

Notes from One in the Statistical Average of Catholic Health Care Ethicists: Claims, Responses and Personal Journeys

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As one who answered CHA's 2014 ethicist survey, I have an interest in how my demographic information and responses compare with that of others. Demographically, I am in the statistical mean (the mathematical average) or mode (most repeated quality). I am male, in my 30s, Caucasian and a lay person. I have two master's degrees (one in education, one in ethics), a doctorate (multidisciplinary Ph.D. in Health Care Ethics), director of ethics title and eight years total experience in Catholic health care ethics, with just over five years of that within Catholic health care systems other than Mercy Health.

Why am I responding to the survey?

First, my education and experience give me a rather different perspective on health care ethics and the survey results. My early background is in student life and student affairs (support services including admissions, diversity and residence life in colleges and universities). Second, I have encountered others' thoughts, questions and perceptions about health care ethicists which is probably also true of many other ethicists. Data from the survey and other sources support my responses to others'

claims, which may be of use even if other ethicists have not encountered the same exact claims and questions. Third, and closely related, this essay may provide a wider context for the CHA's 2014 ethicist survey. Daniel Sulmasy and Jeremy Sugarman use the Wallace Steven poem "Thirteen Ways of Looking at a Blackbird" as a metaphor for the different perspectives and disciplines brought to medical ethics. This essay is yet another view of the blackbird that is, in this case, health care ethics.¹

My response begins with part of my story, which serves as the basis for my responses to the claims of others that are discussed here. I then respond to the observations about health care ethicists that I have heard. The conclusion identifies common themes and suggests opportunities.

My Professional Journey

In the article, "Behind Every Face Is a Story," Lee Burdette Williams writes this about college students: "What would happen if we stopped to notice students, ask questions, and actually listen to their responses? ... Their lives are complicated."² The same is true for others, not *only* students, including health care ethicists. The observation by Williams is one she defines as a refrain to remain "patient, curious, compassionate."³

This refrain is also a beacon for me, warning about the dangers of pigeonholing and stereotyping. For example, it is accurate to categorize me as an ethicist with a still-recent, multi-disciplinary terminal degree within the white, male, layperson majority of Catholic health care ethicists. However, it is an unfair judgment to conclude that I am undeserving (e.g., have not suffered), have not paid my dues, and entered the profession the wrong way (i.e., did not work in health care beforehand and am not a moral theologian, physician, nurse, or other healthcare professional). Dismissing backgrounds such as mine as irrelevant to health care ethics is at best unfair. Yet all of these judgments have been directly levied or inferred in comments.

Also, like many others, I had several academic interests. Experiences in college, including being a resident assistant (RA), ignited a fascination with *ways* people learn, which are not only in the classroom but also over a lifetime. I earned a Master's of Education (MEd) in College Student Personnel – Administration, a track that included emphases on human (student) development, basic counseling skills (topics like active listening, not therapy), program evaluation and assessment, curricula and design, human (student) culture and generational studies, laws, and much more. I was a graduate hall director and a graduate assistant.

Yet, I felt a calling to health care ethics. Working full-time, I enrolled in a master's program, graduating with an MA in Biomedical Ethics and Health Care

Policy. My wakeup call occurred after interviewing for many ethics roles where I received two main messages. I had no experience in health care, so hiring me was a strategic risk employers preferred not to take. I was not a physician, nurse, health care professional, or a health care lawyer, so employers would not create an ethics role (presumably part-time). Some wisely suggested that a doctorate in health care ethics was the only way to transition into health care.

This advice was good. During my doctorate, Trinity Health hired me as the Director of Ethics (a system role) after a short, beneficial and enjoyable apprenticeship with Dan O'Brien at Ascension Health. Mentors encouraged and provided opportunities to gain clinical experience while working in system ethics. Finding my clinical ethics experience enjoyable and rewarding, I joined Mercy Health - Cincinnati where I served as a regional ethicist and, for some time, as a mission leader for two hospitals. I recently transitioned to a system ethics role with Mercy Health (formerly Catholic Health Partners), where I continue to be involved in clinical ethics to the degree possible.

Claims and Responses

This section of the essay addresses claims about ethicists and Catholic health care ethicists that I have heard or overheard at various times. The claims are relevant to the survey results and vice-versa.

Claim One: Those doing ethics should have a clinical background in healthcare,

presumably to be effective or to be most effective.

Clearly, most respondents to the 2014 CHA ethicist survey are not medical doctors or registered nurses, either when considering their primary degree alone (e.g., MD ethicists) or in conjunction with additional education (e.g., RN, PhD ethicists).⁴ This fact reflects the history of bioethics and health care ethics and professionals doing work within these fields.⁵ In the development of bioethics, conference organizers and center founders were researchers, scholars and professionals in medicine, philosophy, and theology.⁶ The beauty and challenge of bioethics is its breadth and multidisciplinary nature as noted by Dan Callahan reflecting on the lead up to the founding of The Hastings Center (as quoted in *The Birth of Bioethics*).⁷ Bioethics reflects influences from medicine and the health sciences, philosophy, literature, theology, anthropology and sociology, law, psychiatry and psychology, public health, feminist thought, political science and more.⁸ Having said this, one cannot make the claim from the survey data that the multidisciplinary profile of ethicists and Catholic health care ethicists *should be* the norm because it *is* the norm.⁹

Similarly, linking ethicists' effectiveness to disciplinary or professional backgrounds (i.e., academic training) seems equally tenuous, as evidenced by the following questions: What makes an ethicist? What standards do we use to gauge the ethicist's effectiveness? Are there differing standards for clinical and organizational

ethics, ethicists in a system or ethicists at the bedside, or between organizations? If so, what are they? How are these attributes comparable? Who is evaluating? Might those in leadership or who evaluate ethicists bring a bias against ethicists with different backgrounds, contributing to critical views toward them?

Callahan stresses that no one discipline should have supremacy because of the need for multiple methods in bioethics.¹⁰ Daniel Sulmasy and Jeremy Sugarman believe the best situation is to have a discipline in addition to the field of bioethics, but do not suggest what the discipline should be.¹¹ Even in a clinical consult, ethics consultants are aware of their discipline, have a certain amount of cross training (per Sulmasy and Sugarman), and rely on others from different disciplines.¹² What is said of the discipline and of ethics consultation can be equally true of those who practice the discipline and do consults.

Ethicists and others may find themselves in the informal role of mentoring others in bioethics and Catholic health care ethics, similar to many faculty and staff members in higher education who are formal and informal academic advisors. Mentorship and advising in this context have many parallels to informed consent because, presumably, the apprentice is competent and free from duress; the mentor and apprentice discuss information after its disclosure, and the apprentice comprehends and authorizes a decision.¹³ Similar to medical decisions, field decisions have gravity because they can significantly alter the course of a

person's life, affecting family, health, finance, geographic location and residency, hopes and aspirations, and more. Also, the risks of 'getting it wrong' in the information disclosure and discussion can be disastrous, and that is, again, comparable to medical decisions.

A way to get it wrong is to make an unfounded claim, such as the one above, which may lead to or perpetuate unfair judgments, expectations or practices. For instance, is it fair for one person to alter their career track to become an "effective" ethicist by way of medical school, residency and an ethics degree if a multidisciplinary ethics degree suffices? What if that person wants to be an ethicist, but not a nurse or physician? What is the message about ethicists from other disciplines? Furthermore, is it an unrealizable standard to ask for experience while not providing opportunity for that experience? Whose responsibility is the experience? Is it the university's, the professional's, the employer's, or all of the above? What if residency programs did not accept medical school clinical rotations as "enough" health care experience? A person has to start somewhere.

Claim Two: Ethicists make too much money, including those in Catholic health care.

I would encourage focusing on comparative compensation data that includes similar roles, titles, and the industry in general.

Let's consider the numbers with this in mind. The salary range by ethics role is from \$50,001 to \$450,001, a \$400,000 span, for those ethicists in Catholic health care responding to the survey.¹⁴ For perspective, it may be helpful to consider compensation for mission leaders because ethicists are often in mission departments within Catholic health care. The 2013 CHA Mission Leader Survey revealed a salary range from \$40,000 to \$300,000+, a span of over \$260,000, which appears to be dependent on local, market (regional), or system roles.¹⁵ With reference to titles, the annual, mean wage for "medical and health services managers" in medical and surgical hospitals was \$108,210 in 2013.¹⁶ Other healthcare professionals have similar annual, mean wages (2013 data)—\$77,890 for occupational therapists (OTs), \$82,180 for physical therapists, \$68,910 for registered nurses (RNs), \$95,070 for nurse practitioners (NPs), and \$191,880 for physicians and surgeons (MDs).¹⁷ In fact, at least five of the top ten jobs ranked by the *U.S. News and World Report* in 2015 are healthcare-related, based upon the balance of challenge and stress, opportunities for advancement and good incomes.¹⁸

Many variables affect wages, as anyone in human resources would attest. Variables include the experience and responsibilities of the individual in the role, title ("rank"), geographic area (cost of living) and education.¹⁹ Pay and role title (e.g., manager, director, vice president) are also linked. In all industries, chief executives have the highest median annual wages (\$168,140), followed by top executives (\$101,650) and then general and

operations managers (\$95,440).²⁰ Wage variance by geography or region (cost of living) is evident, for instance, when considering all medical and health service managers (e.g., physicians' office, home health, skilled nursing, and so on)—\$118,040 in California to \$118,020 in New York to \$93,190 in Ohio.²¹ Another strong correlation occurs between education (presumably highest level achieved) and income, supported by the Bureau of Labor Statistics' median weekly earnings (2013 data)—\$1,714 for those with professional degrees, \$1,623 for those with doctoral degrees, \$1,329 for those with master's degrees, \$1,108 for those with bachelor's degrees, \$777 for those with associate's degrees, and \$651 for those with a high school diploma.²²

For comparison, the annual mean income for ethicist survey respondents should be about \$76,175.51 to \$88,287.52, with a median around \$250,000 and a mode within the \$75,001 to \$100,000 range.²³ Clearly, the income range between mission leaders and ethicists is close. The same is true for the mean income of ethicists, which is close to the mean of RNs, OTs, PTs and hospital managers. Ethicists have comparable incomes to others in mission, others with similar titles and others within the health care industry.

Lest we confuse Hume's distinction of *is* and *ought*, the claim above judges (*ought not*) without relative observation (*why not*). Consider the innate message about mission, ethics and spirituality if clinical and executive counterparts do and 'should' make more money. Determining income is art and science; inequities may

result. An equitable system for one is not for another because of differing notions of fairness. Unequal pay claims should have specific grounds and concepts of fairness for these reasons, placing responsibility on the person making the claim. A particular *why not* must accompany *ought not* to respond with *why* and *ought*. Otherwise, ethicists' incomes seem equitable, especially if fairness follows similar roles (e.g., mission leaders), titles (managers, directors, vice presidents) and industries (e.g., health care).

Claim Three: Catholic health care ethicists need to be, or should be, Catholic.

This issue is of interest to me, having been in different faith traditions. Based upon survey respondents, over one in ten Catholic health care ethicists is not Roman Catholic.²⁴ One could respond that the claim that ethicists need to be Catholic is not true, based upon this data.

Assumptions are inherent in the claim that being Catholic makes one a better Catholic health care ethicist. We should question and, if need be, challenge foundational assumptions: How does one measure if being more formed in the tradition results in better decisions, behaviors, and/or effectiveness as a Catholic health care ethicist? Do the catechism and worship prepare one to be a good, Catholic health care ethicist? How does one gauge if the person embodies her or his catechesis and worship? It is quite possible that someone who is of a Protestant tradition would, for a variety of reasons, make a better ethicist in a Catholic health care setting than someone

raised and trained in the Catholic tradition.

The actual ethics role, what a person does day-to-day, should inform the helpfulness of being Catholic to that role. Generally, health care ethics is interdisciplinary or multidisciplinary; Catholic health care ethics requires an understanding of Catholic teaching. Roles that, for instance, interface with or have systemic interpretations of the Church may require more advanced understanding (e.g., being Catholic, having a pontifical degree). Thus, the issue goes from categorical (i.e., how Catholic health care ethics and education are similar or dissimilar to religious education and practice) to specific (i.e., how this Catholic ethics role is similar or dissimilar from religious education and practice, and what background is helpful).

Another consideration here is the possibility of someone converting to Catholicism. Certainly, ethics and the Church are replete with examples of religious conversion, for example, Alasdair MacIntyre, St. Elizabeth Bayley Seton, Cardinal Avery Dulles, and St. John Henry Newman. Conversions can be the product of evangelization. As Pope Francis explains, we “are active collective subjects or agents of evangelization... [that takes place] in so many different ways,” such as in word and deed.²⁵ Catholic health care, including mission and ethics, can be powerful evangelizers. The goal is not conversion, but exemplifying the Gospel message in all that we do, which can have a profound impact.²⁶

Experiencing the lived mission profoundly affects employees.

Those who fit well with the mission and values of Catholic health care, including prospective Catholic health care ethicists, also merit consideration. Students and coworkers undergo development (e.g., James Fowler’s *Stages of Faith*, 1981, and Timothy Gibson’s *Proposed Levels of Christian Spiritual Maturity*, 2005), which organizations can nurture. Larry Braskamp comments that, “colleges can actively create conditions and campus environments that foster these oft-neglected dimensions of holistic student development.”²⁷ Arguably, it is true for Catholic health care and not only for academic ethics programs. An example is the four domains influencing college student development – culture, curriculum, co-curriculum and community – that also may apply to the workplace (with adaptations – culture, education and service, and community).²⁸ Significant implications exist for students and ethicists who perceive acceptance or rejection by those in Catholic ministries. Ethicists and academics in advisory capacities should keep this in mind along with the disclosure that Catholic health care systems vary in their preferences for hiring Catholic ethicists.

Claims Four and Five: System ethicists should have clinical ethics experience before going into system ethics. System ethicists without this are undeserving (of their roles).

Again, I have a personal interest in these claims. Not only did I begin in system ethics, I recently had the experience of

doing clinical ethics in a regional role (along with being a mission leader for Mercy Health – Anderson Hospital and Mercy Health – Clermont Hospital for a lesser amount of time) and transitioning back to more of a system ethics role. My own view of system ethics effectiveness being contingent on clinical ethics experience has changed, landing somewhere in between.

The final claims are connected. Both posit judgments (*ought*) that observation (*is*) can counter. Not knowing the “other” category’s composition in the survey, single-hospital ethics roles (11.8 percent) are minimal when compared with regional (52.9 percent) and national roles (20.6 percent).²⁹ If survey responses indicate reality, about one in ten ethics roles are in a hospital.³⁰ There is some ambiguity regarding regional roles--some have more clinical focus than others.

Assuming a Catholic ethics ‘tenure track’ (hospital to regional to system), are we setting an expectation that we cannot honor? It is the hospital ethics roles that are the problem; they simply are not too few for the number of new ethicists that would need them.

Furthermore, I have sometimes heard the system office referred to as “the ivory tower” or “the big house” with home office employees called “out of touch” and transitions to the home office termed as “becoming one of them.” Likewise, I have also heard pejorative comments regarding those “on the floors,” or being “out there” with reference to those in clinical work.

Those in education are generally familiar with the town-gown relationship that describes differences between colleges and universities and the greater community. Often these differences are characterized as the “impractical and plodding academic” and the “sloppy and impulsive practitioner.”³¹ These descriptions are actually quite similar to the system/home office-practitioner distinction. Recent business literature as well as some associations are replete with examples of new initiatives and programs to lessen tensions in town-gown relationships.³² Health care could adopt and adapt these programs and initiatives. Such adaptations could serve to give health care ethicists additional experiences and, at the same time, benefit the health care organization.

An example might be helpful. Acute care operations (e.g., patient experience, departmental goal-setting and execution, operational effectiveness, disaster drills, staffing, patient safety and quality, and so on) were important experiences and learnings I had as a hospital-based mission leader. It was also an awakening for me to the relentless pace of hospitals, offices and clinics, and the heroic resilience of clinical caregivers in a race that is both a sprint and a marathon. Similarly, adopting or adapting recently developed town-gown models to the system/home office-practitioner divide could involve system ethicists in hospital operations (e.g., system ethicists doing a study on informed consent documentation for accreditation readiness in a hospital) or hospital ethicists in system operations (e.g., a clinical ethicist serving as a mission leader for a

centralized function or being part of an education team for a system-wide initiative rollout).

However, over emphasizing experience can also be a danger. Many factors mediate experiences and reasoning, such as our awareness and sensitivities, motivation, character, emotions and resourcefulness.³³ Furthermore, experience—as a part of moral reasoning—does not necessarily translate to moral behavior.³⁴ The application of clinical experiences and moral reasoning to other work depends on noticing the appropriate experiences, gleaning the correct lessons, being self-reflective of emotions, examining motivations and assumptions, imagining possible solutions by constructing proper comparisons between situations (then and now) and acting congruently. One ethicist may behave wisely in a system setting based on short-lived clinical experiences. Another system ethicist may not act in accord with decades of clinical experiences. Thus, experience may not equip one to respond appropriately in other situations, so it is unwise to overly romanticize experience.³⁵

We wind up in the middle, as a result. Is clinical experience helpful to system ethicists? It can be. Is clinical experience necessary? It is only if we can support it, otherwise it's an unrealizable standard. How much such experience? It depends on the person. Are system ethicists without it undeserving? No, although this is an opportunity for growth, as it should be for the many other professionals in health care without health care experience.

Catholic Health Care Ethics and Nurture of the Personal Journey

A common element in the responses to the above claims includes being careful of assumptions and judgments about health care ethics and Catholic health care ethics. It may well be that non-traditional backgrounds, degrees and experiences have much to offer the doing of health care ethics. Another common theme is the need to focus on the individual gifts of Catholic health care ethicists. Using narrative to tell the stories of ethicists is one way to accomplish this. The monikers for an individual focus are the proverbial tip of the iceberg for substantive thoughts and calls to action, such as Williams' "every face has a story," Ashley and O'Rourke's "prudential personalism," and Elie Wiesel's "not see[ing] any person in an abstraction."³⁶ Catholic health care can distinguish itself through its inclusiveness of ethicists from many backgrounds. Accommodating the mosaic of ethicists with diverse backgrounds strengthens Catholic health care. The ways or methods we use to "develop and...nourish and support potential candidates" must have an unrelenting focus on the person.³⁷ This closely relates to being careful about assumptions and judgments because generalizations can obscure uniqueness. Statistically, some are in the average, but all ethicists and their narratives are exceptional. The advantage of Catholic health care is its ability to be pastoral, nonjudgmental and inclusive of its and all ethicists.

- ¹ Daniel Sulfas and Jeremy Sugarman, “The Many Methods of Medical Ethics (Or, Thirteen Ways of Looking at a Blackbird),” in *Methods in Medical Ethics*, ed. Jeremy Sugarman and Daniel Sulmasy (Washington, D.C.: Georgetown University Press, 2001), 4-5.
- ² Lee B. Williams, “Behind Every Face Is a Story,” *About Campus* 3, no. 1 (1998): 16.
- ³ Williams, “Behind Every Face Is a Story,” 16.
- ⁴ Catholic Health Association of the United States (CHA), “E6 Respondent Education Background,” in *CHA 2014 Ethicist Survey* (slide presentation of survey results, 2014), slide 7.
- ⁵ For the distinction between a field of inquiry and discipline, see Sulmasy and Sugarman, “The Many Methods,” 5; I often use the term professional to describe ethicists in light of not having a more appropriate term for those in the field of ethics.
- ⁶ See Albert Jonsen, *The Birth of Bioethics* (New York, NY: Oxford University Press, 1998), 3-122.
- ⁷ Jonsen, *The Birth of Bioethics*, 20.
- ⁸ For instance, see Daniel Callahan, “Bioethics,” in *Encyclopedia of Bioethics*, ed. Stephen Post, third edition, vol. 1. (New York, NY: Thomson Gale, 2004), 281-282; Sulmasy and Sugarman, “The Many Methods,” 5.
- ⁹ See David Hume, *A Treatise of Human Nature*, ed. Lewis Selby-Bigge (Oxford: Clarendon Press, 1986), 469.
- ¹⁰ Callahan, “Bioethics,” 281.
- ¹¹ Sulmasy and Sugarman, “The Many Methods,” 5-6.
- ¹² Sulmasy and Sugarman, “The Many Methods,” 5.
- ¹³ For elements of informed consent, see James Tubbs, *A Handbook of Bioethics Terms* (Washington, D.C.: Georgetown University Press, 2009), 85.
- ¹⁴ Catholic Health Association of the United States (CHA), “CE15 Salary Range for Current Position,” in *CHA 2014 Ethicist Survey* (slide presentation of survey results, 2014), slide 16.
- ¹⁵ Brian Smith, Patricia Talone, John Reid, and Maureen Gallagher, “New Survey: Mission Leaders Respond – Executive Summary of the 2013 CHA Mission Leader Survey,” *Health Progress* 94, no. 6 (2013): 74.
- ¹⁶ U.S. Bureau of Labor Statistics, Division of Occupational Employment Statistics. “Occupational Employment Statistics—Occupational Employment and Wages, May 2013, 11-9111 Medical and Health Services Managers.” Last modified in 2014. Accessed March 20, 2015. <http://www.bls.gov/oes/current/oes119111.htm>.
- ¹⁷ U.S. Bureau of Labor Statistics, Division of Occupational Employment Statistics. “Occupational Employment Statistics—May 2013 National Occupational Employment and Wage Estimates United States.” Last modified in 2014. Accessed March 20, 2015. http://www.bls.gov/oes/current/oes_nat.htm#29-0000.
- ¹⁸ U.S. News and World Report. “Careers: Best Jobs—The 100 Best Jobs.” Last modified in 2015. Accessed March 20, 2015. <http://money.usnews.com/careers/best-jobs/rankings/the-100-best-jobs>.
- ¹⁹ Ron Hamel, “Ethicists in Catholic Health Care: Taking Another Look,” *Health Care Ethics USA* 23, no. 1 (2015): 36.
- ²⁰ U.S. Bureau of Labor Statistics, Division of Occupational Employment Statistics. “Occupational Outlook Handbook: Management—Top Executives, Pay.” Last modified in 2014. Accessed March 20, 2015. <http://www.bls.gov/ooh/management/top-executives.htm#tab-5>.
- ²¹ Labor Statistics, Accessed March 2015, Available at http://www.bls.gov/oes/current/oes_nat.htm#29-0000.
- ²² U.S. Bureau of Labor Statistics, Division of Occupational Employment Statistics. “Employment Projections—Earnings and Employment Rates by Educational Attainment.” Last modified in 2014. Accessed March 20, 2015. http://www.bls.gov/emp/ep_chart_001.htm.
- ²³ If my calculations are correct using CHA, “CE15 Salary Range for Current Position,” slide 16.
- ²⁴ Catholic Health Association of the United States (CHA), “D5 Respondent Religious Affiliation,” in *CHA 2014 Ethicist Survey* (slide presentation of survey results, 2014), slide 6.

- ²⁵ Pope Francis, *The Joy of the Gospel (Evangelii Gaudium)* (Washington, D.C.: United States Conference of Catholic Bishops, 2013), 62, 65.
- ²⁶ For examples, see Elizabeth Burns, *Beyond Measure: A Legacy of Mercy—The Sisters of Mercy in Health Care 1879-1976* (Detroit, MI: Gold Leaf Press and Institute of the Sisters of Mercy of the Americas, West Midwest Community, 2009).
- ²⁷ Larry Braskamp, (2007). “Fostering Religious and Spiritual Development of Students during College,” (essay for the Social Science Research Council’s Essay Forum on the Religious Engagements of American Undergraduates, 2007), 6. Accessed March 20, 2015. <http://religion.ssrc.org/reforum/Braskamp.pdf>.
- ²⁸ Braskamp, “Fostering Religious and Spiritual Development,” 2-6.
- ²⁹ Catholic Health Association of the United States (CHA), “CE8 Type of Primary Employer,” in *CHA 2014 Ethicist Survey* (slide presentation of survey results, 2014), slide 9.
- ³⁰ This coincides with my personal observation of the elimination of some hospital-based ethics roles for a variety of reasons including financial ones.
- ³¹ Lawrence Martin, Hayden Smith, and Wende Phillips, “Bridging ‘Town & Gown’ Through Innovative University-Community Partnerships.” *The Innovation Journal: The Public Sector Innovation Journal* 10, no. 2 (2005): 2. Accessed March 21, 2015. <http://www.innovation.cc/volumes-issues/martin-u-partner4final.pdf>.
- ³² For instance, see Martin, Smith, and Phillips, “Bridging ‘Town & Gown,’”; International Town-Gown Association. “College Town Resource Center.” Last modified in 2015. Accessed March 21, 2015. <https://www.itgau.org/Resources>; Yesim Sungu-Eryilmaz, “Town–Gown Collaboration in Land Use and Development” (policy focus report, Cambridge, MA: Lincoln Institute of Land Policy, 2009), 22-29. Accessed March 21, 2015. <http://community-wealth.org/sites/clone.community-wealth.org/files/downloads/report-sungu-eryilmaz.pdf>.
- ³³ For instance, see Renee Anspach and Diane Beeson, “Emotions in Medical and Moral Life,” in *Bioethics in Social Context*, ed. Barry Hoffmaster (Philadelphia, PA: Temple University Press, 2001), 112-116; Barry Chazan. *Contemporary Approaches to Moral Education: Analyzing Alternative Theories* (New York, NY: Teachers College Press, 1985), 79; Kelly Morton, Joanna Worthley, John Testerman, and Marita Mahoney, “Defining Features of Moral Sensitivity and Moral Motivation: Pathways to Moral Reasoning in Medical Students.” *Journal of Moral Education* 35, no. 3 (2006): 387-406; Elena Mustakova-Possardt. “Education for Critical Moral Consciousness,” *Journal of Moral Education* 33, no. 3 (2004): 248-255.
- ³⁴ Jonathan Friday, “Education in Moral Theology and the Improvement in Moral Thought,” *Journal of Moral Education* 33, no. 1 (2004): 23-33.
- ³⁵ Stephen Brookfield, “Understanding and Facilitating Moral Learning in Adults,” *Journal of Moral Education* 27, no. 3 (1998): 285-289.
- ³⁶ Benedict Ashley and Kevin O’Rourke, *Healthcare Ethics: A Theological Analysis*, third edition (St. Louis, MO: The Catholic Health Association of the United States, 1989), 161; Elie Wiesel, *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*, ed. George Anna’s and Michael Groin (New York, NY: Oxford University Press, 1992), ix; Williams, “Behind Every Face Is a Story,” 16.
- ³⁷ Hamel, “Ethicists in Catholic Health Care,” 42.