

# ETHICISTS IN A QUICKLY CHANGING ENVIRONMENT

The new health care environment and the Patient Protection and Affordable Care Act (ACA) have affected ethicists working in or consulting with Catholic health care, as an overview of results from two CHA surveys shows. Ron Hamel, PhD, CHA's senior ethicist emeritus, published the results individually — the first in 2009 and the other earlier this year.<sup>1</sup>



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As a complement to his analysis, this ethics column compares the results in light of events within the nation and the church that occurred during the five years between the surveys. Viewed in that context, the survey responses raise some interesting questions regarding the future of Catholic health care ethics.

slightly less male (62.2 percent), slightly more Catholic (86.4 percent), and more lay (81.8 percent). The 2013 respondents also had a larger range of terminal degrees, and several held the professional doctorate in health care ethics, a multidisciplinary degree. While this latter trend is helpful for the ministry, especially as regards clinical integration, it also raises the question of whether newer Catholic health care ethicists have less professional theological training than their predecessors.

The respondents' range of ages also has changed. Younger ethicists are entering the field, with almost a quarter of respondents to the 2013 survey being under 40 years of age. However, 40 percent of ethicists are now over 60 (an increase of almost 10 percentage points in five years) and will likely retire within the next five to 10 years. It is clear that the ministry must continue its recruitment efforts, since significantly more ethicists will be needed to replace the aging cohort.

The 2013 survey raised another critical issue for Catholic health care ethics: racial and ethnic diversity. To a new question about ethnicity in the 2013 survey, 97.8 percent of respondents answered that they were Caucasian. As intentional as CHA and its member systems have been in recruiting younger ethicists, this percentage suggests we also must become more intentional in ensuring greater gender and ethnic diversity. CHA may need to engage students even earlier in higher education, perhaps at the undergraduate level, where greater diversity exists. CHA's members may need to identify and nurture a greater variety of employees who have the talent and desire to enter this ministry.

## DEMOGRAPHICS

Of the approximately 70 ethicists and ethics consultants in Catholic health care at the time, 49 responded to the 2008 survey. They described themselves as Catholic (77.8 percent), lay (77.8 percent), male (63.3 percent), holding an academic PhD or STD degree (73.5 percent). More than two-thirds of respondents were over 50 years old, with more than 30 percent over the age of 60.

This picture occasioned a 2009 article in *Health Progress* in which Hamel called the aging of Catholic health care ethicists a "significant concern." He added, "these numbers not only suggest an aging cohort of professional ethicists, but also, of even greater concern, disproportionately fewer ethicists coming into Catholic health care than those approaching retirement age."<sup>2</sup>

That concern prompted CHA, in consultation with its members, to articulate a set of competencies for those becoming system and facility ethicists and to work with graduate schools to help develop the next generation of ethicists for Catholic health care.<sup>3</sup>

The efforts seem to have met with some success. Although there were fewer responses to the 2013 survey than before (34 of approximately 70 ethicists), the response rate was still respectable at nearly 50 percent.

Respondents to the more recent survey were

## RESPONSIBILITIES AND ISSUES

Five years does not seem like a long period of time. Yet look at the dates of the surveys: One immediately realizes that a lot happened in health

care in general, and especially in Catholic health care, between 2008 and 2013. The most significant event, of course, was passage of the ACA in 2010. The reforms put in place by the ACA accelerated the growth of forms of collaboration along the health care continuum, such as accountable care organizations and clinically integrated networks.

The law also occasioned a strong reaction by Catholic bishops, first to what they saw as deficiencies in the law regarding abortion, the treatment of immigrants and conscience protections, and later to the contraception mandate. Catholic health care also has experienced more scrutiny regarding forms of collaboration and the interpretation of the theological principle of cooperation.

These trends can account for differences in responses to the two surveys regarding the primary responsibilities of ethicists and those tasks that occupy most of their attention. In both surveys, however, the relative priority of responsibilities

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remained almost identical: education of staff and trustees, ethics committees and clinical consultation continue to be the highest priorities.

There were important differences between the surveys, however. There has been an almost 25 percentage point increase in the number of ethicists who see policy development as a primary responsibility. Similarly, those seeing church relations as a primary responsibility has risen almost 22 percentage points.

These increases reflect the legal and ecclesiastical changes that occurred between the two surveys. One result of the ACA has been the advent of new forms of collaboration, which, in turn, has raised questions regarding the morality of collaboration with entities holding ethical beliefs different from those of the Catholic Church.

The contraceptive mandate also has raised important questions not only for Catholic health care but also for the bishops of the dioceses in which Catholic health care facilities are located. Catholic health care ethicists now are dealing

with a host of questions arising from the increasing moral complexity hospitals find themselves in — remaining true to their Catholic identity while also needing to follow governmental policies.

In both surveys, research and publication remained at the bottom of the priorities list. At a time when Catholic health care seems to be misunderstood by many in this country, however, it may be more important than ever before that Catholic ethicists publish and share their expertise regarding the increasingly complex ethical issues in health care.

One of the biggest differences between the two surveys comes in answer to the open-ended question, “What ethical issues have been most pressing in the last 12 months?” Responses to the 2008 survey were relatively traditional, with end-of-life issues, staff education, organizational ethics and contraception and reproductive issues seen as most pressing.

In the 2013 survey, respondents saw a different constellation of issues. Given the political and ecclesiastical atmosphere, it was not surprising that the item receiving the strongest response was collaboration with other-than-Catholic organizations and the theological principle of cooperation. This item was closely followed by interpreting the *Ethical and Religious Directives for Catholic Health Care Services* regarding reproductive issues.

Among other issues occupying the ethicists’ attention were the ACA and its contraceptive mandate, accountable care organizations and clinically integrated networks, and end-of-life issues, including relatively new issues such as Physician Orders for Life Sustaining Treatment (POLST) and advance care planning.

Occasioned by the events of the past five years, issues of organizational ethics, especially questions of collaboration that involve issues of Catholic identity and the theological principle of cooperation, have grown in importance.

### **LOOKING AHEAD**

Both surveys asked open-ended questions about what contributions Catholic health care ethics would make in the next three to five years, both to the individual organization and to the Catholic health care ministry in general.

In 2008, respondents identified education, broadly understood as its most important contri-

bution, following by better integration of ethics into the executive level of the organization, policy development and value-based decision-making.

The 2013 survey identified ethical consultation, both clinical and organizational, as most critical. This was followed by education and organizational ethics. The rise in the prominence of ethics consultation can be attributed to the well-publicized work in this area by the American Society for Bioethics and Humanities. The growth in prominence of organizational ethics reflects the increasing institutional complexity in responding to issues arising from today's health care environment.

When the question moved to contributions by ethics to the larger ministry, respondents in the 2008 survey suggested that patient and staff support and advocacy would become the major critical contributions, followed by the linking of mission and the core values of Catholic health care to everyday behavior on the part of hospital staff, education for leadership, staff and public, and policy development.

In the 2013 survey, responses were more diverse. The highest priority was that of safeguarding the Catholic identity of Catholic health care, followed by issues around an aging population and end-of-life issues, fostering the success of Catholic health care into the future, and ethical discernment. Over a dozen other issues also were mentioned. Given the complexity of the current environment, the movement to organizational issues and the concern for Catholic identity are quite understandable and appropriate.

Both surveys also asked what issue was most critical for the continuing education of Catholic health care ethicists themselves. In 2008, the highest number of responses named the theological foundations of Catholic health care ethics, following by research ethics, organizational and business ethics, and ethics at the end of life.

In the 2013 survey, the strongest single critical area mentioned by the respondents was the new health care environment, including both the ACA and new venues beyond acute care. This was followed by Catholic social teaching and issues of access and distributive justice and by the theological principle of cooperation.

In what by now should be quite familiar, the political and ecclesiastical events of the past five years, as well as the movement of health care into the broad continuum of care, have created a situation in which today's Catholic health care ethicist

must be as well versed in organizational ethics as in clinical ethics.

#### QUICKLY CHANGING ENVIRONMENT

This look at the two surveys shows the need to understand that much of what Catholic health care ethicists have done in recent years has been in response to a quickly changing environment. As the environment continues to change, the challenge to respond will continue, as well. The surveys suggest that these responses will include:

- Becoming more skilled in issues of organizational ethics in an increasingly complex health-care environment

- Engaging our organizations in a variety of issues around Catholic identity, including becoming more theologically articulate in our responses

- Not losing sight of the important clinical issues that face us, many of which have larger organizational and societal implications

- Taking the time for the important tasks of research and publication, which often become lost amid other responsibilities

- Not only supporting the next generation of Catholic health care ethicists, but also ensuring that those who follow us are as diverse regarding race, ethnicity, and gender as the populations we serve.

A final trait of the Catholic health care ethicist will be flexibility. It would have been extremely difficult in 2008 to foresee the changes in the role and responsibilities of Catholic health care ethicists between then and 2013. It is equally likely that we cannot begin to imagine the changes that will occur in the next several years.

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#### NOTES

1. Ron Hamel, "A Critical Juncture: Surveys of Ethicists and Mission Leaders Indicate Concern about the Future of Ethics in the Catholic Health Ministry," *Health Progress* 90, 2 (March-April 2009): 12-22; Ron Hamel, "Ethicists in Catholic Health Care: Taking Another Look," *Health Care Ethics USA* 23, 1 (Winter 2015): 34-44.
2. Hamel, "A Critical Juncture," 13.
3. For a fuller description of CHA's efforts, see Thomas Nairn, "Nurturing Ethicists for the Future of Catholic Health Care," *Health Progress* 92, 6 (November-December 2011): 83-85.

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