Building Trust, Shaping Culture

The Praxis of the Ethicist in Catholic Healthcare

MARY E. HOMAN, DrPH, MA, MSHCE
Mountain Region Vice President of Theology and Ethics, CommonSpirit Health
GIOVANNI TAFURI, PhD(c)
Greater Denver Market Clinical Ethicist, CommonSpirit Health

As two ethicists with CommonSpirit Health, we wanted to share how we foster relationships in our respective roles as a vice president, primarily focused on organizational ethics, and a clinical ethicist, working alongside front-line caregivers. Through these relationships, we seek to overcome challenges in clinical ethics at the bedside while working toward organizational changes that benefit patients. We also provide examples of collaboration that we hope will be useful to other leaders interested in bringing on clinical ethicists.

MARY'S TAKE:
'PARTNERSHIP OVER DIRECTION'

I was fortunate to begin my first full-time clinical ethicist role in a Catholic healthcare system that valued mission and ethics in distinct ways and placed ethics directors at its major hospitals. I had a supportive direct-line leader who would jokingly call himself my "work dad" even after I moved on to my next role, and a dotted-line leader who constantly challenged me to improve my craft. I also had my own dad, an exceptional mentor and colleague in Catholic healthcare ethics, who coached me and helped me understand what academics call the "hidden curriculum," the unspoken rules and expectations that shape professional success.

So many of us began in the field without strong mentors or a standardized process for going about our daily work. We are now the ones hiring and training the next generation of clinical ethicists, and we have seen significant changes to the role and expectations of clinical ethics over the last 10 to 15 years. We are held to the same quality and efficiency standards as other front-line caregivers,[1] yet many ethics colleagues have never taken a finance course or learned to read a control chart (a tool used to track process stability and quality over time).[2] While we may effectively support clinicians experiencing moral distress or help families navigate complex care decisions, we often fall short of fully articulating our impact.

Mark Repenshek, vice president of ethics and church relations at Ascension, Becket Gremmels, system vice president of theology and ethics at CommonSpirit Health, and I meet regularly to develop tools and strategies to share with other Catholic healthcare ethics leaders so they, too, can show return on investment for clinical ethicists. In our most recent workshop, held last fall at the annual Catholic Healthcare Innovation in Ethics Forum (CHIEF), we helped participants build leadership pitch decks, visual presentations using their own data to demonstrate both the need for clinical ethicists and the expected operational value of these roles.

Following that workshop, a core group continues to meet to create a toolbox, including a guide to cultivating key relationships across clinical and operational teams. We discuss subjects including finance, care coordination, informatics and more.

LISTENING RATHER THAN DIRECTING

Early in my career, I came across a piece from the members of the American Society for Bioethics and Humanities Clinical Ethics Consultation Affairs Standing Committee, "HCEC Pearls and Pitfalls: Suggested Do's and Don'ts for Healthcare Ethics Consultants."[3] While this document remains helpful for early-career ethicists conducting consults, it doesn't go far enough in explaining how to be effective in your ethics role when you're first beginning in the clinical arena. For that, we ought to take a page out of community-based participatory research.

Community-based participatory research stems from academic-community partnerships, particularly in public health. For too long, academics studied, commented on and analyzed the health (or lack thereof) of communities without actively engaging the people who lived in them; something was being done to "them" without "their" permission. Community-based participatory research changes the power dynamic from "them" to "us" and recognizes that collaboration is essential to creating and sustaining change. This can only happen when mutual trust and respect underpin the arrangement, but such a dynamic does not occur overnight.

In my many years working with local health departments, community organizations and research teams, I found that ego often replaced expertise and power undermined successful relationships. Fostering collaborative leadership,[4] which emphasizes partnership over direction, brought greater success and shared responsibility.

The same type of dynamic should be explored in the relationship between the clinical ethicist and their supervisor, as well as between the clinical ethicist and those they work with every day. Recognizing the need to quickly onboard and integrate new clinical ethicists who wouldn't have the luxury of previously knowing their clinical teams, CommonSpirit Health's National Theology and Ethics team set out to develop an onboarding protocol and a variety of tools to help our new ethicists in their early weeks. Some items were as simple as ensuring appropriate access to the electronic medical record, while others detailed how to get connected with complex case discussions and multidisciplinary rounds. We also developed a list of questions and conversation starters for use while rounding on clinical units to discuss and identify ethical issues (see sidebar below).

TRUST, PRESENCE AND PARTNERSHIP

Because ethics leaders and other executive leaders might not witness or lead routine clinical ethics consultations or ethicists might not be present in leadership meetings, laying the groundwork for how the ethicist functions for both clinical staff and executive leadership is critical to a successful ethics consultation service. This is especially important if an ethicist's title doesn't align with those of other operational leaders, as they may be unintentionally excluded from distribution lists and miss key announcements or daily metrics.

Similarly, ethicists may be called upon only to arbitrate or mediate conflicts. Although ethicists often say, "We recommend," it can be interpreted as permission, especially in Catholic healthcare. The ethicist becomes the "sage on the stage" or the

Conversation Starters for Identifying Ethical Issues

Recognizing that ethical issues often emerge through conversation and relationship-building, CommonSpirit Health's National Theology and Ethics team developed a set of questions and conversation starters for clinical ethicists to use with caregivers when rounding in patient care areas, including:

- Where do you see yourself challenged to do what you think is the right thing?
- Did you ever feel like you knew the right thing to do, but you weren't able to do it? Maybe something beyond your control prevented you from doing it?
- Have you encountered any gray areas lately? Maybe a time when you weren't sure about the right thing to do?
- Are there any patients right now for whom you feel like you're no longer doing anything for them, but instead doing things to them?

"squeaky wheel of morality" when what we really want is for ethics consultants to be smoothly integrated into the transdisciplinary team.

As with community-based participatory research, trust is integral to the success of a clinical ethicist. That trust also means being transparent about metrics, key performance indicators and unwritten expectations (for example, how to demonstrate commitment to Catholic identity in interactions with others in addition to adherence to established protocols). Ethicists don't want to walk the halls wearing something like an "Ethicist Deputy" badge, yet many take it personally when someone questions a decision as being too Catholic or too narrow in its interpretation. Often, this boils down to a lack of trust on both sides, a discordance that can simmer when ethicists remain at arm's length rather than embedded in the work. My best advice to an ethics leader is to help your ethicist get engaged in the work of care teams at the bedside to better serve patients and advocate for them and their role to improve patient care.

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GIOVANNI'S TAKE:

'NO ONE DISCIPLINE IS THE LEADER'

Like Mary, I was fortunate to begin my first full-time clinical ethicist role in a Catholic healthcare system with a National Theology and Ethics team diverse in areas of expertise, deeply committed to mission and supportive of one another's work. Unlike Mary, however, I do not have years of experience under my belt. Although I am completing my doctoral degree and have prior clinical experience as an EMT, along with ethics internships and volunteer roles in healthcare systems on the East Coast and abroad (at the Ospedale Pediatrico Bambino Gesù through the Pontifical Academy for Life), I am only a few months into my role as a clinical ethicist. Because of that, I greatly value the support and guidance of our CommonSpirit Health team, rely on the experience of a trusted mentor and utilize standardized processes as I grow in my role.

As a full-time clinical ethicist, my primary focus is addressing the ethical dilemmas that arise in caring for our patients. All providers and staff have my pager number handy and know they can reach me with concerns ranging from professionalism to shared decision-making from beginning-of-life and end-of-life care. I work closely with them to resolve issues promptly and am available in person at any of our six healthcare ministries in the Denver market. No two locations are exactly alike, from smaller medical centers nestled in the mountains to Level I trauma teaching hospitals just on the outskirts of the city, and none previously had an in-house, full-time clinical ethicist. It has been a privilege to be immersed in each hospital's culture and take on the challenge of integrating ethics into each organization.

Being in person has allowed me to attend and participate in patient safety huddles, intensive care unit (ICU) rounds, complex case discussions and goals-of-care meetings. I document these interactions in a rounding tool created by the national team, not for micromanagement, but to identify trends and opportunities for integration. I have found these tools hold me accountable and provide valuable metrics for optimizing my in-person presence.

Unit-based rounds conducted in community, rather than traditional ethics committee meetings focused on retrospective case reviews, provide just-in-time, patient-forward gatherings for teams to proactively address ethical concerns, especially for vulnerable patients such as those without permanent housing or family support. These same meetings help me demonstrate my commitment to the interdisciplinary team, even when there is yet to be an ethics question, and open the door for ethics education and policy development. For example, by attending ICU rounds and interacting with critical care physicians and nurses, I identified opportunities to improve our statewide advance directive policy and created a set of "know-do-share" documents

that codified practices to make the process easier for care teams and patients' loved ones.

MENTORSHIP MATTERS

My growth as a clinical ethicist owes much to my mentor and to our standardized protocols and practices. A few months back, I found myself moving across the country, stepping into my first clinical ethicist role in a state where I was unfamiliar with the regulations that would affect the recommendations I was tasked with making. Having a leader in Mary, one who has been in my shoes before and understands the terrain that comes with the role — the work, stress and expectations — has been essential to settling in quickly.

There is also something to be said about a mentor who wants their mentee to succeed and the impact of their trust. As Mary stated, trust is an integral component of collaborative leadership; it is essential to my effectiveness, and a mentor's trust can help build the credibility needed to gain others' trust and smooth the path of a new role. Though I am not the "sage on the stage," having a leader who serves as a backstage manager of sorts has truly helped in my role.

I am excited that, rather than merely establishing boundaries and rules during an already stressful time in the ICU, we are developing tools that support clinicians and surrogate decision-makers in making informed and proportionate decisions.

As I have made efforts of my own to form relationships with those I work with and take on new projects that align with my responsibilities, Mary has made it a point to introduce me to hospital and system-level leadership. In one instance, I stood in her stead at the opening of a new cancer center, where I had the opportunity to meet a variety of leaders and even identified some collaboration opportunities.

Another example was when Mary introduced me to an already formed work group around prognostic discordance, where differences in expectation between providers and surrogate decision-makers of a patient's recovery exist, and asked me to take the ethics lead. Though I did not have experience in this type of work, the group welcomed me because Mary's trust in me helped earn their confidence.

I am excited that, rather than merely establishing boundaries and rules during an already stressful time in the ICU, we are developing tools that support clinicians and surrogate decision-makers in making informed and proportionate decisions. Our hope is to mitigate instances of conflict-based ethics consults and move toward early identification of ethics issues.

COLLABORATION ROOTED IN TRUST

As Mary explained earlier, our recommendations are not simply a form of permission; the clinical ethicist does not unilaterally decide what to do and what not to do, as we are not the "ethics police." An example of this is our approach to ethics consults about restraints. We want to keep patients and caregivers safe, and we need to be attentive to the dignity of all parties involved. As such, a question such as "Should we restrain a nondecisional patient?" may be answered differently by nursing, patient safety, risk management and ethics. By leaning into the collaborative leadership process, no one discipline is the leader (or ultimate decision-maker). Rather, we all have to buy into a process that might be more time-consuming than simply checking Centers for Medicare & Medicaid Services regulations and asking whether restraints would be ethically justifiable.

Again, with access to a variety of ethicists in our system working on practical issues, I spoke with Laura Webster, our Northwest Region vice president of ethics, who is testing a set of guidelines and a framework for assessing the ethical use of restraints. By using a tool like this to guide the ethics discussion in real time, the clinical team decides collectively and quickly what the decision will be.

This collaboration requires trust. For providers, trust in the clinical ethicist is necessary for an ethics consultation to be requested and for the ethicist's guidance to be incorporated into clinical decision-making, as some physicians still ques-

tion the effectiveness of ethics consultations.[5] Similarly, the clinical ethicist needs to trust the provider to share all the information necessary to develop their ethical guidance.

Building strong relationships and trust goes beyond scheduled meeting times. By taking the time to visit clinical units and engage in conversations with staff about the problems they are experiencing or have experienced, the relationship and trust between the clinical ethicist and providers are developed and strengthened.

The resulting trust in the clinical ethicist is also contagious; when others notice the trust placed in the clinical ethicist, they, too, will request an ethics consult to address the dilemmas they are facing. We do not engage in these conversations with only a "gain" in mind; we do so because we care about those with whom we work and about the patients we collectively serve as a ministry.

MARY E. HOMAN is Mountain Region vice president of theology and ethics at CommonSpirit Health. **GIOVANNI TAFURI** is a Greater Denver Market clinical ethicist at CommonSpirit Health.

NOTES

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