-terms; Harvard Medical School, "Medical Dictionary of Health Terms," 2011, available at https://www.health.harvard.edu/a-through-c; St. George's University School of Medicine, "75 Must-Know Medical Terms, Abbreviations, and Acronyms," 2021, available at https://www.sgu.edu/blog/medical/medical-terms-abbreviations-and-acronyms/.
- Whom is responsible for what? – (Covered in *The Health Care Handbook*)
- Public speaking, education, and adult learning – BrightMorning, "The Principles of Adult Learning," available at https://brightmorningteam.com/wp-content/uploads/2019/08/Principles-of-Adult-Learning.pdf; Cornerstones Education Limited, "The Six Steps of Curriculum Design," infographic, available at https://cornerstones--live.s3.eu-west-2.amazonaws.com/uploads/2021/07/19092736/The-six-steps-of-curriculum-design-ENGLAND-UPDATED-JUL21-2.pdf; C. Gallo, Talk Like TED – *The 9 Public-Speaking Secrets of the World's Top Minds*, New York, NY: St. Martin's Press, 2014; M. North, "10 Tips for Improving Your Public Speaking Skills," Professional Development, Harvard Division of Continuing Education, 2020, available at https://professional.dce.harvard.edu/blog/10-tips-for-improving-your-public-speaking-skills/; J. Stark and L.

Lattuca, "Academic Plan," diagram.
- Tourism Academy, "Adult Learning Realities: An Infographic," available at https://blog.tourismacademy.org/infographic-the-reality-of-adult-learning; Western Governors University, "10 Simple Principles of Adult Learning," 2020, available at https://www.wgu.edu/blog/adult-learning-theories-principles2004.html#close.
- Other modes (podcasts, TED talks, online training) – "W;t" movie; MasterClass "Organizational Ethics: Examples of Ethical Business Practices," available at https://www.masterclass.com/articles/organizational-ethics.
- A work that describes the heritage and founding of Catholic healthcare in the US, either one that is unique to the founding congregation(s) of the health system or one that discusses Catholic healthcare in general, for example
  - Mann-Wall, Barbra. Unlikely Entrepreneurs: Catholic Sister and the Hospital Marketplace, *Catholic Health Association*, 2021.
  - Williams, Shannon Dee. Subversive Habits: Black Catholic Nuns in the Long African American Freedom Struggle, *Duke University Press Books*, 2022.
  - Farren, Suzy. A Call to Care: The Women Who Build Catholic Healthcare in America, *Catholic Health Association,* 1996.
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- K. O'Rourke, T. Kopfensteiner, and R. Hamel. "A Brief History – A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services," *Health Progress* 82, no. 6.

Intro to Clinical Ethics

- Fletcher's *Introduction to Clinical Ethics*, 3rd edition
- A. Derse and D. Schiedermayer. *Practical Ethics for Students, Interns, and Residents: A Short Reference Manual*, 4th ed., Hagerstown, MD: University Publishing Group, 2017.
- Resolving Ethical Dilemmas: A Guide for Clinicians, 5th edition
- Addressing Patient-Centered Ethical Issues in Health Care: A Case-Based Study Guide
- *Improving Competencies in Clinical Ethics Consultation: An Education Guide*, 2nd edition
- *Core Competencies for Healthcare Ethics*, 2nd edition
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- Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants (5 pages)
- The Zadeh Project – A Clinical Ethics Consultation Narrative: The Zadeh

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- The Zadeh Project – A Frame for Understanding the Generative Ideas, Formation, and Design (p 1-15) (15 pages)
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Ethics Education in the Field with Clinicians

Ethics issues and consultations often include multiple steps to resolve the issue. In the first article, Kelly Stuart brings attention to an underemphasized process in ethics consultation and education – coaching. Next, Paul Wagle introduces an Ascension Health ethics education initiative focused on behavioral health. Their descriptions of both the coaching mode and behavioral health content (and process) make them easily replicable.

The third and fourth articles detail education piloted to nurses. Jason Lesandrini and David Reis present an ethics program made for nurse managers at Wellstar. Finally, one academic plan has been used by at least four health care systems in different ways and with different professionals. Readers can either use it verbatim or continue to adapt it in ways that serve a system best. For instance, it is short enough that it could be a part of a morning huddle, announcements, or as an extension to a reflection.

Next, Kelly Turner describes an academic plan has been used by at least four health care systems in different ways and with different professionals. Readers can either use it verbatim or continue to adapt it in ways that serve a system best. For instance, it is short enough that it could be a part of a morning huddle, announcements, or as an extension to a reflection. Lastly, Becket Gremmels and Kristine Ehlert describe a virtual ethics education program designed to teach volunteer ethics consultants skills related to mediation and clinical ethics consultation

EXECUTIVE COACHING IN ETHICS CONSULTATION AND EDUCATION

KELLY STUART, MD, HEC-C

Current work on developing standards for accreditation of ethics fellowships prompts consideration of what to include and how to provide comprehensive education and development. When I transitioned from clinical work as a neonatologist to full-time ethics work in 2010, I soon realized that understanding and articulating ethical principles and medical standards, as well as leading clinical consultation processes, even after practicing medicine for many years, only took me so far. Most ethical dilemmas do not require consultation; the issues are effectively addressed by patients, caregivers, and clinicians within the therapeutic relationship, as health care professionals generally possess the basic skills, knowledge, and experience to resolve them and move forward.

The cases escalated to ethics consultation are almost never purely ethical and medical at the patient care level; rather, they often include additional complex components related to

resources, health disparities, trust, statutory and regulatory limitations, litigation risk, social circumstances, mental illness, etc., that persist even when the best (or least bad) options that align with patient values are identified. Helping stakeholders to achieve sufficient alignment to move forward is challenging in our evolving American health system, and "teaching" the skills required for this work requires a multimodal approach. Advanced degrees, clinical training, and experience only go so far partly because these cases require many areas of expertise and partly because they raise difficult social questions that ethics consultation cannot "fix." Even identifying and focusing on the ethical question or concern can be a challenge.

That is why I decided to pursue formal studies in negotiation and conflict resolution (NCR), and this course of study introduced me to executive coaching. I decided to learn more through executive coaching certification so I could help health care professionals use their expertise more effectively. Along the way I have discovered that comprehensive ethics services that include coaching methodologies may do more to further ethics education and professional development than simply giving recommendations. In addition, a coaching approach may achieve professional development goals for both teams and individuals.

Executive coaching literature is plentiful in the business realm, but there is less written about coaching in ethics consultation. Kockler and Dirksen translated American Society for Bioethics and Humanities (ASBH) ethics consultation competencies into coaching competencies and applied this work to a case involving informed consent and decisional capacity.[1] Although the competencies the authors created do not all directly correlate to International Coaching Federation (ICF) core competencies, their insightful bridging of ethics consultation competencies and coaching can be applied directly to clinical cases and fellow training, and it supports the notion that ethics education should include professional development using coaching strategies.[2] Benoit (Belgium) and Rose (USA) also affirm that clinicians respond well to coaching aimed at increasing participation in advance care planning, although their coaching strategies are less clear.[3] This makes sense since coaching deliberately acknowledges the skills and knowledge of the person being coached; it is more collegial and less hierarchical than simply advising.

Coaching is substantively different from didactic teaching and clinical training experiences. Coaches assume the basic ability and knowledge to perform are already present and require further cultivation. Coaching swimming is technically different from teaching a person to swim. A person who cannot swim might easily drown - that person is not safe in the water and needs to learn basic skills - but coaching swimming helps the athlete improve their efficiency by increasing awareness of their own form and refining it with intentional adjustments, practice, and strength training. Coaching team sports adds a level of complexity because achieving success requires the team to work as a unit and to trust in each other's abilities.

The same is true in ethics work. Coaching in the ethics realm assumes that health care professionals are already reasonably familiar with basic ethical principles and moral

deliberation, and they have specific clinical skills and good intentions. Clinicians may also have a significant amount of experience and know what works in practice. This acknowledgement of existing ethical and clinical knowledge and experience may enhance an atmosphere of mutual respect and make clinicians more receptive to ethics services.

Coaching is also different from mentoring. A mentor can certainly move into coaching mode in the moment, but mentoring involves a long-term relationship in which a person learns by example and good counsel. Mentors are frequently in the same or similar field of work as the mentee, and their professional position is often aspirational for the mentee. Mentors give direct advice and help to prime professional pathways for advancement through personal recommendations and networking. With coaching, advice is best kept infrequent and based in broad truths rather than specific decisions, and the coach may or may not interact within the client's professional circles. Coaching is focused on specific areas of improvement. Most significantly, executive coaches ask questions and provide tools that invite the person being coached to create their own improvement path. So mentors might take a coaching approach in the moment, but mentoring is a more comprehensive relationship and commitment.

Advantages of incorporating coaching modalities into fellowship training and consultation services include promoting a culture of ethical engagement, supporting clinical teams in addressing ethical concerns independently, and resource stewardship. In circumstances where ethics consultation resources are spread across multiple sites, empowering clinicians to address immediate concerns is important. In addition, in cases where the patient-professional relationship has broken down, introducing another professional may be risky. In non-health-care settings, downstream developmental effects of executive coaching include better leadership abilities, confidence, and work satisfaction - all current focus areas in health care.[4]

Case: A 61-year-old man with cognitive impairment from childhood sustained a traumatic upper extremity fracture requiring open reduction and internal fixation. His guardian would not permit any post-operative pain medications, including acetaminophen or ibuprofen. The clinical team consulted ethics, and the response was timely, collaborative, and ethically thorough, but it was ineffective in that the guardian was permitted to deny the medications for more than two days because of legal constraints. This case caused moral distress for providers, and the patient endured significant pain according to nursing assessment. The clinical team and the ethics consultant felt that the guardian should not have been permitted to deny pain medications and requested a case review.

In addition to pertinent questions related to the guardian's reasons for denying pain medications, some coaching questions for both the ethics consultant and the medical team to answer are:

1. How is pain management different from other surrogate decision making?
2. How is this patient's vulnerability a factor in our response to his pain?
3. What are the standards of care for pain treatment in this clinical circumstance?

4. What are the legal and ethical obligations of a surrogate decision maker, in this case a guardian, to permit pain assessment and treatment?
5. What are the moral, legal, and regulatory requirements of the caregivers?

Further coaching involved organizational change that the ethics consultant could lead:

1. If organizational change is warranted, what is the best vehicle and level for change (e.g., system policy or guidelines; educational case conference)?
2. Who participated in the initial decision making, and what other stakeholders should be included?
3. What evidence will be required to influence leadership that surrogate decision making should be limited in this case?
4. What is our obligation as a ministry of the Catholic Church?
5. How can we minimize organizational risk if we override a guardian's decision?

The questions sometimes seem obvious to experienced ethicists, but it can be difficult for care teams and inexperienced ethics consultants to formulate them in the moment. A disciplined coach will ask the questions and leave the consultant and medical team to provide the answers, and raise additional questions, with support and guidance. This case presented an opportunity to demonstrate to the care team that advocating for patients by raising ethical concerns and collaborating with the ethics consultant can lead to better care for future patients. It also presented an opportunity for the consultant to navigate organizational change with executives and clinical leaders. Following the case, the ethics consultant achieved organizational change in two system policies and collaborated with clinicians in a case conference.

There are limitations in coaching. First, not everyone is coachable. Accepting coaching requires maturity and openness to change. Second, "there is an important distinction between providing general education or coaching about communication principles and giving specific advice about a particular patient that may lead to important decisions about that patient's medical care."[5] Although there can usually be coaching components to consultation, it is important to complete the consultation process, including documentation, when specific recommendations and follow up are warranted. Some may be concerned that ethics consultation numbers may fall off if coaching is an accepted modality, but that seems unlikely since consultant engagement usually increases consult numbers overall, and few consults can be satisfied with coaching alone.

Incorporating coaching modalities into ethics training and consultation is a simple strategy for developing and engaging clinicians and consultants. It has potential for great benefit in both clinical and organizational ethics work. For more information about executive coaching training, see the Center for Executive Coaching.[6]

BRIDGING THE GAP: BEHAVIORAL HEALTH ETHICS EDUCATION IN CATHOLIC HEALTHCARE

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Why Ethics Education in Behavioral Health Matters Now

In 2023, the nonprofit Mental Health America ranked my home state of Kansas dead last—51st out of 51 states and territories—for both mental health and access to care.[7] While the state rose to 22nd in the 2024 report, the statistics remain sobering: nearly one in four Kansas adults reported a mental illness, and over 30,000 children disclosed serious suicidal thoughts.[8] Nationally, more than 3 million children in 2024 alone went without needed mental health treatment.[9]
For Catholic healthcare, called to serve the most vulnerable, these numbers are not just statistics—they are a call to action. Behavioral health is ethically complex terrain where neurochemical imbalances meet structural injustice, stigma, and profound human suffering. These situations demand careful moral discernment.

Recognizing this gap, Ascension launched an ethics education initiative focused on behavioral health. What began as a response to pressing clinical concerns has grown into an interdisciplinary, Mission-driven model equipping providers across specialties to serve patients with behavioral health complexities. Here is how it came to be, how it functions, and how it is shaping both our care for vulnerable patients and our growth as clinicians and ethicists.

Recognizing the Ethical Gaps

This program aimed to equip all clinicians—not just those in behavioral health units—to navigate daunting ethical challenges and extend the compassion of our faith-based Mission to patients who suffer from a behavioral health diagnosis. Grounded in Directive 3 in the Ethical and Religious Directives (ERDs), which calls Catholic healthcare to distinguish itself by care for people with mental and physical disabilities, this initiative addresses a population historically marginalized. These moments ask: What do we owe our patients, especially those whose struggles defy easy understanding?

Beyond individual cases, systemic challenges have historically neglected behavioral health care. From underfunded institutions to societal stigma that isolates patients, those with mental illness have too often been treated in ways that fail to honor their dignity—such as being denied the resources and care they deserve. Catholic social teaching calls us to solidarity with these marginalized groups, affirming their inherent worth and demanding systemic reform. This initiative responds directly to these structural injustices, striving to cultivate an ethical culture that resists discrimination and advances justice.

What It Looks Like in Practice

The behavioral health ethics initiative was designed as a quarterly, system-wide webinar series, co-led by behavioral health and ethics leaders and open to all Ascension associates across the county. Each session was offered live, then recorded and made available as an enduring continuing education module through our Interprofessional Continuing

Education (IPCE) platform. While some attendees registered for CE credit, many more accessed the sessions without formal registration—highlighting the widespread hunger for support in this area.

Our steering committee—social workers, counselors, nurse leaders—began not with preaching but with listening. The first sessions were grounded in real consultations I had encountered, which I brought to the committee to compare against their lived experiences. Rather than starting with textbook ethics cases, we drew on the lived experiences of clinicians facing these challenges daily—spanning inpatient, outpatient, emergency and critical care settings.

To gather broader input, we created a Google form that was disseminated throughout the healthcare system. The form provided background framing and asked clinicians what ethical topics were most relevant to them when caring for patients with behavioral health and substance needs. The open-ended responses gave us a rich understanding of the ethical pressure points clinicians experience, and shaped both content and delivery.

This program's scope was intentionally wide. While many assumed it was only for psychiatric units, we emphasized that behavioral health touches every clinical setting—from med-surge and ICU to ambulatory clinics and social services. For example, the session on Scarce Resources explored moral obligations when community mental health resources are scarce, invoking the Catholic principles of stewardship and just distribution.

Each session included polls, moderated chat, and interactive segments to invite participation. Presenter selection was key: we sought individuals with lived expertise who could speak to complexity, nuance and Mission. These voices became ethical witnesses, drawing others into deeper discernment.

Topics to date have included:

- Understanding Suicide and Suicidal Ideation
- Addressing the Stigma Surrounding Mental Health and Substance Use
- Decision-Making Capacity - Increasing Awareness and Improving Evaluation
- Legal, Clinical, Risk and Ethical Dimensions of Involuntary Committals and Holds
- Safe Discharge Planning and Scarce Resources

What We've Learned Data and Transformation

Over 1,000 clinicians have engaged with these sessions, half attending live and half completing enduring modules. The results are compelling:

- **High satisfaction:** 70–80% of participants rated sessions as "Excellent," with nearly 100% saying objectives were met and content was free of bias.
- **Commitment to change:** Over 80% pledged concrete practice changes. The top areas include:
  - Clinical communication (20–22%)
  - Safety (25%)
  - Teamwork and roles (16%)
  - Diagnosis and screening improvements (up to 15% in live sessions)
- **Confidence:** Participants reported average confidence scores of 8–9/10, with over 40% rating 10/10 in their ability to implement

changes.

- **Knowledge sharing:** ~50% shared learnings with teams, influencing entire care units.
- **Barriers:** 50–70% reported no barriers to applying changes; others cited organizational constraints, time, or resource limitations.

Qualitative feedback tells the human story:

"I changed my discharge planning to honor patient self-determination."

"I finally understand the difference between capacity and competency—it's transforming our assessments."

This is not abstract ethics; it is incarnational. It forms clinicians who navigate foggy, high-stakes decisions with courage and compassion.

A Model for Vulnerability-Informed Ethics Education

Though this webinar series sunsets in 2025, the model it established endures as both relevant and replicable. The recorded sessions remain available through IPCE, offering ongoing education well beyond the original events. More importantly, the principles it embodied provide a roadmap for similar efforts elsewhere. The initiative was built on four key strategies:

1. **Listen to front-line associates** – Ethics education must begin with the real questions clinicians are wrestling with. By asking rather than assuming, we built relevance, trust, and genuine engagement.
2. **Balance legal realities with ethical education** – While behavioral health laws very by jurisdiction, core Catholic commitments—human dignity, subsidiarity, and common good—transcend these boundaries. We framed sessions in a way that respected compliance while also cultivating moral understanding.
3. **Empower passionate leaders** – This initiative thrived because we entrusted clinicians to co-lead. Their credibility and energy gave the content life and sustained participation.
4. **Position the ethicist as guide on side** – The most powerful moments arose from clinicians' lived experiences. The ethicist's task was not to dominate but to frame those stories through ethical lenses, making intentional connections that highlighted their deeper moral dimensions.

This model reflects a spirituality of accompaniment: we do not merely educate about ethics—we walk with clinicians in the ambiguity of care. Done well, this work does more than shape decisions; it forms consciences, cultivates virtue, and reshapes the culture of caring.

Conclusion

This did not start with strategy decks. It started with a moral wound that could no longer be ignored.

Directive 3 in the ERDs and Ascension's Mission call us to accompany the marginalized. As I reflected on Luke 10:25–37—the Sunday gospel reading shortly after I was invited to write this piece—I was reminded of the Good Samaritan's call to be a neighbor to those on the margins. Behavioral health ethics education is one small step toward living out that call in shared solidarity.

Ethics education in Catholic healthcare must be more than theoretical. It must ask: Are we walking by the wounded traveler, or are we stopping to serve? This initiative shows what can happen when we choose to stop and serve: clinicians are equipped, patients are safer, and our shared Mission is brought to life—with courage, competence, and compassion.

BUILDING ETHICAL COMPETENCE: WHY NURSING LEADERS NEED TAILORED ETHICS EDUCATION

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In today's complex healthcare environment, nursing leaders face unique ethical challenges that require specialized knowledge and skills. The intersection of clinical care, leadership responsibilities, and organizational dynamics creates a distinct ethical landscape that traditional ethics training often fails to address adequately.

At Wellstar Health System, we recognized this gap and developed a targeted ethics education program specifically for nursing leaders. Our approach was shaped by two key insights: the ethical patterns we saw in our consultation data and the absence of others we expected to find. In clinical ethics, absence is not necessarily a good thing. A former mentor of one of the authors, once shared the idea that "the lack of data can mean a lot of things," e.g., that there are not really ethics issues present or that there may be other challenges: normalization of acceptance of ethical challenges, barriers to speaking up, or general lack of moral awareness.

Learning from What We See and What We Do Not

Ethics consultation services provide valuable windows into the ethical challenges that reach a critical threshold within healthcare organizations. Our analysis of ethics consultation patterns helped identify prevalent ethical issues encountered by nursing leadership teams, from surrogate decision-making to navigating complex discharge scenarios.

However, equally revealing were the ethical issues that rarely or never appeared in our consultation data. This absence does not indicate these challenges do not exist—rather, it suggests they may be normalized, unrecognized, or addressed through other channels. It is often what we do not see in the ethics consultation service that should worry us most. These blind spots might include subtle power dynamics, slow ethical drift in organizational culture, or systemic inequities that become invisible through familiarity. Our program was designed to address both the visible ethical challenges and these hidden dimensions of ethical leadership.

To address these visible and hidden issues, we created a 6-week program for assistant nurse managers and above to bring awareness to key ethical issues. Unlike ethics education for frontline nurses, which often focuses

primarily on patient care dilemmas, our nursing leadership curriculum incorporated elements of ethical culture and ethical leadership. For example, the program includes sessions on moral distress, ethical leadership, obligations to ourselves, and bedside clinical ethics topics of forced treatment and combative patients, end-of-life care, surrogate decision-making, and against medical advice (AMA) discharges. Our hope is that after this initial roll out we can take the education system wide and involve all nurse leaders.

Addressing Moral Injury and Professional Suffering

One of the most urgent drivers for specialized ethics education is the widespread experience of moral distress among healthcare professionals. Further complicating this issue is that nursing leaders must not only navigate their own moral distress but also support team members experiencing ethical challenges.

Our program equipped nursing leaders with core knowledge to improve understanding and identification of ethical issues either they or their teams may encounter.

Furthermore, we provided specific education on the impact these ethical challenges have on individuals and the unit with a focus on creating psychologically safe environments where team members can voice ethical questions. Understanding the time constraints facing nursing leaders, we designed our program to integrate into existing team meetings rather than adding additional commitments. Each 45-minute session is focused on practical application rather than abstract theory, making ethics education accessible and immediately relevant.

From Individual Skills to System-Wide Culture

Ultimately, our goal is not just to enhance individual ethical competence, but to build "a system-wide culture of ethical practice." By equipping nursing leaders with both ethical awareness capabilities and methods for resolution, we aimed to create a ripple effect throughout the organization. As healthcare continues to face unprecedented challenges, investing in the ethical formation of nursing leaders represents a vital strategy for supporting clinical teams, improving patient care, and building resilient, values-driven organizations.

DEVELOPING AND DELIVERING STAT EDUCATION FOR SSM NURSES

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While working as an Ethics Graduate Assistant in the Mission Integration department at SSM Health, I took an existing design for hospital ethics education (STAT from CHRISTUS Health), developed modules for SSM, and then piloted one at a community hospital for my practicum project. The long-term goal of this project is to implement STAT modules as an available ethics education format for SSM Mission leaders and Ethics Committee members; however, I will focus on the justification for, process of, and experience with developing a pilot STAT at SSM here.

Choice of STAT for Ethics Education at SSM

The idea for this project began with identifying a general gap within SSM Health's ethics educational programs. Little, if any, in-person, on-location (hospital floors) ethics education occurs for healthcare providers at SSM hospitals who are not Ethics Committee members.

Thus, there is a need for it, which would also increase the visibility of our ethics committees, the ethics consultation process, and existing ethics educational resources for interested SSM clinicians. Fortunately, the SSM SVP of Mission & Ethics shared a recent presentation he had seen at the Catholic Healthcare Innovation in Ethics Forum (CHIEF) conference, delivered by Steven Squires: a short, 5–10-minute ethics education called STAT (Short, Timely, Applicable, Team-based) that had been piloted at nursing huddles.

STAT is intended to be delivered verbally, in small teams, and cover a very narrow topic or situation relevant to ethics or commonly encountered in ethics consults. The format is simple: (1) three to five most important points about a topic, (2) a short, typically paragraph length, case study that sets up a related problem, (3) three to five questions that facilitate case discussion and underscore the points to remember, and (4) three to five resources available to participants for further learning on the topic (e.g. publicly available or accessible educational resources, such as organizational policies). The content fits onto one page, is easily adaptable for a range of topics, and non-experts can deliver it with minimal training (at CHRISTUS Health, chaplains frequently delivered STAT on the hospital floors).

These features of accessibility, adaptability, and brevity made the STAT method particularly appealing for on-the-ground education and optimal for frontline healthcare workers. Steven developed STAT in response to feedback from clinicians. He had found that his colleagues responded positively to a) concrete ethics problems they encountered in their daily work and b) case discussions. Clinicians tended to learn better when content was brief and in their own setting. Since STAT seemed suitable for SSM's ethics education needs, I developed STAT modules for SSM (with permission), based on the skeleton template.

Creation of STAT modules for SSM

I chose the topic of surrogate decision-making for a pilot STAT module, based on frequently occurring ethics issues in ethics consults at the selected hospitals. Nurses frequently encounter this topic, and clinicians often have misconceptions about it. For instance, some believe that Missouri has a surrogate decision-making hierarchy of family members like other states. Moreover, the applicable policy would pertain to any of SSM's Missouri-based hospitals ("Missouri-Advance Directive"), including the three hospitals identified for the pilot.

With the chosen topic, I drafted the first STAT after reviewing the recent ethics consult logs for these cases and trying to anticipate frequent questions or points of confusion on this topic from providers. The most common iteration was when multiple family members were involved in a patient's care and disagreed about the treatment plan. A common situation involved one or two family members disagreeing about transitioning to

comfort care or stabilizing a patient in critical condition, often with significant neurological damage. I crafted the module after deciding on the specific scenario ("surrogate disagreements about patient care decisions") and the paradigm case of three adult children debating tracheostomy and PEG tube placement for their mother after her stroke.

I worked backwards to determine the three to five specific points that the nurses would need to know for approaching similar cases:

- The name and significance of the legal document designating a specific surrogate (dHPOA document or advance directive),
- The preference for mediation and, ideally, gaining consensus from all the surrogates,
- That close friends of the patient can be involved in decision-making, which may be preferable over distant relatives if they know the patient's treatment preferences better, and
- The clinical team could designate a surrogate based on assessing the person who knows the patient's wishes best as a last resort, should the decision-makers' conflict be truly intractable.

My case study questions encouraged participants to directly apply any of the four points to reinforce the material:

- 'What would be your first step to address the conflict?' - was aimed at addressing the first and second points (appropriate responses would be to look for an advance directive and/or to attempt to gain consensus among the patient's adult children)
- 'What questions would you ask the adult children?' and 'When family members are making decisions on behalf of patients, what considerations should guide those decisions?' - were aimed at addressing the 'substituted judgment standard' considerations embedded in my third and fourth points to remember.

I provided the following resources for the participants:

- A webpage on 'Advance Directives and Surrogate Decision Making' from the Missouri University School of Medicine, which provided detailed advance directive and surrogate decision-making standards (known wishes, substituted judgment, best interests) information in accessible language
- The publicly available State of Missouri health care power of attorney, or dHPOA, document template, which I chose for two reasons: to show nurses what these documents looked like, and because they were likely to come across one of these completed documents
- SSM's regional policy on Advance Directives, to provide a policy reference for nurses should they need it when either interacting with other clinicians or with family members.

Once this first STAT was drafted, I wrote more two modules to showcase a few different topics and prove that the format was adaptable to different scenarios.

Partnering with SSM Stakeholders and Piloting the Education

With the modules complete, I decided which of SSM's three community hospitals would be

best for piloting STAT, based on the hospitals in which there was access to nursing huddles, interest in ethics education, and investment in continuing the education. A nursing director at St. Joseph's-Lake St. Louis (SJ-LSL), who also chairs the ethics committees at SJ-LSL and SJ-SC, volunteered to help locally. She loved the idea of STAT, and we decided that SJ-LSL was a particularly good hospital at which to pilot STAT given her position there and the fact that many of their ethics consults are placed by nurses.

Before the nursing director and I planned the pilot SJ-LSL, we ironed out a few logistical details. We wanted to make sure that the nurses would have access to the STAT module handout after we did the education, but worried that handing out pieces of paper was not the most effective way to do this. Thus, we designed a QR code that would be on the back of the 1-page handout used to conduct the module, which would link to a SharePoint site that had both the handout information and the links to the additional resources. The paper handout could then be pinned to huddle boards and nursing breakroom boards with the QR code side facing out, so nurses would be able to scan it and access the information if/when they needed it.

I conducted the STAT pilot (using the "Surrogate Disagreements about Patient Care Decisions" topic) on April 19th, 2024, with about 8 nurses at SJ-LSL. We first explained the purpose of the education. I used the handout to verbally talk through the four points, read the case, and then worked our way through the three questions following the case. The participants responded well to the interactive portion (the 3-5 questions after the case). Once I asked the first question, we were able to facilitate a productive dialogue that demonstrated their awareness of the points I'd intended to cover with the second and third questions. I thus nixed these last two questions in the pilot.

After the session, I collected verbal feedback from participants to see whether they found the information useful and preferred this mode of ethics education to more traditional education formats. The feedback was overwhelmingly positive. A few participants shared that they had learned new things from the session. Everyone stated that they enjoyed this format more than longer, traditional mode of ethics education ("short and sweet," in the words of one participant). Moreover, despite the fact that the participants had expressed some hesitancy before the session when I stated that I would be asking them a few questions during the module (one nurse asked, "Do I have to say anything? Are you going to quiz me afterwards?"), most participants mentioned that they enjoyed the interactive portion. When I asked the participants which features of STAT they liked the most or found the most useful, they stated that they found the case discussion helpful given its similarity to recent situations of surrogate disagreement they had encountered.

Plan for Long Term Implementation and Future Directions

I reported back to the SVP of Mission & Ethics and presented this education at our next Ethics Committee chairs meeting. We posted the STAT template and examples to both the Mission Integration and Ethics Committee Teams sites, so that both Mission leaders,

committee chairs, and committee members can access existing modules and make their own. Eventually, I envision a bank of available STAT modules on the bread-and-butter basic clinical ethics topics (e.g. different facets of decision-making capacity, treatment refusals, potentially inappropriate treatment, etc.), though we will need to make sure these modules are tailored to particular ministry contexts. Finally, while Steven Squires originally created STAT for nurses, I think the format would also be well-suited for residents and medical students (for example, before or after convening for morning rounds).

For more on STAT Ethics, go to Bioethics for the People at: https://www.bioethicsforthepeople.com/episodes/stat-ethics-education-with-steven-squires

ENDNOTES

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CommonSpirit Health Clinical Ethics Intensive

Requiring standard training for everyone providing ethics consultation in a health system helps create common practice expectations and improves the quality of ethics services. The Clinical Ethics Intensive (CEI) is one of three parts to CommonSpirit Health's approach to meeting these needs.[1] The CEI offers high-intensity training on practical aspects of clinical ethics for ethicists and Ethics Responders who are or will be involved with clinical ethics consultation at CommonSpirit Health ministries. The purpose of the CEI is three-fold: (1) provide a standard base of training for everyone in the system who provides clinical ethics consultation; (2) give participants a chance to practice the skills needed for clinical ethics consultation; and (3) allow the ethicists to evaluate participants to see who is able to provide consultation on their own and who needs more time to shadow and observe consults.

At CommonSpirit, the title "ethicist" is used for people who are employed full time for ethics consultation and other ethics activities like education and policy review. An Ethics Responder is someone who has another role in CommonSpirit (social worker, nurse, chaplain, physician, etc.) and spends some of their time doing clinical ethics consultation during their regular working hours.

CommonSpirit's CEI is an entirely virtual program. This enables us to engage experienced ethicists from across the organization to share teaching responsibilities. In a similar fashion, virtual training increases opportunities to develop Ethics Responders in small or rural markets. Facilitating interaction between ethicists and Ethics Responders from a variety of locations also contributes to building a collaborative team, normalizing accessibility of ethicists for consultation, and ongoing coaching. Participation is limited to a maximum of 40 participants at a time from across the health system to make the virtual experience easier to manage. With three to four sessions a year, we can accommodate 120 to 160 Ethics Responders annually. We first offered the CEI in 2020 and began requiring it for Ethics Responders in 2023. In total, over 530 people in our health system have gone through the program.

The CEI is a skills based training. Ethics content such as norms, principles, laws, and concepts like informed consent or decision making capacity are covered in EthicsLab podcast episodes which participants are required to complete prior to CEI. Resources and materials are available digitally on our website. Other courses are available to Ethics Responders to expand their foundational knowledge.

The CEI spans two six hour days. Both days are facilitated through Zoom with multiple breaks throughout each day to make virtual

learning easier. Each day begins with one hour of didactic; the first day focuses on conceptual tools and analytical skills, while the second covers conflict negotiation and mediation skills. The didactic is followed by role play sessions that occur in small groups in virtual breakout rooms. The role plays, which are the majority of the CEI, are designed to help participants develop specific skills in a supportive environment by utilizing those skills and tools in realistic scenarios. Finally, we end each day with a review of how to use the standard documentation tools for ethics consults, including both the electronic medical record and an internal database.

Over the five immersive role play sessions in the CEI, participants have one or two chances to play the role of Ethics Responder. Other participants intentionally experience the skills being practiced as they play the role of family member, nurse, physician, or chaplain. The role plays are based on realistic clinical ethics cases and are described in a short one-page summary that every participant receives. Each role also has a half page description unique to that role that provides background information about that role known only to the participant; in acting terms it is their "motivation". Participants are asked to stick to their character and use phrases or sentences they have heard in real life to make it realistic but not overly difficult. We hope to strike a balance between creating some learner's tension for participants to struggle through but not create frustration that overshadows the opportunity for learning.

Each role play session is facilitated by a coach, usually one of the CommonSpirit ethicists, whose role is to provide real-time feedback to the Ethics Responders on their ethics consultation skills. Coaches provide feedback during the debrief at the end of each role play, and may also send private direct messages with real-time suggestions, or pause the role play mid-scene to offer suggestions if participants get stuck. Coaches use an evaluation tool that identifies the participants' use of essential skills and tools in clinical ethics consultation that have been implemented in the role play, and pinpoints areas for additional coaching. This tool was developed based on a combination of sources including relevant articles in the literature and the experience of our ethicists.[2] After the CEI, the ethicist works with participants in their region to either join the ethics consultation service, or set up a period of continued observation and evaluation.

The CommonSpirit CEI adds a few unique features compared to similar training programs at other health systems (See Table 1 on the next page):

Table 1

Unique Features of CommonSpirit CEI	Advantages
An entirely virtual format	• Allows feedback from multiple ethicists giving participants varied perspectives • Multiple feedback modalities such as private direct message with real-time suggestions from a coach • Participants interact and learn from each other across a broad geography • Increases comfort level and experience facilitating virtual ethics consultation
Real-time feedback from a professional ethicist	• Allows for deep insights in a short amount of time, focused critique on essential points • Group debrief allows all participants to learn from each other and incorporate essential points into their practice, even if they were not an Ethics Responder in a particular case
Exclusive focus on patient case consultations	• Focuses on meeting with a patient, family, and clinicians rather than ethics content like principles, norms, concepts, or issues • Helps newer Ethics Responders distinguish ethics consults from goals of care discussions or palliative care meetings • Reviews skills related to features unique to ethics consults and gives participants multiple opportunities to practice them

We have also found several disadvantages to the way we have structured the CEI. First, a virtual role-play will never perfectly imitate an in-person interaction. Reading body language and responding to emotional cues can be difficult. This can make it hard to fully assess participants' skills. Second, it can be hard to always have the number of professional ethicists needed to serve as coaches. Ethicists are a scarce resource and sometimes urgent priorities arise. Third, most virtual events have a high no-show rate of registered participants. Relying on participants to fill essential roles in the role-play makes it hard to create an effective

learning environment if several do not show up or have to leave for a period of time during the day. Lastly, participants who are new to ethics consultation or who lack general experience in family meetings may struggle. For some, the CEI is their first exposure to ethics work, which sometimes causes role-plays to pivot to conceptual questions rather than practical ones. We are continuously working to overcome these gaps. For example, we have started a separate education program focused on foundational knowledge and concepts in ethics. We have also on occasion asked some more experienced Ethics Responders to fill in when not enough ethicists are available.

On the whole, we have found virtual learning to be effective for providing initial education on practical skills and tools for clinical ethics consultation. The way we have structured the CEI allows us to engage a larger number of participants in a short amount of time. This is only one part of an education program for Ethics Responders, but it is a key component that complements in-person evaluation and ongoing observation. At the very least, it shows that virtual education in the practical elements of clinical ethics can be successful.

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ENDNOTES

1. The CommonSpirit CEI is based on similar training programs originally started at Ascension Health in 2012 and later CHRISTUS Health in 2015.
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HCEUSA | A Quarterly Resource for the Catholic Health Ministry

Health Care Ethics USA © 2026 is published by the Catholic Health Association of the United States (CHA) and the Albert Gnaegi Center for Health Care Ethics (CHCE) at Saint Louis University.

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