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

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

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

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

Promotions start with the strategy that anyone

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

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

GRAPHIC 1

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

Interest

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

Committee Onboarding

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

Consultant Onboarding

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

The brochure outlines at a high level:

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

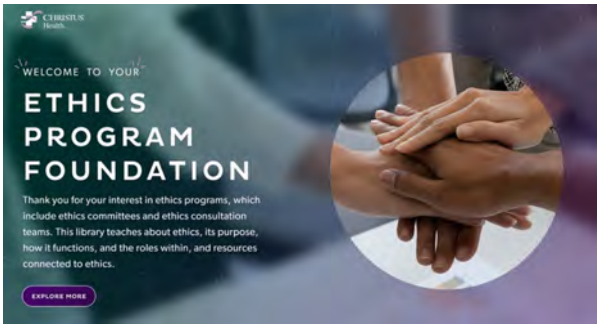
Associates are extremely busy. Ethicists and ethics leaders should make every effort to minimize time burdens and maximize personal and organizational benefits for those in ethics. Communicate this in simple, understandable ways prior to them starting on the committee and/or consult team. For instance,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

GRAPHIC 2

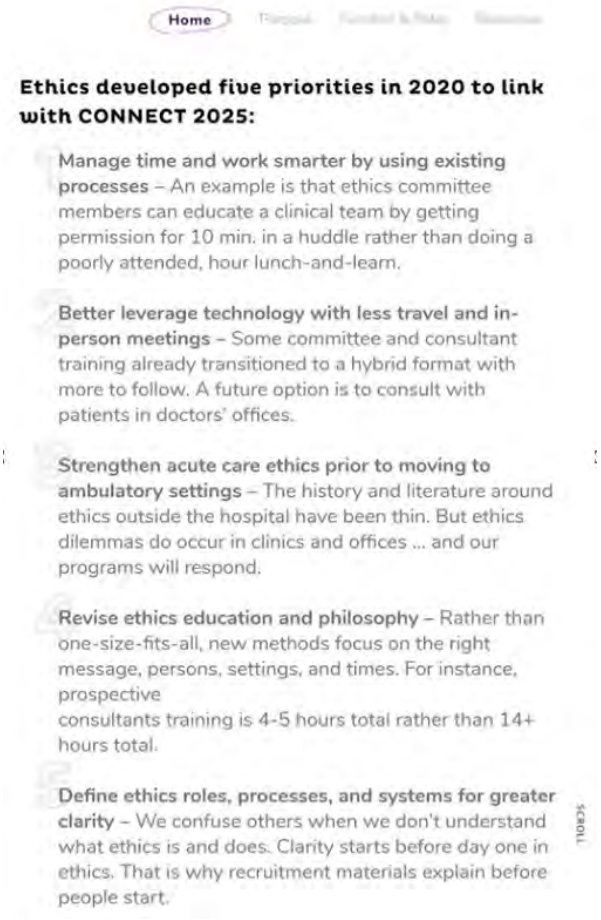
Third, the brochure's QR code links to a landing site called the ethics program foundation site, which includes more high-level information about ethics. A short video welcomes people. Another video gives five tips for new ethics program members. Ethics consult stats are on a page. Other modes and topics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

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

GRAPHIC 3



GRAPHIC 4



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

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ENDNOTES

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

Clinical Ethics as Liturgical Activity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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ENDNOTES

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