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SAINT LOUIS UNIVERSITY

The Seventh Annual Catholic Healthcare Innovation in Ethics Forum

The Seventh Annual Catholic Healthcare Innovation in Ethics Forum (CHIEF) was hosted virtually in September 2025 by SSM Health. This year's conference successfully accomplished CHIEF's mission: to provide a dynamic forum for ethicists to exchange innovative ideas and promote effective integration of ethics in Catholic healthcare. The conference was coordinated by the CHIEF planning committee that consisted of membership representing Catholic healthcare. Members were ethicists from SSM Health, Hospital Sisters Health System, CommonSpirit Health, Franciscan Missionaries of Our Lady Health System, Mercy, OSF Healthcare, Ascension, and Intermountain Health.

Similar to prior years, CHIEF welcomed presentations on a variety of topic areas such as:

- Community and Belonging
- High Reliability in Clinical Ethics
- Beyond the Common Consult
- Professionalism and the Ethicist

This year's conference took place over the course of three days and included three types of learning sessions: a keynote address, lightning talks, and workshops.

KEYNOTE ADDRESS

Peter J. Cataldo, PhD delivered the CHIEF 2025 Keynote Address titled, "The Via Media and the Profession of Catholic Healthcare Ethics." Dr. Cataldo offered some reflections on his career in Catholic healthcare ethics, inviting participants to consider connections to their own context and the profession in general. The central theme for his keynote was identifying the via media in Catholic healthcare ethics as a way to avoid extremes, and he provided several examples from his own career as well as prominent examples in Catholic healthcare ethics today. Dr. Cataldo has graciously provided a written summary of his keynote address in this special issue on CHIEF 2025.

LIGHTNING TALKS AND WORKSHOPS

Lightning talks are 7-minute presentations that are limited to three slides of content. In total, there were 23 lightning talks that included time for Q&A with the presenters. Of the many fascinating topics, we had several talks in the "Beyond the Common Consult" category that focused on caring for particularly vulnerable patients.

CHIEF 2025 also offered a total of three workshop sessions. In one workshop, Rafael

Flores and Tim Cotita led a discussion on "Ethics as a formative process." In another workshop, Alexandria Lescher shared about "Magnetic: a new approach to marketing ethics services." The final workshop was a featured workshop led by Becket Gremmels, Mary Homan, and Mark Repenshek on "A standard process for assessing the ROI of clinical ethics consultation." This final workshop provided opportunities for CHIEF attendees to share in small groups about work we are all engaged in to learn from one another.

CELEBRATING OUR FIELD

Last year, the CHIEF Planning Committee added a new Emerging Ethics Leader Award. The award was established to recognize an ethicist who has been working full time for two to seven years in Catholic healthcare. The intent of the award is to recognize an ethicist who has moved beyond the start of their career and is emerging as an established, consistent contributor within a Catholic healthcare organization and the broader field. The winner of the Emerging Ethics Leader Award in 2025 was Laura Webster, DBe, RN, HEC-C. Laura serves as vice president of the Northwest Region of CommonSpirit Health. She was nominated by her colleagues at CommonSpirit Health. Congratulations, Laura!

As we have done in previous years, CHIEF recognized attendees' publications from the prior year (September 2024 through September 2025). This collection of writings identified the exciting contributions of many ethicists. CHIEF attendees published 11 articles in seven peer-reviewed journals during the prior year. Additionally, six articles appeared in trade and popular magazines, and attendees contributed to one book chapter, with several more forthcoming in 2026. These publications highlight the significant contributions ethicists in Catholic healthcare are making to the field of bioethics.

FEEDBACK ON THE CONFERENCE

Following the conclusion of CHIEF 2025, post-conference survey results showed a 4.8 (out of 5) overall rating – a tremendous success! Of the 19 respondents, 84% of the attendees indicated they were "very likely" or "somewhat likely" to implement changes to their ethics services from content learned at the conference.

In 2025, CHIEF provided 8.25 hours of Continuing Medical Education (CME) for attending the conference. The post-conference survey sought feedback on the value of offering CME. Of the 19 respondents, 11 indicated that they are not pursuing HEC-C and therefore do not need CME, while 6 respondents stated they would report the CME hours to meet their HEC-C requirements.

Feedback also showed that the virtual forum of CHIEF is highly valued. The virtual setting balances out other in-person opportunities and provides an accessible opportunity for people to attend, even amongst their busy schedules. The three partial-day schedule of CHIEF was also strongly affirmed in the post-conference survey.

CHIEF 2026

For those who missed the 3-day CHIEF conference, recordings are available at this link.

Thank you to all the attendees who participated in this year's conference. We are excited to return for the Eighth Annual Catholic Healthcare Innovation in Ethics Forum, hosted by Intermountain Health. Please contact Christopher.Ostertag@imail.org for any questions about CHIEF 2026 and you can expect a save-the-date in early spring.

Thank you to the CHIEF Planning Committee Members for collaborating and providing input on this conference summary!

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The *Via Media* and the Profession of Catholic Healthcare Ethics

It was an honor and privilege to have been invited to give the keynote presentation for the 2025 CHIEF conference on September 10th. Several conference participants suggested that I submit a summary to *HCEUSA* and I am happy to do so. The Planning Committee made many helpful suggestions, including that I reflect on learnings from my career in Catholic healthcare ethics, the prophetic role of the ethicist in Catholic healthcare, my approach to working with bishops, some areas of concern in Catholic healthcare ethics, and to speak to the importance of theoretical endeavors in the work of Catholic healthcare ethicists.

Among these topics, my presentation highlighted an important dimension of the Catholic healthcare ethics profession: interpreting and applying Catholic moral and social teaching and tradition. As I reflect on my career and ministry in Catholic healthcare ethics, it has included what I characterize as a *via media* between opposing extremes in the interpretation and application of Catholic moral and social teaching and tradition. The history of the Catholic Church is replete with opposing extremes, including the condemned extremes of rigorism (tutiorism) and laxism. With Catholic teaching as a fixed reference point, it is important that ethicists navigate between a narrow, ridged, and strict interpretation or application on the one hand, and the opposite extreme of jettisoning or fundamentally changing Catholic doctrine pertaining to heath care ethics on the other. Since Catholic teaching and doctrine is the fixed reference point, what constitutes the "middle" in the *via media* approach does not shift or drift with time, unless new data and facts require a shift. In this way, the integrity of the teaching is maintained as it is interpreted and applied to the particular and complex circumstances of reality.

The *via media* approach maintains a positive notion of doctrine and does not fear it. Pope Leo XIV's description of doctrine is especially helpful. He characterizes doctrine as not being devoid of reason, or as sealed off from input, or as simply abstract and removed, but as inherently oriented toward the challenges of life and prudential decision-making.[1] At the same time, the *via media* approach in Catholic healthcare ethics embraces the values of inclusion, listening, accompaniment, dialogue, and balance. It is an approach that in the words of Pope Francis allows "itself to be seriously challenged by reality."[2] To find the middle way in Catholic healthcare ethics demands that the ethicist be what Pope Francis wrote of theologians: "Good theologians, like good pastors, also smell of the people and of the street and, with their reflection, pour oil and wine on the wounds of men. [Theology must have an] [o]penness to the world, to man in the concreteness of his existential situation, with his problems, his wounds, his challenges, his potentialities."[3]

The prophetic role of a *via media* approach is twofold: to challenge the rigorist and laxist views of today, and to advance new interpretations and applications of Catholic teaching for issues facing Catholic healthcare ethics. This effort must be informed by a fair assessment of the new issues facing Catholic healthcare, by new data, and by the new and changing environment of healthcare. It must also be prepared to revisit some old problems whose ethical resolution would benefit from new data. Even if there is no specific teaching on an issue, general teaching that is relevant can be interpreted and applied in new ways using a *via media*. Such new interpretations and applications are neither a development of doctrine nor a change of doctrine itself. Rather, such an approach expands and deepens our understanding of the same doctrine or teaching in new contexts.

I shared with the CHIEF participants a reflection on the lives and work of individuals from my professional past who I had the good fortune of learning from directly and who exemplified a *via media* approach in their own work. These were: Frank Morrisey, OMI, the well-known canonist in Catholic healthcare; Albert Moraczewski, OP, ethicist and founding president of the Pope John XXIII Medical-Moral Research and Education Center; and James Collins, historian of Modern Philosophy at Saint Lous University. Each person in his own way exhibited the values of a *via media* approach that greatly impacted me both personally and professionally.

On the subject of working with bishops, it is important that ethicists appreciate their perspective on issues in Catholic healthcare. For any given question that is brought to their attention, bishops seek solutions that preserve Catholic identity, are consistent with Catholic teaching, are appropriately pastoral, and that avoid theological scandal. With respect to scandal, it is important to show bishops that there are various measures that can mitigate the risk of insurmountable theological scandal, especially since they are usually not aware of the options available to Catholic healthcare institutions for reducing the risk of scandal. It is also important for ethicists to distinguish between reducing the risk of scandal and the phenomenon of pharisaic scandal. There is no obligation to overcome pharisaic scandal. In general, ethicists should ground the analyses they provide for bishops in Catholic teaching and the ERDs and should use solid reasoning. Ethicists should make confident and respectful recommendations, and show bishops that there is a middle way between the existing extremes that provides a potential solution.

I highlighted certain aspects of AI, Catholic and other-than-Catholic collaboration, care of transgender patients, and moral certitude in the determination of death by neurological criteria as some issues of concern. AI is and will be critically important for medicine. I pointed out that among the various ethical questions facing AI, the lure of a materialistic and reductionistic view of the human intellect and will in connection with AI is a potential problem. The other three issues exemplify the important need for a *via media* approach that employs the traditional notion of solidly probable opinion.

I finished the presentation with some reflections on finding a balance between theory and practice in the work of Catholic healthcare ethics. There is a reciprocal

relationship between "theory" (research, writing, publishing, and academic learning) and "praxis" (the day-to-day clinical and operational work of ethicists). Theoretical work without the contribution of praxis is uninformed by essential elements of the subject-matter and is unhelpful. Praxis without theoretical input can lack the objective grounding and a deeper understanding that is required for it to be sustained and to meet the needs of those we serve. Achieving this balance across a career in Catholic healthcare ethics is important and should be written into the position descriptions for ethicists.

CHIEF has become an invaluable opportunity for growth, learning, dialogue, and solidarity among ethicists in Catholic healthcare. Institutions and individuals alike are the beneficiaries of the work of CHIEF. I am very happy and grateful to have contributed to this important effort. ✣

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ENDNOTES

1. Pope Leo XIV, Address to "Centesimus Annus Pro Pontifice" Foundation, May 17, 2025, at https://www.vatican.va/content/leo-xiv/en/speeches/2025/may/documents/20250517-centesimus-annus-pro-pontifice.html.
2. Pope Francis, Motu Proprio, *Ad Theologiam Promovendam*, November 1, 2023, n. 8, at https://www.vatican.va/content/francesco/it/motu_proprio/documents/20231101-motu-proprio-ad-theologiam-promovendam.html. English translation is from Google Translate.
3. Pope Francis, Motu Proprio, Ad Theologiam *Promovendam*, n. 3.

Care Coordination for Ethics Consults: Strategy of Care Notes and Best Practices

SETTING THE STAGE: STRATEGY OF CARE NOTES

The Strategy of Care (SOC) note in Epic is a powerful tool designed to address critical concerns that impact patient care in the acute setting while supporting continuity of care after discharge. By standardizing documentation, SOC notes help reduce provider variability in common areas such as pain management, patient nonadherence, or refusal of essential diagnostics and treatments. They also ensure consistency in goals of care when providers transition on and off service, creating a unified approach across the care team.

Beyond improving clinical alignment, SOC notes serve an important role in establishing or re-establishing expectations of care for patients and families, aligning these expectations with recognized standards of medical practice. It is essential to note that SOC notes are not intended as contracts or binding agreements; rather, they are a communication tool that influences patient behavior without attempting to control it. In many cases, SOC notes complement behavior contracts, working together to reinforce shared goals and foster collaboration between patients, families, and providers.

At Mercy, SOC notes have proven especially valuable in ethics consultations for complex care patients. Mercy Joplin and Mercy Springfield frequently collaborate on ethics consultations due to internal transfers for high level of care and the close geographical proximity of both hospitals. We discovered that utilizing SOC notes supports a unified approach across the health system, reinforcing expectations set by providers, and ensuring continuity of care for patients and families navigating challenging decisions.

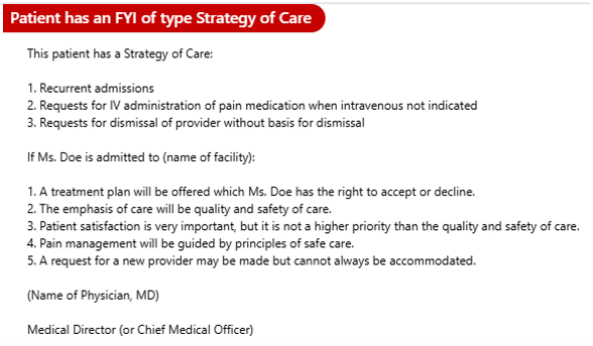
PROCESS AND REASONS FOR SOC

Establishing a Strategy of Care (SOC) note in Epic is a straightforward yet impactful process designed to ensure visibility and alignment across the care team. Once a SOC note is created, a prominent red banner appears at the top of the patient's chart, displaying essential information immediately. This visual cue alerts all providers to the presence of a SOC note, ensuring that critical context and expectations are immediately accessible during patient encounters. (See the example attached below.)

The decision to implement a SOC note typically arises in situations where patient care is at risk due to behavioral, ethical, or clinical complexities. Common reasons include:

- **Over-exercise of patient or family autonomy** or a misapplication of respect for autonomy, resulting in medically inappropriate care requests or complex goals of care.
- **Inappropriate patient behavior/violence against staff** or nonadherence to indicated care or diagnostics, which can lead to missed clinical indicators and acute declines.
- **Repeated refusal of indicated care**, which may be understood as a revocation of the consent-to-treat agreement and, in some cases, can serve as an indication for discharge.
- **Targeted clinical domains with complex care** such as behavioral health or pain management.

By documenting these concerns in a SOC note, the care team creates a unified, transparent approach that reinforces standards of medical practice while maintaining ethical integrity. This strategy not only mitigates risk but also supports continuity of care across transitions, ensuring that expectations remain clear for both patients and providers.



Patient has an FYI of type Strategy of Care

This patient has a Strategy of Care:

1. Recurrent admissions
2. Requests for IV administration of pain medication when intravenous not indicated
3. Requests for dismissal of provider without basis for dismissal

If Ms. Doe is admitted to (name of facility):

1. A treatment plan will be offered which Ms. Doe has the right to accept or decline.
2. The emphasis of care will be quality and safety of care.
3. Patient satisfaction is very important, but it is not a higher priority than the quality and safety of care.
4. Pain management will be guided by principles of safe care.
5. A request for a new provider may be made but cannot always be accommodated.

(Name of Physician, MD)

Medical Director (or Chief Medical Officer)

BEST PRACTICES FOR UTILIZATION

The inclusion of a Strategy of Care (SOC) note in a patient's chart can unintentionally introduce bias among providers and caregivers who may not fully understand the circumstances that led to its creation. Without a consistent approach, these notes risk misinterpretation and confusion about expectations.

We identified two critical challenges:

- **Inconsistent language and usage** can lead to ambiguity and undermine trust.
- **Outdated strategies** raise questions about when and how revisions or inactivation should occur.

The overarching goal of a Strategy of Care is to restore right relationships between patients, providers, and caregivers. It aims to foster understanding, strengthen trust, and promote quality care, patient safety, and improved health outcomes.

Step 1: Developing SOC notes

Creating a Strategy of Care is a collaborative process involving clinical and leadership representatives. The intent is to reduce provider variability, which can send conflicting messages or inadvertently enable manipulation.

Key principles for development:

- Align with **Patient Rights and Responsibilities**, while recognizing that SOC is not a contract—it focuses on behaviors providers and caregivers can control.

- Ensure each element is **clinically and ethically sound**, achievable, and supported by administrative and clinical leadership.
- Obtain **consensus and leadership approval** before implementation in the EHR.

Teams should also determine:

- Whether the strategy is **continuous or time limited.**
- Who is responsible for **scheduled reviews and updates.**
- If applicable, use EHR features to **set expiration dates** for time-bound strategies (e.g., an 8-week antibiotic course or a 6-month postoperative period).

Step 2: Communicating and Implementing SOCs

Transparency and honesty are essential when discussing SOC with patients—except in rare cases where safety concerns justify withholding details.

Who should lead the conversation?

The designated communicator must remain calm under pressure and assert authority respectfully. This dialogue should:

- Acknowledge any provider or caregiver contributions to misunderstandings.
- Recognize the stress and loss of control patients may feel during hospitalization.
- Reinforce norms of patient safety and quality care.
- Reassure patients that expectations are consistent with those for all patients, not punitive or unique.

This structured approach ensures SOC notes serve their intended purpose: clarity, consistency, and compassion in care delivery.

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Toward a New Art of Dying, ACP and Catholic Healthcare

Catholic healthcare finds itself in a unique position within the healthcare space because of its multi-faceted commitments to providing healthcare to all but also keeping itself accountable to the internal morality of the Catholic tradition. Because of this, Catholic healthcare has a unique perspective into the patient-provider relationship. Of note, there is a foundational commitment to serve all in all aspects, physical, mental and spiritual based in the Catholic-Christian example of Christ's healing ministry.[1] This means that all who approach Catholic healthcare should be treated in all forms available depending on the needs of the patient. However, there is a growing sentiment in the United States that believes physician-assisted suicide and medically assisted death are valid and meaningful forms of medical care and should be offered.[2] With each passing year, more states are adding laws that legalize assisted death in the U.S.[3] This then puts Catholic healthcare at odds with this growing subset of people who are genuinely seeking these interventions as forms of care. While the Catholic tradition can never accept assisted death as valid medical care, there should still be an appropriate response from Catholic healthcare on how to approach death and dying in a way congruent to the Catholic tradition to serve people who request assisted death. At present, there is not a good framework for presenting this "Catholic method" of dying. The Catholic Art of Dying that is proposed here is therefore a combination of the medieval *Ars Moriendi* and the contemporary "Art of Dying" as a way to guide those in Catholic healthcare on how to die well. While this framework is still incredibly young and undeveloped, the pieces of this framework can still be explored and begin taking shape through this discussion.

Advance Care Planning (ACP) is a powerful tool in the healthcare ethics space. ACP allows patient voices to persist beyond the biological ability to voice one's own preferences, values, and goals at the end of life. This is usually executed through the form of Advance Directives, Living Wills, and the growingly popular POLST (Physician/Portable Orders for Life Sustaining Treatment).[4] However, ACP is more than written documents. Rather, these documents are the fruits of multiple conversations about a patient's current medical condition, exploring the expected outcomes of the patient's condition, and appropriately weighing the benefits and burdens of various treatments/interventions against the patient's preferences, goals, and values.[5] Often they detail treatment directives and surrogate directives that state a preference for or against life-sustaining interventions and a preferred person to enact medical decisions, all to be referenced when the patient no longer has the capacity to make medical decisions.

Catholic healthcare already places a great deal of importance on these items individually as extensions of the Catholic moral tradition.[6]

Of note, the 7th edition of the *Ethical and Religious Directives for Catholic Healthcare Services* (ERDs) specifically references the need to support patients with life-limiting and terminal illnesses in specific ways citing a "duty" to provide end-of-life care in alignment with Catholic teaching.[7] This includes things like palliative care, personal accompaniment, and all the medical, emotional, and spiritual supports both patients and their families need in the dying process. These elements are at the heart of the proposed Catholic "Art of Dying." Inspired by the medieval *Ars Moriendi*, the currently proposed Catholic "Art of Dying" is a combination of the Catholic teachings about how to approach the end-of-life and the current medical practices of ACP and palliative care.

The medieval *Ars Moriendi* was a text that was created as a way to help guide the Catholic faithful on how to die well through prayer and community.[8] While this was initially intended for a society that did not have medicine and had to rely on spirituality to make sense of death and dying, its intention and goals are still valuable to contemporary medicine and should continue to be studied.[9] It is the author's belief, then, that this medieval text gives a great deal of insight into a potentially new *Ars Moriendi* informed by the contemporary practices of end-of-life care, palliative care, and the current Catholic teachings on how to approach death and dying.

Palliative care is already well supported as part of the Catholic tradition to the point it has been mentioned directly in the 7th edition of the ERDs. However, ACP is a powerful end-of-life care tool that has yet to be fully tapped in the Catholic healthcare space as part of this new "Art of Dying." The first aspect to be highlighted is about how ACP can be a very powerful tool for the dying to carry forward their preferences and goals long after a person has lost the ability to voice them. This is highly important in the Catholic tradition as all persons are entitled with free will based on humanity's shared nature as creations of God.[10] Therefore, promoting and defending this experience of free will is something that should be of high priority in the Catholic medical institution. A second aspect of ACP to be highlighted in the Catholic healthcare space are the benefits that can arise for those grieving.[11] It must not be understated how sorrowful the death of a loved one is. Those who surround the dying, those grieving and caring for the dying, are of strong importance as much as the dying. Not only with their grieving but also in their duty to help the dying experience a "good death."[12] ACP therefore is helpful as it gives insight into what the patient would have wanted and how to proceed forward without the patient's vocal guidance. The third and arguably most fundamental aspect of ACP to highlight is that ACP provides space to explore and discuss how the dying person wishes to experience death itself.[13] Often ACP is reduced to a list of do's and don'ts about treatments at the end-of-life. While this is a valid way to use ACP, it is so often lacking because humans are so multi-faceted that a simple yes or no cannot fully capture the needs and wishes of the dying person.[14]

These then are the hallmarks of how Catholic healthcare can and should continue developing ACP as part of a new Art of Dying. Catholic healthcare has the unique nature of being a healthcare institution that brings a strong

sense of spirituality to the table and can demonstrate a positive, affirmative form of ACP that refocuses end-of-life care toward the whole of the human person rather than focusing on the avoidance of pain and suffering seen in the "Right to Die" movement.[15] Catholic healthcare by virtue of its ties to the Catholic tradition and in the spirit of the *Ars Moriendi* should advocate for more opportunities for people to engage in ACP at all phases of illness and should be brought to the forefront of end-of-life care discussion. This should include things such as the setting in which the dying person wishes to be, those surrounding the dying person at the moment of death, and of course the various traditional aspects of ACP like whether the patient wishes to continue receiving life-sustaining treatments or wishes to be kept as lucid as possible during death. ✣

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ENDNOTES

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2. M. Buchbinder, "Access to Aid-in-Dying in the United States: Shifting the Debate From Rights to Justice," *Am J Public Health* 108, no. 6 (Jun 2018).
3. "In Your State," 2025, accessed December 17, 2025, https://deathwithdignity.org/states/.
4. Robert C. Macauley, *Ethics in Palliative Care* (New York: Oxford University Press, 2018), 70-83.
5. Macauley, *Ethics in Palliative Care*, 70-71.
6. Bishops, "Ethical and Religious Directives for Catholic Healthcare Services," no. 24-25; "Samaritanus Bonus: On the care of persons in the critical and terminal phases of life," Congregation for the Doctrine of the Faith, 2020, accessed Dec. 17, 2025, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html; "Declaration on Euthanasia," Congregation for the Doctrine of the Faith, 1980, accessed Dec. 17, 2025, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html
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8. "Ars Moriendi," St. Mary's University, 2025, accessed Dec. 17, 2025, https://www.artofdyingwell.org/about-this-site/ars-moriendi/; M. Therese Lysaught, "Ritual and Practice," in *Dying in the twenty-first century: toward a new ethical framework for the art of dying well*, ed. Lydia S. Dugdale (Cambridge: The MIT Press, 2015), 69; Donald F. Duclow, "Ars Moriendi," in *Macmillan Encyclopedia of Death and Dying* (New York: Macmillan Reference USA, 2003).
9. "Ars Moriendi."; Farr A. Curlin, "Hospice and Palliative Medicine's Attempt at an Art of Dying," in *Dying in the twenty-first century: toward a new ethical framework for the art of dying well*, ed. Lydia S. Dugdale (Cambridge: The MIT Press, 2015), 3-6, 50-52.
10. *Catechism of the Catholic Church*, Second ed. (Città del Vaticano: Liberia Editrice Vaticana, 1997), no. 1700.
11. Macauley, *Ethics in Palliative Care*, 71; David I. Shalowitz, Elizabeth Garrett-Mayer, and David Wendler, "The Accuracy of Surrogate Decision Makers: A Systematic Review," *Archives of Internal Medicine* 166, no. 5 (2006).
12. Lysaught, "Ritual and Practice," 69-71.
13. Bishops, "Ethical and Religious Directives for Catholic Healthcare Services," no. 62; Faith, "Samaritanus Bonus: On the care of persons in the critical and terminal phases of life."
14. Macauley, Ethics in Palliative Care, 74.
15. Curlin, "Hospice and Palliative Medicine's Attempt at an Art of Dying," 57-59.

Ethics in the Foundation: A Philanthropic Discernment Aid

Philanthropic Support Foundations provide a crucial service for our ministries and local communities by managing charitable gifts and building relationships with donors. Aligning resources with needs fulfills a key part of our Mission as a Catholic health ministry. Yet, some gifts or donors do not completely align with our Mission. We created the Philanthropic Discernment Aid to help address such situations of misalignment and to assess potential gifts or donors through the lens of our Mission and Catholic identity. The tool helps gift officers and foundation leadership: (1) assess if the misalignment is acceptable or if the gift should not proceed; (2) mitigate individual bias; and (3) determine whether they should contact someone else to help assess the situation. We hope this tool will help foundations and ethicists at other Catholic health systems think through similar situations.

From the perspective of philanthropic staff, this aid transcends a mere policy document; it is a critical instrument for navigating the complex ethical landscape of fundraising. It provides not only guidance but also confidence for gift officers who are often the first point of contact with donors, and thus the first to encounter potential ethical ambiguities. By offering clear parameters, the aid empowers them to engage in initial assessments independently, fostering a culture of informed discernment within the fundraising foundation. This proactive approach ensures that ethical considerations are woven into the very fabric of donor relations, rather than being an afterthought. Moreover, the tool implicitly communicates to donors that our ministry upholds high ethical standards, reinforcing trust and long-term partnership based on shared values.

We modeled the Philanthropic Discernment Aid after the CommonSpirit Ethics Discernment Framework because the discerning approach of the Framework provided an open-ended starting point for assessing Mission misalignment.[1] The Framework can be used in three ways: as a team, with a discernment facilitator, and adapting a pre-existing process. The Aid is an example of this third method in which the Theology and Ethics Department works with another department to modify their regular decision making process to reflect elements of discernment.

The creation process followed several design principles. First, plain language. The words and phrases in the tool are not theologically technical, or are at least easily understandable without discussion with an ethicist. Second, simple to use. The intention is for gift officers to use the tool on their own to resolve most concerns without involving anyone else. Assistance is available if needed, and the last step guides the user on when and who to ask for help. Third, short and to the point. The tool is only one page and centers around three straightforward steps.

Step 1: Donor categories generally not accepted
Step 2: When to seek input from others
Step 3: Who to seek input from

A few best practices are also listed at the bottom. We find most situations or questions can be assessed in a few minutes, and those that require input from someone else usually only need a brief conversation.

The tool assumes that many (if not most) gifts and donors have at least some misalignment with our Mission since "all have sinned and fall short of the glory of God." (Romans 3:23) Thus, while the initial concern might be whether a gift or donor has a misalignment with our Mission, it often quickly shifts to whether the misalignment is acceptable. Misalignment happens most often through the source of the funds, the public image or actions of the door, or the circumstances of the gift. Certainly some gifts or donors have no misalignment, but this framing clarifies that almost every situation will have some misalignment if examined closely enough.

Conceptually, the Philanthropic Discernment Aid focuses on two theological principles: cooperation and scandal. While it is unlikely that receiving a charitable gift would constitute illicit cooperation, some actions were deemed concerning enough to be ruled out even if involvement might constitute licit cooperation in some narrow circumstances. This led to significant discussion during the design process regarding what kind of actions to include in the list of categories that are not accepted in Step 1. While some might be ruled out due to concerns of illicit cooperation, and others are ruled out for concerns of scandal, the tool does not distinguish between the rationale and simply alerts the gift officer that this category should not be accepted.

We determined that concern for scandal is usually the most relevant theological principle in assessing Mission misalignment for potential charitable gifts. Thus, most of Step 2, which is the longest step, focuses on scandal and provides a non-technical description of the theological definition. This step leaves a lot of room for the judgment of the individual gift officer to assess the risk of scandal. However, since the most concerning actions are ruled out in Step 1, and there are some specific directions given in the Best Practices section at the bottom, we believe the flexibility in Step 2 allows the gift officer appropriate freedom and boundaries to decide how to proceed.

The true strength of the Philanthropic Discernment Aid lies in its ability to integrate ethical reflection into the everyday operations of a support foundation. It empowers gift officers to be frontline guardians of the ministry's Catholic identity, transforming what could be perceived as an additional bureaucratic step into a vital act of mission stewardship. By providing a clear, accessible, and supportive framework, the Aid ensures that every gift accepted not only advances our healing mission but also reinforces our unwavering commitment to the ethical principles that define us as a Catholic healthcare provider. This creates a powerful synergy, where philanthropic success is inextricably linked to ethical integrity, yielding benefits far beyond financial contributions.

Certainly this tool will not resolve all issues.

If extended discernment is needed, the normal CommonSpirit Ethics Discernment Framework is available. The Best Practices section directs the gift officer to a discernment in certain situations, such as a large or national campaign, or disagreement among people providing input. Nevertheless, we have found the Philanthropic Discernment Aid to be a constructive support to guide gift officers and philanthropy leaders through many situations that raise ethical concerns and Mission misalignment. We encourage ethicists in other health systems to consider developing similar applied discernment tools for various departments to spread the benefits of discernment to other difficult decisions.

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ENDNOTES

1. CommonSpirit Ethics Discernment Framework, www.missiononline.net/csh-ethics/discernment. The Philanthropic Discernment Aid is one example of the third manner in which the CommonSpirit Ethics Discernment Framework can be used as described on the second page, namely to adapt a pre-existing process.

Philanthropic Discernment Aid

This guide is intended to help philanthropy teams determine if a gift should be pursued when a potential gift or funder might not be mission aligned. Through a series of guided questions, any team can examine the issues without personal bias affecting the outcome while also knowing clearly when to engage the hospital CEO and/or mission leader. This guide is to be used when a situation falls outside of existing CommonSpirit Health policies (including 4.94 Gift Acceptance Policy).

Discernment Aid Questions

QUESTION 1: Donor categories generally not accepted:

- Gun manufacturers
- Tobacco or vaping industry
- Funds generated by means that are illegal at the local, state, or federal level
- Groups that advocate discrimination or racism of any kind
- Adult industry (films, stores, clubs, etc.)
- Abortion providers
- Payday loans companies
- Groups that advocate for physician assisted suicide or euthanasia (e.g. Compassion and Choices)
- Donor is confirmed to be incompetent due to dementia or other factors

If the Foundation intends to accept funds from any of the above, a documented discernment process using this guide is required.

QUESTION 2: When to seek input from others:

Existing negative media or publicly available information

- Negative press and/or social media

Risk of scandal

- Scandal is a situation in which someone may be confused about who we are as CommonSpirit Health and what we stand for as an organization.
- Are there other funders who can help us accomplish our goal without the risk of scandal?
- Is it the gift itself or the program it is supporting the true concern? Or is it simply the association with the donor or grant provider?
- Appearance of cognitive issues by the donor
- If the gift is going to be publicized via a press release/social media or has a gift agreement and there has been no research done on the donor.

Concerns raised by board members, support staff, or others

- Board and staff concerns should be heard, documented, and balanced with legitimacy of the concern.
- Would accepting the gift jeopardize existing donor relationships?

Donor has a personal agenda

- Donor asks what they get in return for donating
- Does the donor have an intent to offset their past bad behavior by donating?
- Is there a political or bipartisan balance in our overall gifts received?

What is the motive for the gift?

- Is the gift self-serving in a way that conflicts with our values?
- Does the donor have a desire for a future potential gain or special/preferential treatment or access to their chosen doctor?

QUESTION 3: Who to seek input from:

Checklist of potential people to consider

- Colleague in Philanthropy, in your department, system shared services/operations or at another CommonSpirit ministry
- Your supervisor
- Administrative Team Leaders (CEO/President, Compliance, HR, Finance, Legal, Mission, Community Benefit/Health, Advocacy, etc...)
- Ethicist
- Leaders in the department or program that would receive the gift
- Executive Committee of Foundation Board
- Division or System Advocacy Leader where appropriate

Best Practices

- CEO and Mission Leader should be informed regularly, but not always need to be directly involved.
- If you seek input from two individuals and get drastically different answers, consider bringing together a larger group to utilize the Ethics Discernment Framework.
- If the issue involves a large campaign, a national campaign, or requires input from multiple departments outside Philanthropy, consider using the Ethics Discernment Framework with a facilitator.

Gift Acceptance Policy 4.94

Socially Conscious Investment Standards

CommonSpirit

The IRB As a Guardrail for Healthcare AI

Artificial intelligence (AI) in healthcare has significant promise, potentially allowing earlier disease detection, expanded access to care, and reduced administrative burden on clinicians. For Catholic and other mission-driven healthcare systems, this seems providential: technology that advances access for the poor and vulnerable and improves care for all. Yet medical breakthroughs have often produced novel moral hazards. AI is no exception.

The moral questions raised by AI are extensive, and should be extensively examined. They touch on privacy, bias, responsibility, and the shifting role of clinicians. They also reach deeper, into questions of dignity, justice, and the moral character of institutions and societies. Catholic healthcare, with its long tradition of ethical reflection, is well positioned to examine these risks. However, lofty principles alone are not enough. Best practices for ethically implementing healthcare AI require incorporating ethics input throughout the lifecycle of development and implementation of AI in hospitals and clinics.[1] As AI tools move from design to deployment, they encounter a crucial checkpoint: the Institutional Review Board (IRB).[2] We outline our experiences with early review of healthcare AI at the IRB level to explore how IRBs can be positioned to respond to the novel challenge of implementing AI at the bedside.

IRBs protect human subjects in research, a checkpoint for ensuring that study design is appropriate. Today, they face a new challenge: evaluating how healthcare AI will be developed and tested. This means tracking risks to study subjects from opaque algorithms, weighing benefits, and reviewing unanticipated events. IRB evaluation of AI studies will represent a re-review of the ethical principles involved in the development of the goals of AI and a targeted examination of impacts of integrating AI into a healthcare setting. The IRB sits at a "mid-level" of oversight—between the high-level ethical principles and regulation of clinical realities. Here, commitments to justice and dignity become concrete questions: What risks does this tool pose? Who might be harmed? Whose voices are missing?

In this sense, an IRB effectively tuned to evaluate the novel moral issues raised by healthcare AI is not merely a bureaucratic hurdle but serves as a moral forum. An IRB well-prepared to address AI can be a space where hype and skepticism are balanced. When the future of healthcare is being so strongly impacted by the integration of AI, an IRB can be a place where this is debated in miniature.

CHALLENGES IN AI REVIEW

Our experience with our IRB's first encounters with healthcare AI highlights the challenges others may encounter. Panelists steeped in

research ethics and medicine felt ill-equipped to evaluate technical aspects of AI. They asked, how does one assess risk when errors are probabilistic rather than deterministic? How can we evaluate implementation risks without the ability to predict possible mistakes? How confident can we be in the accuracy of performance evaluations of evolving algorithms? Panelists researched AI error sources and outcome predictions, but reported research was difficult because of the hype and misinformation surrounding AI. In addition to questions about how AI works, panelists had questions about the ethical considerations relevant to data use, AI design, and AI implementation. Panelists asked ethicists to provide summaries of ethical frameworks for AI design and implementation.

Researchers, especially those steeped in the culture of AI development rather than healthcare, too, had questions about IRB review. Some questioned whether IRB oversight applied to their work. They viewed AI implementation as quality improvement rather than research. Others equated AI ethics with data governance, overlooking broader questions of risk, justice, and responsibility.[3] Researchers unfamiliar with IRB guidance did not initially provide complete responses to IRB questions about potential harm or privacy, and were surprised by IRB follow-up questions. These education gaps left AI-interested researchers uneasy about engaging with the IRB structure. This experience, if repeated, might lead to a "cooling" of researchers' ability to reach out to IRB staff with questions about study design, or a hesitance for AI researchers to develop healthcare AI and engage with an unfamiliar regulatory structure.

These potential tension-points can be proactively addressed with education, offering IRB panelists and researchers alike guides for the unfamiliar space of IRB reviewing healthcare AI. IRB members should have training in the operation, risks, and ethical pitfalls of AI. One-pagers for IRB members to review, supplemental specialized education courses, or presentations from experts on AI design and ethics with Q&A may all be helpful. Researchers in the AI space, in turn, need grounding in the history and expectations of medical research ethics. Orientations and onboarding to these as well as technical IRB requirements could similarly be provided. Ethicists and those engaged in IRB development can develop these materials and organize this education before their institutions begin to review healthcare AI research, to avoid miscommunications.[4]

OPPORTUNITIES IN AI REVIEW

Tension and novel moral hazards are inevitable with major change, but IRBs are uniquely suited to respond to these. Research ethics culture is familiar with hype: IRB panelists reference memories of earlier “miracle cures” to temper more outlandish claims surrounding AI. IRBs are designed to ask scientific and ethical questions in moments of innovation and uncertainty, and to integrate existing guidelines for the ethics of particular treatments. The IRB’s ability to question, identify gaps, integrate new ethical principles, and to resist over-optimism or cynicism are invaluable in the rapidly changing world of healthcare AI.[5]

Moreover, the diversity of perspectives and on-the-ground experience with integration of new technology in healthcare on IRBs

proved fruitful. Clinicians, ethicists, and researchers raised questions about clinician work environments, data disclosure, and the pragmatics of implementation. These were concerns that had been overlooked. Panelists shared experiences with past changes in healthcare delivery and also raised questions for researchers about feasibility in study design based on this history. IRB panelists can have the research ethics resources to hold healthcare AI to realistic and firm standards, and AI researchers can find partners with novel perspectives and experience in innovative research. Panelists also reported being more optimistic about healthcare AI in their own practice following the opportunity to research for an IRB review.

In our Catholic healthcare context, the shared language of mission and dignity further enriched these discussions. Panelists were impressed by resources like the Rome Call for AI Ethics, giving language to the societal and spiritual hazards of AI use.[6] The Catholic philosophical and moral tradition on AI and the more secular tradition of AI ethics are evolving quickly, which will provide healthcare institutions with the resources to think through broad questions about AI.[7]

CONCLUSION

AI will transform healthcare, but this is not healthcare's first transformation. Healthcare innovation has long brought ethicists, clinicians, and institutions new challenges, revealing the enduring need for moral guidance. Properly equipped, IRBs can be pillars of this guidance. For Catholic healthcare, this is not merely a technical task but a moral vocation: shaping medicine to honor dignity and serve the vulnerable. At its best, an IRB is not a hoop for healthcare AI research to jump through or an outdated committee whose importance is waning in the world of AI, but a place where the ethical, clinical, and cultural dimensions of AI are tested, and where the story of AI in healthcare can be co-written as one of innovation as well as justice. ✠

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Unrepresented Patient Ethics Consultations: An Integrated Process for Decision-making When a Patient's Voice is Absent

Over the past several years organizations across the country have experienced a growing number of patients who are determined by their providers to lack capacity and who, at the same time, do not have an identified decision-making representative. These patients are often referred to as "Unrepresented Patients" (or "Unbefriended Patients", though respect for their dignity and personhood compels the shift in vocabulary to the more compassionate language of "Unrepresented" vs. "Unbefriended"). They are, indeed, one of our most vulnerable patient groups since their voices are nearly or completely absent in conversations about their treatment goals, perceptions of risks and benefits, and values and preferences.

Given the complexities and vulnerabilities inherent in these cases, we have implemented a formalized Unrepresented Patient Ethics Review process (a copy of which you can find at the end of this article). This process, aligned with both the longstanding American Bar Association Consensus Statement from 2003 and the recently revised American Geriatric Society Position Statement from 2024, aims to:

- Acknowledge and address the vulnerabilities of patients without a voice;
- Represent the patient's known or perceived preferences as closely as possible;
- Navigate clinical realities without delaying necessary treatment decisions;
- Uphold the patient's dignity throughout their care experience; and
- Support the care team with multidisciplinary and administrative collaboration and thoughtful deliberation.

This ethics review process is started when the designated care team member (usually a social worker or case manager) identifies a patient without capacity as also being without a decision-making representative. We have found that early activation has increased the efficiency of our process and seems to be reasonable from a logistics perspective. Once activated, the Unrepresented Patient Ethics Review process continues until the patient regains decision-making capacity, a legally authorized representative is identified, the patient is transferred to another facility, or the patient passes away.

In order to facilitate the ethics review process, the Unrepresented Patient Ethics Review

flow sheet includes several key questions for consideration, including:

- What, if any, decisions does this particular patient have the capacity to make at this time?
- Is there a way to ascertain what the patient's values/preferences might be? What the patient might say/is saying?
  - For example, cautious consideration of past behaviors/decisions, or perceptions of acquaintances.
- What are the goals of treatment and how would this intervention move towards those goals? What is the usual treatment plan for patients in this clinical condition (standard treatment/ clinical best interest)?
- How would interventions being considered promote the overall dignity of the patient as defined by the following:
  - Promotion of health and human flourishing
  - Totality & right to bodily integrity (ie., least invasive/restrictive means, reversibility of treatment/outcomes)
  - Maintenance or enhancement of comfort and function
  - Prevention/alleviation of suffering; pain and symptom management
  - Obligatory nature of treatments considered ordinary/standard vs. extraordinary/reaching limit of what medicine can do
- How is this decision aligned with institutional guidance (i.e., the ERDs, Mission Statements, regulatory requirements)?
- What relevant state laws or organizational policies should be considered for this situation?
- What are the potential sources of conflict of interest and bias within the review team and how can we mitigate?
- From whose voice(s) have we not yet heard? Can we hear from them prior to the decision?
- Is there an opportunity if the patient regains capacity to identify a possible surrogate or explore future patient preferences?

We also include a fairly rhetorical question designed to keep us humble within the context of our process:

- What if the patient would disagree with this plan even after careful review?

While there is often limited or no opportunity to follow-up with patients who do not regain capacity or who pass away to determine if they would actually agree or disagree with the decision, we consider inclusion of this type of question important as it calls us to continually consider that each individual patient is unique, and that our deliberation process, though thoughtful and as thorough as possible, does not entirely replace the unique perspective of each person we serve.

While we've had a version of this Unrepresented Patient Ethics Review process in place for several years, we recently identified a need for review and revision. For example, there had been delays in implementing the process because of a misperception that the process was intended only to determine if it would be appropriate to seek outside guardianship. Because public guardian resources are often scarce, and because the appointment of a guardian may impose additional burdens on the patient if and

when capacity is regained, we wanted to include key questions for consideration to help evaluate whether or not a guardianship appointment is the most ethically reasonable option. The revised tool includes questions to help with this evaluation and is required within our ministries as a first step towards moving forward with public guardianship appointment processes.

We also identified a need to re-educate providers and team members about the process, and opportunities to clarify key points within the flow-chart itself. The revised version you see here includes clarification that the process should be implemented as soon as the patient is assessed to lack capacity and identified as not having a representative available to assist with medical decisions. It clarifies that it is typically the responsibility of the case manager or social worker to contact the Ethics Consultation Service to start the process. Finally, it clarifies what to do if urgent (not emergent) medical decisions need to be made before the first meeting or between meetings, by prioritizing due diligence to start the Ethics Consultation process but allowing for decisions made by consensus of at least two providers to avoid unnecessary delays in treatment.

While we believe that this process offers an ethically sound approach to decision-making in these circumstances, there are certainly challenges and limitations. These include the time involved in gathering the review team with the wide scope of key stakeholders, the continual turn-around and attrition of key stakeholders which requires continual education about the process itself, and the inherent conflict of interest resulting from an exclusively organizationally-affiliated review team. While some states served by our organization require community members as participants in their Unrepresented Patient Ethics Review consultations, we chose instead to review the process itself with our Patient and Family Advisory Councils to solicit their broader feedback and community-based perspective. We plan to revisit these groups with updates on the process, to share statistics and trends, and to gather any additional feedback from these groups in the near future.

Overall, we have found the Unrepresented Patient Ethics Review process to be an effective approach to medical decision-making in cases where some of our most vulnerable patients' voices are difficult to hear. We will continually work to improve this process in order to identify opportunities to improve efficiency, effectiveness, responsiveness, and representation for those we serve in this way. ✣

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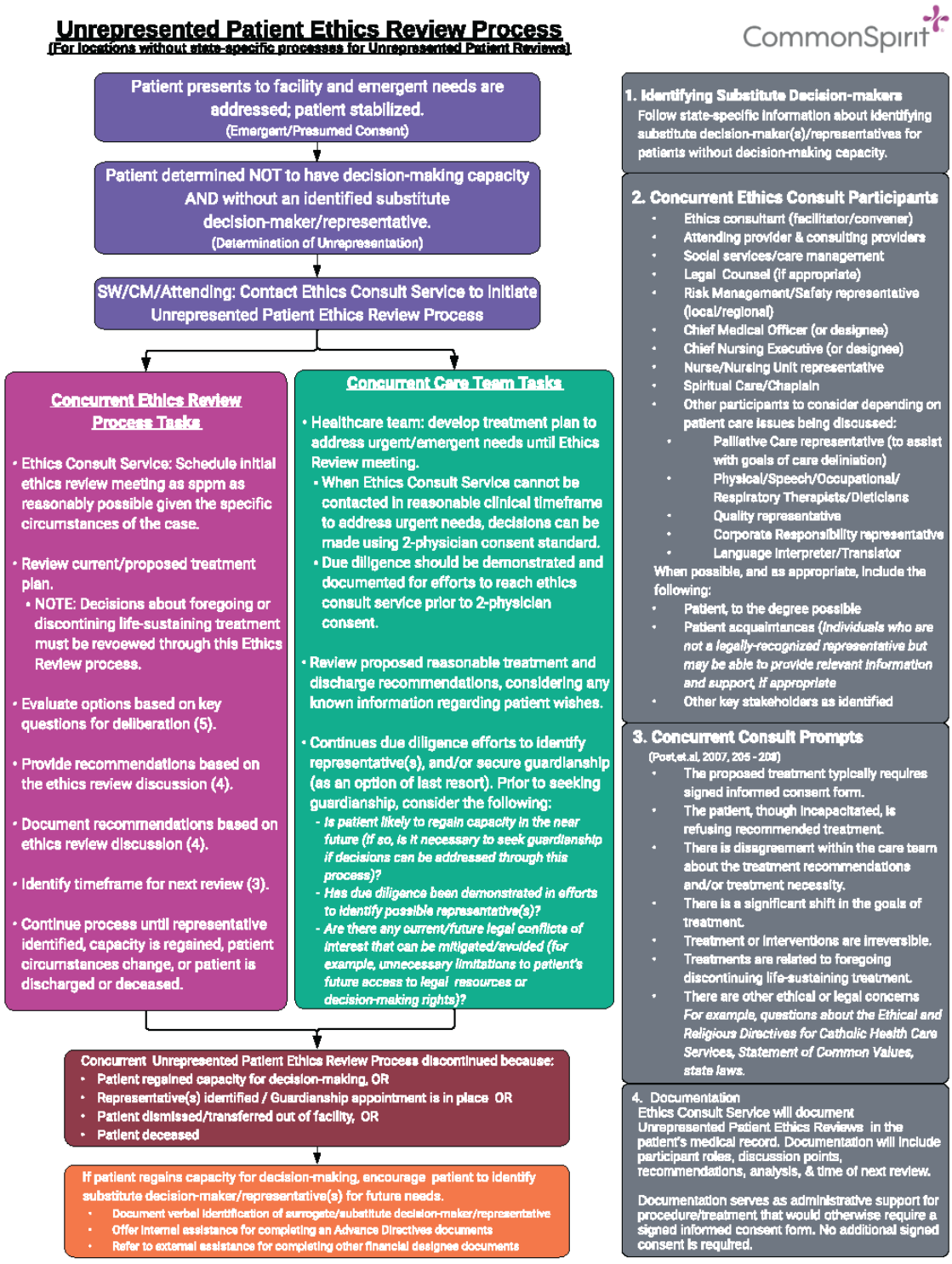

5. Key Questions for Consideration

- What, if any, decisions does this particular patient have the capacity to make at this time?
  Note that decision-making capacity can vary based on the type of decision and over time.
- Is there a way to ascertain what the patient's values/preferences might be? What the patient might say/is saying?
  For example, cautious consideration of past behaviors/decisions, or perceptions of acquaintances.
- What relevant state laws or organizational policies should be considered for this situation?
- What are the potential sources of conflict of interest and bias within the review team and how can we mitigate?
- What are the goals of treatment and how would this intervention move towards those goals? What is the usual treatment plan for patients in this clinical condition (standard treatment/clinical best interest)?
- How would interventions being considered promote the overall dignity of the patient as defined by the following:
  - Promotion of health and human flourishing
  - Totality & right to bodily integrity (ie., least invasive/restrictive means, reversibility of treatment/outcomes)
  - Maintenance or enhancement of comfort and function
  - Prevention/alleviation of suffering; pain and symptom management
  - Obligatory nature of treatments considered ordinary/standard vs. extraordinary/reaching limit of what medicine can do
- How is this decision aligned with institutional guidance (i.e., Mission Statements, regulatory requirements)
  - For Catholic institutions, the **Ethical and Religious Directives for Catholic Health Care Services** (ERDs)
- From whose voice(s) have we not yet heard? Can we hear from them prior to the decision?
- Given all of the information at hand what is the most ethically reasonable option at this time?
- What if the patient would disagree with this plan even after careful review?
- What opportunities might there be to proactively identify a decision-making representative and/or clarify patient preferences if the patient regains decision-making capacity?

Hallmarks of a Well-Designed System

(American Bar Association Consensus Statement – 2003)

- **Focus on the patient.** *Any system should be patient-centered.*
- **Independence and freedom from conflicts of interest.** *There should be sufficient objectivity so that decisions are not subject to undue personal and institutional biases.*
- **Continuity of care.** *Care should not be disrupted or needlessly postponed while the process operates.*
- **Applicability to a full range of decisions.** *While any one mechanism might be limited in scope (for example, specifically excluding end-of-life treatment decisions), the system as a whole should cover the gamut of medical treatment.*
- **Emphasis on least restrictive alternatives.** *Options that stress patient involvement where possible and do not unnecessarily remove fundamental rights are preferred. Thus, guardianship, which strips individuals of basic rights and puts their lives and medical treatment in the hands of the court, is truly a last resort.*
- **Promptness.** *Decisions should be timely. As with justice, care delayed is often care denied.*
- **Cost-effectiveness.** *As states and localities face budgetary crises, they must prove that systems are economical. Careful tracking may show that effective decision-making mechanisms for this at-risk population can actually save public dollars over time.*
- **Accountability.** *Decisions should be tracked and regularly evaluated to ensure a high quality system.*
- **Expertise.** *Decision-makers should have sufficient background and/or receive training on health care law and ethics and on communicating with elderly patients—and should have timely access to sufficient expertise on clinical issues.*
- **Credibility.** *The system should be recognized as a qualified arbiter on health care decisions and have the trust and confidence of professionals and the public.*

Policy & Clinical Practical Advice

(American Geriatric Society Position Statement - Rev 2024)

- *The term "unrepresented" should replace the term "unbefriended" when referring to a person who (1) lacks decisional capacity to provide informed consent to a particular medical treatment; (2) has not executed an Advance Directives document that addresses the medical treatment at hand and lacks capacity to do so; and (3) lacks representation from a surrogate decision maker (ie. family, friend , or legally authorized surrogate.)*
- *Clinicians and institutions should advocate for the inclusion of nontraditional surrogates wherever appropriate.*
- *Clinicians, health care organizations, communities, and other stakeholders should work proactively to prevent older adults without potential surrogates from becoming unrepresented.*
- *Clinicians, healthcare organizations, communities, and other stakeholdesr should develop innovative, efficient, and accessible approaches to promote adequate protections and procedural fairness in decision-making for unrepresented older adults.*
- *Medical decision-making for unrepresented older adults should include adquate safeguards against ad hoc approaches, seek consensus where possible, and ensure procedural fairness.*
- *Clinicians should assess medical decision-making capacity in a systematic fashion.*
- *Clinicians and healthcare institutions should develop, standardize, and systematize methods to make decisions for unrepresented older adults in urgent, life-threatening situations.*
- *Clinicians and healthcare institutions should ensure that patients long-term icapacity have longitudinal access to a decision-making surrogate who is familiar with the patient's medical condition and specific circumstances.*
- *When applying the best interest standard to unrepresented older adults, institutional committees should synthesize all available evidence, and should take steps to guard against perpetuation forms of potential bias in decision-making for this highly vulnerable population.*

Re-Imagining Ethics Education: A New Approach to the Clinical Ethics Intensive

INTRODUCTION

As healthcare systems navigate increasingly complex clinical environments, the need for intentional and proactive ethics has become central to high-quality care. In response to this need, Ascension has undertaken a comprehensive re-imagining of how it trains Ethics Integration Committee (EIC) members to participate meaningfully in proactive clinical ethics processes. This work culminated in a redesigned version of the Clinical Ethics Intensive (CEI), Ascension's flagship ethics education program.

The new CEI positions EIC members not as passive recipients of ethics expertise, or as "miniature ethicists," but as embedded ethics resources who play an essential and active role in the identification, triage, and analysis of ethical concerns from the perspective of their own field of expertise. The CEI trains participants to listen for ethics within their existing workflows, articulate concerns as structured ethics questions, and connect cases to the appropriate ethics processes. The CEI is not simply an educational module; it represents a strategic intervention aimed at reshaping how clinicians recognize, name, and respond to ethical concerns at the bedside.

A PROACTIVE ETHICS INTEGRATION PARADIGM

To illustrate proactive ethics integration, the CEI envisions a river along which patients, families, and clinicians move and where ethical concerns, if not addressed early, can place individuals at risk of drowning in unresolved conflicts, moral distress, or crisis.

Upstream, the goal is early identification. Ethics integration at this stage involves listening for ethics in everyday clinical encounters, promoting clear pathways for requesting ethics support, providing education on common ethics consult categories, and implementing ethically aligned processes. When ethics is integrated upstream, teams are better equipped to anticipate concerns and address them before escalation.

When ethical concerns cannot be fully anticipated, ethics leadership deploys a responsive life raft, engaging in real-time patient-specific consultation or partnering with clinical and operational teams to ensure policies, processes, or initiatives align with Ascension's Catholic identity prior to implementation. Downstream, following serious ethics events, near misses, or successful process implementation, ethics provides and participates in retrospective reviews to identify

education gaps, process failures or successes, and quality improvement opportunities that inform upstream prevention.

Ethics committees are a critical component of Ascension's ethics infrastructure. They function as the defined mechanism for responding to ethics consultations and supporting ethics leaderships through structured, reliable processes. Committees provide forums for retrospective review of complex cases, enabling learning, identifying education gaps, and informing quality improvement. Ethics committees and consultants are often engaged too far downriver, after goals of care have fractured or conflict has escalated. Clinicians frequently express that they "sense something is off" long before they feel equipped to name the underlying issue.

The CEI responds directly to this need by expanding the ethical vocabulary and confidence of the frontline. Its overarching goal is to promote ethics engagement consistent with best practice criteria, including timely consultation, interdisciplinary participation, and the effective use of committee mechanisms. In doing so, the CEI strengthens the quality, reliability, and accessibility of the ethics program across ministries.

DESIGN AND PEDAGOGY

The CEI is delivered in two parts, the "Core Session", and "Deep Dives". The Core Session is modular, interactive, and case-driven, allowing for use across diverse markets and adaptable to multiple formats (in-person, virtual, hybrid). It includes:

1. *Foundations of Clinical Ethics Practice*

Participants explore what a clinical ethics service does, how Ascension approaches ethics, and how personal morality differs from clinical ethics as a disciplined practice rooted in the Catholic moral tradition. It includes:

- Introduction to common ethical principles within the Catholic moral tradition
- Overview of the Ethical and Religious Directives for Catholic Healthcare Services
- Review of the Clinical Ethics Deliberation Process - highlighting exactly where EIC members contribute

One of the biggest paradigm shifts represented in the CEI is evident in this section. Rather than teaching participants primarily how to apply these principles and the ERDs to specific cases, the focus is on the ability to recognize the principles at play to identify and articulate ethics issues and connect to resources. While the CEI introduces and engages principles of Catholic healthcare ethics, it does so in the context of an ethicist-driven consult model that leverages the ethicist as subject matter expert in Catholic ethics principles.

2. *Listening for Ethics*

The Core Session established the foundation for this redesign, emphasizing the fundamental responsibility of all committee members to "Listen for Ethics." Listening for Ethics is a practice of recognizing ethical dimensions in routine clinical care before those dimensions escalate into crises. Participants learn to identify common ethical themes, distinguish between unfortunate situations and ethically problematic ones, and surface early indicators

of ethical tension. EIC members serve as the"front line" to:

- Identify ethical dimensions of clinical practice;
- Assess the key facts to articulate the Ethics Question; and
- Connect the case to the appropriate ethics resources or consultation processes.

Through guided discussion and vignettes, participants consider what ethics "sounds like" and how ethical dimensions emerge in conversation and workflow. This structure makes ethics a shared organizational competency, not the sole purview of professional ethicists. Participants explore ethical issues with depth, nuance, and practical relevance. This approach reflects a key insight: ethics is learned not only through theory, but through guided reflection on lived experience.

3. *Assessing Ethical Concerns and Formulating Ethics Questions*

Participants learn to articulate ethical concerns as structured ethics questions, which integrate relevant case facts, values conflicts or perspectives, and actions under consideration. Building this skill is challenging but critical, as well-constructed ethics questions support clear consult requests, efficient fact-finding, and reliable ethics analysis.

4. *Connecting to Ethics Resources*

The CEI equips EIC members to connect care teams to appropriate ethics resources. EIC members are trained to function as trusted intermediaries who translate clinical unease into ethics questions and help determine the appropriate pathway for engagement. This approach reduces reliance on crisis-driven consultation and promotes consistency across ministries. Connecting to ethics is framed not only as a reactive function, but as a proactive strategy that supports early engagement, organizational learning, and alignment with Catholic identity.

Building on the Core Session, the Deep Dive Sessions explore how EIC members participate in patient-specific clinical ethics consultation. These five sessions focus on content relevant to the participant's area of work: acute care, maternal-fetal, ambulatory, behavioral health and pediatrics. They clarify how EIC members contribute as subject matter experts and provide case-based practice that mirrors real clinical consultation processes. This approach helps demystify ethics consultation, reducing the perception that ethical analysis is inaccessible, intimidating, or untethered from the practicalities of patient care, demonstrating a structured process grounded in the clinical realities participants already know well.

CONCLUSION

The redesigned Clinical Ethics Intensive reflects Ascension's commitment to building a culture that is proactive, collaborative, and mission-aligned. In a healthcare environment marked by complexity, uncertainty, and profound human vulnerability, the CEI offers a scalable model for interdisciplinary collaboration and reaffirms our collective commitment to dignity, justice, and the common good in every patient encounter. By training embedded ethics resources to recognize the early signals of ethical dimensions of care and bring their

own expertise to consultation discussions, the CEI is an essential programmatic element that cultivates ethics capacity across disciplines and strengthens the moral fabric of clinical practice.

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A Ministry-Wide Policy for Potentially Medically Inappropriate Care: One Year of Challenges and Successes

INTRODUCTION

It is a scenario familiar to clinical ethicists: a consultation from the Intensive Care Unit where a patient has had a long, protracted hospitalization and is not improving, despite all interventions. A provider may characterize the care as "futile" but feels some obligation to continue because "it is what the family wants." Mercy has worked over the past two years to implement a ministry-wide policy to help adjudicate medical care requests from patients or their surrogate decision makers when the care team no longer feels comfortable providing that specific medical intervention. This article is to summarize what has been effective with the policy's implementation and identify the challenges that remain.

BACKGROUND

To address this issue, Mercy ethicists worked with multiple specialty councils such as the critical care council to create a standardized process to address requests for potentially medically inappropriate care. Before the implementation of this ministry-wide policy, only one facility in Arkansas had a policy to address requests for care the medical team no longer felt was appropriate. The work to develop a ministry-wide policy began in St. Louis where Mercy is headquartered.

The policy focuses on proactive communication and follows the four recommendations of the policy statement endorsed by five critical care professional societies titled "An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units." In this statement, the five societies make a distinction between physiologically futile care and care that is potentially medically inappropriate. Care that is physiologically futile is a very high threshold, and there is no obligation to provide care that meets this threshold. With care that does not meet the physiologic futility threshold, termed "potentially medically inappropriate," the paper implores the importance of proactive communication as well as engaging multiple disciplines to help the family understand the severity of the patient's condition. The specialties mentioned in the paper include ethics and palliative care. Mercy also includes as standard practice our spiritual care department.

STRENGTHS

A strength identified in the implementation of the policy was that it was widely welcomed by providers of all specialties. One of the largest challenges in developing a ministry-wide approach to any initiative is provider buy-in; having the support of physicians facilitated the policy implementation. The endorsement of professional societies, including the disciplines of thoracic surgery, critical care nursing, pulmonologists, intensivists and critical care specialists (European and American) offers the credibility of professional consensus. Mercy ethicists responded to the provider receptiveness and socialized the policy with providers and caregivers to familiarize them with the purpose, definitions, and processes of the policy. Mercy ethicists met with not only providers but leaders of nursing units to help familiarize the care team with the new policy.

Another strength was the emphasis on proactive communication. How often we hear from families one physician seemed optimistic, and the next day they received "bad news" for the first time. Or they struggle to understand the optimism of one specialist only to be confronted later with an overall poor prognosis. Leadership appreciated that the policy implored that all reasonable measures ought to be taken to avoid an intractable conflict between provider and families. This policy wasn't designed to provide a fast lane or a foregone conclusion to withdraw care but to help clinicians thoughtfully walk through a difficult process.

Finally, providing a standardized process across the ministry gave providers more confidence in navigating these complex scenarios. Prior to the implementation of this policy, providers reported feeling unsupported, like they were "on an island" and open to liability since it was their medical judgment stating the care was potentially medically inappropriate. Having a document they can refer to helped providers feel assured they weren't reinventing the wheel each time they encountered this scenario. The participation of legal counsel in Complex Care discussions, and Public Relations personnel in those cases where families engage with social or traditional media, allows clinicians to focus on the clinical needs of patients.

CHALLENGES

With change, there will often be growing pains. Some of the challenges included communication issues, questions about who initiates the process, and variation in practice between providers. To begin, the communication issues stem from the fact that most patients have had an incredibly long length of stay, with multiple providers signing on and off weekly. Maintaining a consistent message across providers in various specialties can prove challenging. In practice, Mercy ethicists encourage providers to have a verbal handoff to the next provider to better articulate nuanced circumstances, but that does not always occur due to logistics, time limitations, or providers' communication preferences.

Another trend that has been noticed is that occasionally a caregiver other than a clinical provider will ask "Is this inappropriate care?" prior to any clinical care team member raising the question. This was an opportunity to provide education to our non-clinical care

team members that this policy is provider-led, meaning that it is paramount that the determination that the care is potentially medically inappropriate is made on clinical factors assessed by a physician. While other specialties and departments can offer invaluable insight and are integral to the process, it is critical that the initial assessment of the effectiveness of care is made by a physician familiar with the patient. This can cause moral distress in other care team members who might see things differently than the attending physician, but it is important to keep this distinction, so the process is initiated based on clinical appropriateness.

Another issue that Mercy ethicists have noted is that occasionally the attending physician simply wants to maintain the status quo even when there is a consensus among other members of the medical team, including previous attending physicians, that the care is potentially medically inappropriate. Ethicists try to work with these hesitant physicians to understand the rationale behind their hesitancy. If the hesitancy is rooted in fears of legal liability or angering the family members, ethicists draw on resources which can help share the burden as a team, providing support for legal and moral analysis, family coping skills, and managing conflict. However, if the current attending physician has a differing opinion of the appropriateness of the care or the long-term prognosis, they may continue care that they assess to be clinically appropriate.

Finally, in rare circumstances, a provider continues to escalate care according to family preferences while the rest of the care team has agreed to limitations on the potentially medically appropriate treatment. Like the previous challenge, it is important to understand the physician's reasoning for escalating care when there is otherwise a consensus. Mercy ethicists respect that providers might have differing medical judgments about what constitutes potentially medically inappropriate treatment but want to take care to mitigate fears of legal liability or hesitancy to upset family members further.

CONCLUSION

The implementation of the policy has largely been positive, but there will always be challenges to identify and overcome. Mercy is still learning from the implementation of this policy and will address new issues as they arise. In addition, as new providers come into Mercy, we anticipate that introduction will be needed for providers who have not already had experience with similar approaches. ✣

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An Exploration of Ableism in Healthcare Resource Allocation

INTRODUCTION

When healthcare resources become scarce and providers must choose who receives treatment, the Hippocratic principle of Justice is often the most difficult to honor. Clinicians may turn to decision-making algorithms in hopes of minimizing personal bias, but these tools inevitably introduce the biases of their creators. Algorithms do not transcend prejudice; they reproduce it. If bias exists in an algorithm's parameters, it will shape its outputs. A common tool among rationing algorithms is the use of Quality of Life Years (QLY), a metric that appears objective but in practice embodies ableist bias. This paper explores the discriminatory nature of QLYs, examining their origins, definitions, and conflicts with core principles of medical ethics.

ALGORITHMS BORN OF BIAS

With the rise of "black box" algorithms and deep learning systems, researchers have recognized that algorithmic outputs are only as good as the data and structures upon which they are built.

Belief in algorithmic objectivity is widespread but unfounded: algorithms, whether advanced neural networks or simple clinical guidelines, reflect the values of the societies that create them[1, 2]. Thus, when society undervalues certain populations, algorithms inevitably do the same.

One clear example is the treatment of disabled individuals. Research repeatedly demonstrates that society undervalues their quality of life, a dynamic captured in the "Disability Paradox"[3].

Although disabled people themselves often report meaningful and fulfilling lives, broader societal perception continues to assume diminished well-being. Historical injustices, culminating in the 1990 Anti-Disability Act[4], illustrate recognition of these biases at a cultural and political level, but healthcare rationing guidelines remain slow to adjust. Asch argues that stigma runs even deeper, rooted in psychological discomfort: disability serves as a reminder of human vulnerability, fueling subconscious desires to marginalize disabled people, as evidenced by permissive attitudes toward physician-assisted suicide in cases of severe disability.[5]

Another factor complicating equality is the structural difference between disability and other forms of marginalization. While stigma against most other demographic groups can be addressed by shifting attitudes, disabled people require both destigmatization and material investment. A wheelchair user, for instance, cannot fully integrate into society until physical accommodations like ramps are provided. This dual burden (needing both acceptance and resource allocation) makes destigmatization even harder to achieve. Shakespeare suggests

that such obstacles can make bias feel insurmountable, and current rationing protocols inevitably reflect these systemic inequities.[6]

QLYS IN CONTEXT

QLYs aim to quantify the benefit of medical interventions by multiplying survival years by a score for perceived quality of life. Despite their fragile theoretical foundations, they remain central in rationing decisions. The UK's National Institute for Health and Care Excellence (NICE) explicitly incorporates them in its guidelines.[7] In the United States, the Organ Procurement and Transplantation Network (OPTN) does not directly admit to the use of QLYs, stating reliance on principles of Utility, Justice, and Respect for Persons. However, "Utility" is defined to consider survival and quality of life as decisive factors.[8] Because disabled patients are often defined as having both reduced survival and lower quality of life, they are systematically disadvantaged. The dynamic known as "double jeopardy" is exemplified by the OPTN's transplant protocols, which state that the health state of these individuals is further harmed by deprioritization due to an existing health condition. The OPTN's lung transplant system explicitly cites conditions commonly associated with disability such as rheumatoid arthritis and cystic fibrosis as lowering quality of life and reducing priority for organ allocation.

Other organizations cloak QLY use through Cost-Effectiveness Analysis (CEA), a framework borrowed from economics that evaluates value per dollar spent. While useful for budget allocation, CEAs reflect utilitarian ethics rather than the deontological traditions of medicine. During COVID-19 ventilator shortages, hospitals often avoided explicit CEAs[9], but researchers and policymakers used them in modeling and simulations to optimize distribution.[10, 11] This approach risks shifting care away from patient benefit toward economic efficiency, penalizing those with disabling conditions that might lower perceived post-treatment productivity. Although CEAs are not explicitly utilized in most cases, their reliance may expand as cost pressures increasingly shape healthcare systems.

DEFINITIONAL PROBLEMS WITH QLYS

At its core, a QLY multiplies life-years by a quality score. This seems straightforward, but in practice the numbers are arbitrary. They depend on one group's assessment of another's lived experience, a process fraught with inaccuracy. The Disability Paradox highlights the gulf between societal perception and disabled people's self-reports. Broader psychology confirms this mismatch goes beyond quality of life and is fundamental to the human experience: people's self-judgments differ dramatically from how others rate them across traits such as attractiveness, intelligence, and psychological well-being.[12]

Experts have shown that quality-of-life numbers are not only biased but also inconsistently generated. Some are assigned by physicians with limited perspective on the conditions in question, while others are set by policymakers or insurers with no clinical expertise.[13] Attempts to improve accuracy by polling disabled individuals also face limitations. Research shows that newly disabled people often rate their quality of life poorly at first, but

over time, adaptation leads to improved self-assessments.[14] This phenomenon of adaptation complicates any effort to distill lived experience into a single decimal. Ultimately, QLYs reduce the richness of human life to an oversimplified metric ill-suited for ethical decision-making.

THE PROBLEM OF QLYS IN MEDICINE

Although QLYs are convenient, they are incompatible with medical ethics. Economists champion them because they align with utilitarian ideals[iv], and societies often revert to utilitarianism in times of crisis, such as an acute shortage of a healthcare resource.[15] Yet medicine has worked to move beyond this "default" ethical mode. Justice in medicine emphasizes equity rather than maximizing majority outcomes.[2, 16] By prioritizing those with the greatest utilitarian return, QLYs and CEAs deny disabled individuals equitable access and reinforce systemic disparities.

Disability scholarship further undermines QLY assumptions. The Medical Model defines disability as a deficit managed by physicians, while the Social Model reframes it as a mismatch between ability and environment.[17] Most scholars recognize reality lies between these models, but QLYs remain entrenched in the Medical Model, ignoring environmental adaptations that can dramatically alter functionality. For example, a wheelchair user facing stairs and one facing a ramp may experience vastly different abilities, yet QLYs assign both the same reduced score.

Such rigidity reinforces outdated views and undermines fair allocation of resources.

PROPOSALS FOR REFORM

Deprioritizing disabled people not only worsens disparities but also deprives society of the contributions they could make if given equitable care. Continuing to use biased algorithms is unjust; once bias is identified, the only ethical path is reform. Survival criteria already disadvantage disabled people due to shorter life expectancies, while resource commitment criteria compound discrimination by undervaluing their quality of life.

Bioethicist Stramondo proposed combining survival with an inverse form of current resource commitment standards, essentially adjusting for bias by weighing algorithms in favor of those who need the most care, during ventilator distribution debates in the COVID-19 pandemic.[18] This approach seeks to maximize lives saved while ensuring that disabled patients are not excluded. While no algorithm can ever be fully unbiased, revising endpoints to prioritize fairness is a step toward equity.

Even so, theoretical fixes have limits. Algorithms require expert oversight, and as artificial intelligence grows more complex, fewer users fully understand their mechanics. This raises the risk of blind reliance on flawed tools. The most effective path forward may be less about perfecting algorithms and more about recommitting to patient-centered care. Clinicians must strive to understand not only the technical tools and medical processes that guide decisions but also the lived experiences of their patients.

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A Workshop on Standard Process for Assessing the ROI of Clinical Ethics Consultation

The field of clinical ethics currently has no standard process for evaluating its return on investment (ROI).[1] The most recent Catholic Healthcare Innovation in Ethics Forum (CHIEF) provided an opportunity to leverage the expertise of participants through a workshop format to develop a draft process to support ethicists in collecting and analyzing the data needed to show the ROI of clinical ethics and collaborate with operational partners to this same end. The workshop started from the position echoed by the American Society for Bioethics and the Humanities' (ASBH) Core Competencies which acknowledges that "[e]thics consultation services should be able to assess and demonstrate their value to the recipients of the service, as well as to hospital leadership who support the service."[2] Our goals for the workshop were ambitious: (1) identify relevant metrics for clinical ethics consultation, (2) craft early formulations of those metrics as an ROI, (3) determine who and how to ask for similar data across participant health systems, and (4) structure an ROI "pitch" for clinical ethics consultation using a needs assessment framework for system leaders. Where we ended was more realistic. Namely, knowledge and process gaps were identified by participants in an effort to guide future work. This piece is therefore more descriptive than argumentative in an effort to summarize the insights of workshop participants and provide a bit of a roadmap for the ethics community as to where the subgroup's work will head over the coming months.

DEFINITIONS

We began the workshop with a set of definitions to ensure participants were approaching the topic similarly. Most important of these definitions included ROI itself. We used the following formula to define ROI to conceptually think about value:

ROI = (Net Profit / Cost of Investment)[3]

Using the metric of volume (i.e., the number of clinical ethics consults performed in a year) as an example, we emphasized that an ROI has to demonstrate a benefit to the organization through a relationship among a set of metrics.

Clarifying how we would define and explore an ROI for the participants also required clarifying a few terms that would be essential to the exploration:

Metric	require both a means of measurement and interpretation; used to evaluate a business strategy, e.g. ROI, improved efficiency
Benchmark	measurement or standard against which comparisons can be made
Benchmarking	comparing business processes and performance metrics to industry bests or best practices from other industries
Key Performance Indicator (KPI)	*limited number* of financial and operating indicator metrics that measure performance critical to the success of an organization
Outputs	direct products of program activities
Outcomes	specific changes in program participants' behavior, knowledge, skills, status and level of functioning

Table 1. Definitions[4]

We concluded the opening portion of the workshop with a brief overview and a brainstorming exercise on commonly used metrics in healthcare – length of stay (LOS), readmission rate, reimbursement (cost vs. charges), throughput times, volume, case mix index (CMI), and voluntary turnover rates. This exercise served as a catalyst for participants to think about clinical ethics consultation in the context of how healthcare already thinks about demonstrating value through relationships of common quantitative metrics. From this discussion, we were able to illustrate how ROI has evolved through distinct "generations," shifting from simple financial arithmetic to complex, multi-dimensional strategic frameworks. Thus, volume of clinical consultation is an important metric, and while likely critical to calculating an ROI, it is not an ROI itself.

GENERATIONS OF ROI

During our discussion, we wanted to demonstrate to participants the longitudinal changes and more sophisticated metrics being employed to study ethics consultation. In what we termed "Traditional or Generation 1" metrics, studies included the number of consultations as well as other descriptive statistics about the study population, e.g. age, race. Generation 1 quality improvement studies were (and continue to be[5]) more qualitative[6] in composition and look at the decreased variation[7] in practice. Generation 2 studies examined the impact ethics consultation has on reducing a patient's length of stay[8] and comparison[9] of the ethics consultation between similar facilities. Generation 3[10] studies took us one step further into interventional research by demonstrating that ethics consultations improved contribution margin and there was a

decrease in the variance of length of stay, not just a decrease in overall days past expected discharge. This is an important distinction because the biggest payers (government and commercial) utilize very sophisticated modeling to predict the length of stay for patients with the same type of diagnosis which is especially critical when many patient populations are shifting from traditional fee-for-service models to value-based care models. This then led us to discuss with the group what would Generation 4, an advanced and predictive ethics model, look like.

CORE COMPONENTS OF A NEEDS ASSESSMENT

We utilized a standard needs assessment framework[11] with our workshop participants to ensure each of the three groups were aligned in their approach while also creating an opportunity for replicability for post-workshop utilization in each respective participants' healthcare system. This framework served as a roadmap for the remainder of the workshop to help participants move from current reality to early concepts of an ROI.

1. Describe the problem	• How to describe problem to operations leader (i.e., why should s/he care)?
2. Proposed Solution	• What's the connection to the work? Why is this necessary in the first place? • What metrics are important? How will you gather data?
3. Proposed Methodology	• What do you propose the structure to be like?
4. Current State	• What is currently happening with our structure?
5. The Ask/Future State	• Where do you envision next steps lie? • What are the early essentials to get there? • How will you measure success?

Table 2. Gap Analysis Framework

Perhaps the most important issue identified through the workshop was a general feeling among participants that they did not know where to begin. For some, the idea that there is a "problem to solve" seemed to suggest that there is something to eradicate within the healthcare industry. For others, the concepts of metrics and KPIs were entirely new and thus unclear. Similarly, the terminology of finance and operations were foreign, creating a very high bar for entry. After all, most ethicists did not study healthcare management in graduate school.

There also seemed to be some sense that clinical ethics consultation, by its very nature, is self-evidently of importance and therefore not necessarily in need of an ROI and therefore no real problem to solve. However, this led to discussion on how or why clinical ethics consultation should be "set apart" from innumerable healthcare fields where performance, efficiency and cost effectiveness dominate. Participants ultimately struggled with articulating the overall empirical improvements in the ethical dimensions of care that result from clinical ethics consultation, much less a causal relationship between the work and the claimed outcomes.

For those groups who did see a role for an ROI, linking an ROI to full-time equivalents (FTEs) seemed to too narrowly focus value on "saving roles" and not the value of clinical ethics consultation itself. Trying to move away from FTE associated ROIs, the discussion quickly stagnated with little certainty of how to proceed among the participants.

Interestingly, although the needs assessment framework and exercise envisioned for this workshop did not lead to early concepts of an ROI for clinical ethics consultation services, it did lead to broad consensus that a primer or a "101 course" on data analytics in healthcare would be extremely useful for those who lead clinical ethics consultation services or programs in order to begin to better communicate the value of the work to operational leadership. While some participants may have this expertise, in general the participants felt ethicists as a field lack familiarity with financial terms and data analytics or data management skills.

WHERE TO GO FROM HERE

Over the next year, a subgroup will take the gaps identified in the workshop to create an easy-to-use tool for ethicists to analyze ROI for their own clinical ethics programs. Several workshop participants volunteered to work on the project with us. Our goal is to develop a straightforward process that requires the ethicist to have little to no specialized knowledge of finance, data analytics, or healthcare operations. Ethicists will be able to take this tool to leaders in their own system in departments like IT, operations, and finance to help them identify and collect the data needed to calculate and analyze an ROI. We hope this will help ethicists in Catholic healthcare, or anywhere in the country, show the operational value that clinical ethics provides to the organization. ✠

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Book Review: Jordan Mason. *Being Beheld: On the Liturgical Consummation of Clinical Ethics Consultation* (New York: Bloomsbury Academic, 2026).

Born from a conceptually clear and well-argued doctoral dissertation, Jordan Mason's first book speaks prophetically to the professionalizing discipline of clinical ethics at a critical juncture of debate about the heart of the practice itself. In *Being Beheld*, Mason examines the push toward standardization of process in clinical ethics consultation (CEC), questioning the merits of doing so rather than, as many in the field are currently debating, what the standard process ought to be. While a move toward robust engagement of process is a fruitful result of a historical move away from overreliance on theory and application of rules, what has emerged is a challenging-forth mode of revealing the moral problems, possibilities, and proposals for resolution that ultimately miss "being" in all its dynamism. For Mason, to miss being is to fail to encounter the person(s) before us and by extension, the good(s) we seek to promote through the practice of CEC and the practice of medicine. This sidestepping of being is not due to misapplication of technique but a feature of the use of extractive and universal modes of revealing that qualify as challenging-forth. To illustrate the ways that the standard models on offer lead even well-meaning practitioners into this mode of challenging-forth, Mason walks through five models on their own terms.

For each she points out the ways the model seeks efficiency and repeatability, constrains moral analysis, and prevents encounter between persons beyond the rigid (and somewhat artificial) roles of contemporary healthcare. But Mason warns us not to be lured into thinking that we can ameliorate the practical drawbacks of one method by crafting a hybrid of multiple models: "we are not escaping the enframing that each of these standardized techniques brings once they are begun (17, emphasis original)." While it is certainly helpful to have one's own familiarity with the CEC models included in her analysis, Mason describes each one in turn, presenting them charitably before her critique.

Mason's deft use of Heideggerian philosophy to critique standardized CEC methods is precise without adding extraneous concepts to the flow of the book. Where this text truly shines is in the innovative weaving of Christian metaphysics and liturgical theology into a rich

understanding of what CEC can be in the hands of a practitioner truly committed to beholding being. Instead of seeking efficiency and repeatability, Mason outlines that seeing reality for what is and persons for who they are (insofar as we can deeply know others within the limited time they are in our care) is the path toward responsive and responsible CEC. While the purposes and expected activities of CEC should be explainable to stakeholders, especially to those requesting the consultation, each request should be addressed with a flexibility and moral encounter of persons that standardized methods do not permit. In looking to the non-identical repetition that a patient is, next steps are always contingent, circling, and dependent rather than set, linear, and independent. Instead of relying on our own power to enact a specified technique, a liturgical gaze sets the mystery of creation and the good as the ultimate horizons of inquiry. Ethicists are often perceptive individuals, with enough experience in healthcare to give rise to cynical expectations of stakeholders, but such cynicism and overconfidence in our own power of perception can stunt our moral imaginations. There are many takeaways for a practicing ethicist from this book, but chief among them is to always, always, allow oneself to be surprised.

As is custom in bioethics literature, a few well-placed case studies guide the reader to consider the practical application of the theoretical groundwork that Mason has laid out. The last vignette, which is designed to show a liturgical stance, is helpful in showing that simply following a standardized process would not have unearthed the real concerns and goods at stake for the patient. However, it is unclear how the liturgical stance is markedly different than the phenomenological approach associated with Richard Zaner. His preferred interventions of drawing out the narrative of the patient through repeated conversation and looking to the main stakeholders to identify the relevant features of a solution are both present in the actions of the ethicist in the vignette. Perhaps it is simply the case that a liturgical stance truly does have some commonalities with a more purely phenomenological approach, though Mason is persuasive that a liturgical stance is more capable of de-centering the ethicist in a way that Zaner does not achieve.

A focused book, there is little that one is left wanting from *Being Beheld*. For all the incisive critique of the techne of standardized CEC, Mason does not fully flesh out how such techniques malform their users. It would have been interesting to hear her analysis of what specific effects standardized processes have on the ethicist herself, thus lending more contrast to the discussion of the role of phronesis in a liturgical stance.

In all, Mason both offers a complete critique and positively argues for another way, a liturgically-informed doing of the practical ethics that is CEC. At the same time, Mason will start new conversations as the field begins to grapple with the proffering of a new path amidst the move to professionalization. ✠

JACQUELYN HAROOTUNIAN-CUTTS

ENDNOTES

- Thank you to Dylan Manson for proofreading this piece.

Recent Contraception Literature

Not only did the 2022 *Dobbs v. Jackson Women's Health Organization* decision lead to the implementation of abortion restrictions in some states, but it also affected clinician and patient behavior in the realm of contraception due to access to these services being inextricably linked. In states which have enacted the most restrictive bans post-*Dobbs*, there are concerns that contraceptive restrictions will also be enacted, especially on emergency contraception (EC). Many family planning clinics have closed in these 26 states, eliminating a source of contraceptive access that approximately one in ten women rely on.[1] Others fear that clinicians will pressure or coerce patients to adopt their preferred methods in contraceptive counseling.[2] The Ethical and Religious Directives (ERDs) echo the Catholic Church's prohibition of contraceptives utilized with the purpose "either as an end or a means, to render precreation impossible," because this violates the inseparability of the unitive and procreative facets of the marital act.[3] ERD 52 states: "Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning." It may appear, therefore, that restrictions on contraception have no effect on the provision of Catholic healthcare services. However, the ERDs note two instances in which the use of contraception is permissible. First, in ERD 36, the USCCB outlines the licit usage of medications which "prevent ovulation, sperm capacitation, or fertilization" for women who are victims of sexual assault. Although it is impermissible to remove, destroy, or interfere with the implantation of a fertilized ovum, the provision of "compassionate and understanding care" may call for the use of contraceptives as a form of defense against conception following rape. In ERD 54, "procedures that induce sterility" can be licit via the doctrine of double effect, under which "the direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available." Legal shifts affecting the availability of contraceptives, therefore, may impact the ability of Catholic healthcare systems to provide adequate medical care. The articles reviewed below capture trends in oral and emergency contraceptive use post-*Dobbs*, as well as changes in clinician counseling of adolescents following the landmark decision.

> Qato, Dima M., Rebecca Myerson, Andrew Shooshtari, Jenny S. Guadamuz, and G. Caleb Alexander. "Use of Oral and Emergency Contraceptives After the US Supreme Court's *Dobbs* Decision." JAMA Network Open 7, no. 6 (June 26, 2024): e2418620. https://doi.org/10.1001/jamanetworkopen.2024.18620.

Qato et al. examined the effects of the *Dobbs* decision on monthly fill rates of oral contraceptive pills (OCPs) and emergency contraceptives (ECs), comparing states which implemented full abortion bans (12 states) following the decision with comparison states (14 states), which maintained a consistent

level of restrictions pre- and post-*Dobbs*. Using IQVIA's National Prescription Audit, PayerTrak, and the 2021 American community survey, the authors calculated the monthly rates of pharmacy-dispensed oral contraceptive fills per 100,000 women of reproductive age during four time periods: pre-*Dobbs* oral arguments, between the *Dobbs* oral arguments and the announcement of the decision, the first year post-*Dobbs*, and more than one year after the decision.

142.8 million prescriptions for OCPs and 904,269 prescriptions for ECs were filled nationally at pharmacies between March 2021 and October 2023, spanning the duration of the study. The monthly fill rate declined 25.6% nationally between these time points, dropping from 6784 to 5049 fills per 100,000 women. Fill rates for non-oral hormonal contraceptives also declined steadily over this time span. When examining EC rates, the authors found that the period during which *Dobbs* was under review witnessed an increase from 33.3 to 40.5 fills per 100,000. This number peaked at 52.6 following *Dobbs* in July 2022, but declined to reach pre-*Dobbs* levels (32.9/100,000) and fell even lower in the most restrictive states.

When examining the states which became the most restrictive with comparison rates, the authors found that states which implemented full abortion bans experienced a 4.1% decline in OCPs (285.9/100,000 fewer fills) in the year following the decision. Past the one year mark, the most restrictive states underwent an additional 5.6% decline (386/100,000 fewer fills) compared to comparison states. While EC fills increased in both groups of states in the first year following the decision, the most restrictive states saw a 65% decrease in EC fills (13.2/100,000 fewer fills) after the one-year mark. At the same time point, levonorgestrel and ulipristal fills had declined by 48% (5.8/100,000 fewer fills) and 89.9% (7.4/100,000 fewer fills) in these states, respectively. Using a sensitivity analysis, the authors determined that declines in oral contraceptives were not offset by increases in use of other contraceptive methods.

The authors attribute these results to the closure of family planning clinics, one-third of which provide contraceptive prescriptions – both OCPs and ECs – to be filled at pharmacies. Supporting this claim is the fact that "post-*Dobbs* declines in ECs were greatest in the most restrictive states that had closed a larger share of their family-planning clinics". They also hypothesize that confusion regarding the legal status of ECs may have led to the decline in fills of ECs following the decision; recent policies such as "the exclusion of ECs from contraceptive coverage mandates, the lack of Medicaid coverage for over-the-counter ECs, and policies that allow pharmacists to refuse to dispense contraceptives due to moral, ethical, or religious objections" may be contributing factors to the decreased rates in the most restrictive states. The authors conclude by pointing to the need for further research on changes in the use of long-acting and permanent contraception post-*Dobbs*.

Bullington, Brooke W., Emily S. Mann, Madeline Thornton, Joline Hartheimer, Kavita Shah Arora, and Bianca A. Allison. "Clinician Perspectives on Adolescent Contraceptive Counseling Following *Dobbs v. Jackson*: Implications for Young People's Contraceptive Autonomy." Journal of Pediatric and Adolescent Gynecology 38,

no. 1 (February 2025): 75–78. https://doi.org/10.1016/j.jpag.2024.10.007.

Bullington et al. hypothesized that, post-*Dobbs*, clinicians prescribing contraception to adolescents may prioritize pregnancy prevention and pressure patients to adopt specific methods over their preferences or to utilize contraception against their wishes. The authors attribute this pressure to worries about the consequences of unintended pregnancy and efforts to maintain the national public health goal of preventing adolescent pregnancy.

After conducting semi-structured interviews with 16 clinicians (15 physicians and one nurse practitioner, all of whom see adolescent patients) sampled from an American Academy of Pediatrics conference, three themes emerged. First, participants spoke of an increased focus on pregnancy prevention in counseling, with one participant noting, "I like [pregnancy] prevention rather than [abortion] so, if we can just avoid it altogether, it would be ideal." Second, participants spoke of using the *Dobbs* decision to promote long-acting reversible contraceptive (LARC) methods – such as one respondent who noted they are "pushing IUDs much, much more and much earlier". One participant said, "Oh, [the *Dobbs* decision] is actually helping me, because I'm saying, listen, I don't know what else they would do [if they got pregnant]", as well as how the Supreme Court decision "added a talking point to [their] push for LARC". Another explained that they advised caution for a patient who was moving to a state with limited abortion access for college, skewing their recommendation towards LARC. The third and final theme identified was that location of practice and the state's abortion legislation influenced the counseling provided, with some counseling not changing significantly in areas unaffected by *Dobbs* and some counseling becoming highly influential following abortion restriction.

In their discussion of the results, the authors note that physicians must be aware of the potential biases created and amplified by the *Dobbs* decision, which inhibit adolescent autonomy and act as barriers to achieving the national recommendations of "person-centered, impartial contraceptive counseling." Clinicians must examine their values and beliefs and ensure that they are not emphasizing their priorities and public health goals at the cost of excluding patient preferences and needs. The authors call for a change in practice to include "comprehensive contraceptive care provision, provider training in unbiased and affirming contraceptive counseling, and continued refinement of developmentally tailored contraceptive decision aids" so that reproductive care does not come to constitute an assault on reproductive justice.

RECENT NATURAL FAMILY PLANNING (NFP) LITERATURE

Natural family planning refers to the use of knowledge of "natural biologic markers to estimate a woman's fertile phase within her menstrual cycle" in order to avoid or achieve pregnancy.[4] Catholic proponents of NFP claim that this practice, incorporating periodic abstinence, maintains the proper expression of conjugal love, as opposed to the use of contraception, which stands in opposition to the virtue of chastity.[5] Non-religious proponents claim that the use of

NFP can strengthen marriage by facilitating a greater understanding of fertility, as well as increasing communication, self-mastery, intimacy, appreciation for intercourse, and spiritual well-being; others raise concerns of detriment and stress caused by NFP due to challenges in implementation, lack of spontaneity, and fear concerning pregnancy. Either way, there has been an increase in the number of women who wish to manage their fertility through non-hormonal methods (from 1.1% use of fertility-based awareness methods in 2008 to 3.2% use in 2015), such as through applications which chart and track the menstrual cycle, due to hormonal contraception's side effects.[6] Considering the effects of *Dobbs* on contraceptive use behaviors and attitudes towards contraception, we should examine the effectiveness and effects of NFP methods, which require no prescription but need education and consistency to be effectively implemented. The articles below detail a study of the effectiveness of the Marquette NFP Method and the effects of NFP on marital relationships to determine whether NFP can serve as a suitable alternative to prescription contraceptives.

> Mu, Qiyan, Richard J. Fehring, and Thomas Bouchard. "Multisite Effectiveness Study of the Marquette Method of Natural Family Planning Program." The Linacre Quarterly 89, no. 1 (February 2022): 64–72. https://doi.org/10.1177/0024363920957515.

The use of NFP and other fertility-based awareness methods for contraception raises concern among healthcare providers; these methods are not deemed effective due to "worries and concerns of user inappropriateness, lack of accurate knowledge of female fertility and of NFP methods, and clinical time constraints to teach the method." Modern NFP incorporates more advanced technology, but still presents a typical use failure rate between 2 and 23 percent depending on the method. The Marquette Method, developed in 1998, uses urine hormonal monitoring technology to estimate the cycle's fertile window. Traditional aspects of NFP like mucus monitoring and temperature taking may also be incorporated, and the method must be taught by a teacher who has been trained with a theory course, practicum course, and medical applications course.

Mu et al.'s study was a retrospective and longitudinal investigation over the course of 12 months, using the teaching records of ten Marquette Method teachers in the United States and Canada. This group of teachers was comprised of professional nurses, advanced practice nurses, a family practice physician, and a physician assistant. The average woman receiving the education was 29.63 years old, and of these women, 32.9% had regular cycles, 60.7% were postpartum and breastfeeding, and 5.6% had irregular cycles. The 1,221 women used a variety of indicators, with women using basal body temperature, cervical mucus monitoring (CMM), electronic hormonal fertility monitoring (EHFM), luteinizing hormone urine monitoring (LH test), or a combination of these. The majority (61.8%) used a combination, with the most popular choice being the use of the LH test with either CMM or EHFM (38.6%), followed by EHFM only (27.2%), then the combination of CMM and EHFM (23.2%), and finally, the use of CMM alone (9.3%).

Correct-use unintended pregnancies (pregnancy resulting despite avoidance of intercourse in the fertile window) are contrasted from incorrect-use unintended pregnancies (pregnancy resulting from intercourse in the fertile window or an incorrect calculation of the fertile window). A total of 42 unintended pregnancies were reported in this study, with 11 of these marked as correct-use unintended pregnancies. The overall typical use pregnancy rate was calculated to be 6.7 per 100 women over the course of 12 months; when examining each subgroup, the rates are 2.8, 8.0, and 4.3 pregnancies per 100 women for the regular cycle group, the postpartum and breastfeeding group, and the irregular cycle group, respectively. When examining pregnancy rate by method, the rates were 4.1 per 100 women who used LH with CMM or EHFM, 8.1 per 100 women who used EHFM alone, 14.1 per 100 women who used CMM and EHFM in combination, and 15.6 per 100 women who used CMM alone.

These findings are consistent with previous research on the Marquette Method's effectiveness. The Marquette Method is also comparable to other NFP methods, and the unintended pregnancy rates are close to that of the hormonal contraceptive pill (8/100 unintended pregnancies in a 12-month period) and the male condom (12/100 unintended pregnancies in a 12-month period).

The authors note several limitations of the current study: the retrospective design does not allow for the calculation of correct-use pregnancy rates by correct months of use, and the data set lacks demographic information about religion, economic status, race, ethnicity, marital status, and level of motivation for avoiding or achieving pregnancy (once motivation levels fall below 8 on a 1-10 scale, there is a significant increase in unintended pregnancies). Despite these limitations, this study demonstrates that "healthcare providers who completed the Marquette Method teacher training program can successfully teach women and couples NFP and achieve consistent results comparable to those of previous effectiveness studies."

Fehring, Richard J., and Michael D. Manhart. "Natural Family Planning and Marital Chastity: The Effects of Periodic Abstinence on Marital Relationships." The Linacre Quarterly 88, no. 1 (February 2021): 42–55. https://doi.org/10.1177/0024363920930875.

Fehring et al. set out to examine the influence of contraception and the use of NFP on divorce, separation, and cohabitation rates in women of reproductive age. They begin with a review of the current literature surrounding NFP and periodic abstinence (PA), concluding that the majority of male and female users of NFP report that the practice has helped their marriages despite some difficulty adhering, and these individuals may even demonstrate higher self-esteem, higher levels of intellectual, relational, and sexual intimacy, and greater spiritual well-being when compared to contraceptive users. Small sample size and convenience sampling present limitations in this literature, but one cited study shows that 62% of couples using NFP reported that the practice improved their relationship, while 1.4% stated it worsened their relationship. When examining contraception, the same study

found that 12.5% of contraceptive-using couples felt it improved their relationship, while 22.5% reported that use worsened their relationship. The authors' review of the literature led them to conclude that there was no significant difference in frequency of intercourse between NFP and contraceptive users. Finally, they present the strong claim that ever-use of family planning methods like sterilization, vasectomy, OCPs, condoms, and abortion were all associated with increased odds of divorce when compared with women who had never used these methods in one study; however, they point out the very small sample size of women who have ever-used NFP and that many other factors (such as religiosity) could lead to or prevent divorce.

Fehring et al.'s study hypothesized greater odds of divorce and cohabitation for women who ever-used the aforementioned contraceptive methods when compared to those who never-used those methods, as well as lower odds of divorce for frequently church-going women who have ever-used NFP and report religion's import in their lives. They used the data set from the National Survey of Family Growth, including interviews with 2,582 women who had ever been married. Of these women, 70.8% were married, 19.7% divorced, 7.8% separated, and 1.7% widowed. 51.4% of women were Protestant, 20.5% were Catholic, 17.9% reported no religious affiliation, and the remaining 10.1% were of other faith systems.

Results of this study showed that the most common method of contraception was sterilization; comparatively, only one percent of women reported current NFP use. Divorce and separation rates were 39.4% for women who had ever-used sterilization, 27.7% for those who had ever-used condoms, and 14% for those who had ever-used NFP. As demonstrated, "women who had ever-used NFP had lower odds of divorce compared to those women who never-used NFP." Ever-use of oral contraceptives increased the odds of divorce or separation by 40%, and sterilization did so by 60%; ever-use of NFP decreased the odds by 31%, and church attendance did so by 49%. Cohabitation, which religiosity significantly protected against, was also associated with a 2.4 times increase in the odds of divorce or separation compared to women who had never cohabitated. This finding ties into the study because the ever-use of sterilization, OCs, and condoms is associated with between a 1.7 times and 3 times increase in the odds of cohabitation when compared to women who never-used these methods. These findings are limited by the low number of NFP users and the investigation of ever-use of NFP as opposed to consistent use, but the results indicate that the use of periodic abstinence as a component of NFP serves to strengthen the marital relationship.

CONCLUSION

Evidently, the historic overturning of *Roe v. Wade* did not only impact abortion access in the United States. Another study investigating the differences pre- and post-*Dobbs* in four states found a decline in sexual activity, a decrease in the reception of high-quality contraceptive care, an increase in barriers to contraceptive access, and an increase in condom use.[7] The ripple effects of shifting abortion legislation on contraception decisions are merely beginning to be investigated, and the reproductive landscape will continue to shift as states continue

to deliberate their abortion services and provision of reproductive care service. These shifts make it critical to devote attention to changes in contraceptive access, the efficacy of different contraceptive methods, and the effects of different contraceptive means on relationships, as well as to craft policy that mitigates the effects of abortion restrictions on reproductive autonomy in the realm of contraception. Evidence suggests that the inaccessibility of abortion may lead to a greater push, both by women and their healthcare providers, for contraceptive use. Although increased utilization of NFP techniques – performed while the couple remains open to procreation – stands in alignment with the teachings of the Catholic tradition, contraceptive use which disrespects the marital act by separating union from procreation does not. In light of these shifts, Catholic healthcare systems may need to emphasize and clarify the Church's position on contraceptives while continuing to provide compassionate and understanding care to women who seek contraception, for reasons both licit and illicit.✠

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ENDNOTES

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