





Partners in Healing at the Intersection of Medicine and Mission

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A chief medical officer (CMO) routinely interacts with other members of the senior leadership team, including the chief executive, chief nursing officer and chief financial officer. While these relationships may be expected, there is another member of the senior leadership team that chief medical officers should strongly consider partnering with more fully: the chief mission integration officer (CMIO).

So, what does a chief mission integration officer do? The chief mission integration officer is an executive-level leader who brings an expertise in theology and ethics, coupled with a strong familiarity with health care operations, to ensure that the mission and values of a Catholic health care ministry are fully integrated into the day-to-day operations and strategic direction of the ministry. This work can manifest itself in a number of ways, including contributing as a strategic partner, assisting in the navigation of complex ethical issues and advocating for both high-quality spiritual care and the needs of the poor and vulnerable.

In our roles as CMO and CMIO, we have developed a close working relationship. By sharing examples of how we have mutually benefited by bringing our skill sets and experience together, we hope to invite others in these roles to consider how closer collaboration could better serve the ministry.

ETHICAL ALLOCATION OF A SCARCE RESOURCE

On May 1, 2020, in the midst of the COVID-19

pandemic, the Food and Drug Administration approved remdesivir for patients under certain conditions through an Emergency Use Authorization, with the stipulation that it be administered in a hospital or health care setting capable of providing acute care comparable to inpatient hospital care.¹ This was the first pharmaceutical treatment to receive FDA approval for COVID-19, and shortly thereafter was released in limited supply.²

Two weeks later, on May 14, 2020, Providence Holy Cross Medical Center received its first allocation of remdesivir. The amount received was enough to treat, at most, four of the 61 COVID-positive patients being cared for at the time.

Following the recommendations of both the Providence Office of Theology and Ethics and the California Department of Public Health, leadership at Providence Holy Cross formed a clinical discernment team to wrestle with questions about the just and ethical allocation of such a scarce resource. Participants included physicians from palliative care and infectious disease, as well as hospitalists, intensivists and clinicians from infection control, pharmacy, nursing

administration and ethics. Together, as CMO and CMIO, we chaired the discernment team.

The team was aware that unconscious or implicit bias had the potential to cloud our process. Therefore, as a safeguard, we established a set of inclusion and exclusion criteria that was grounded in the medical literature existing at the time, drawn from the initial finding of the remdesivir study,³ and consistent with guidelines provided by the California Department of Public Health.⁴

The value of the collaborative partnership between the two of us became particularly evident when the team found itself spending a significant amount of time discussing issues around quality of life and whether or not this should be a factor in determining if a patient would be offered the medication. Through team discussions and literature review, some argued that reduced physical capacity and the dependence upon others for assistance with daily activities of living should “count against” a particular patient when assessing their suitability for receiving this medication.

This was not merely an academic exercise — a slight drop in a patient’s overall assessment could remove them from consideration for this invaluable medication. Combining our skill sets — the medical knowledge and professional credibility of a CMO with the ethical training and moral credibility of a CMIO — we made a persuasive argument that only evidence-based, objectively observed factors should be considered. Ultimately, our discernment team developed a process that made this treatment available to the most appropriate patients in the fairest possible way.⁵

ADVANCE MEDICAL DIRECTIVES AND DISCERNMENT

For any provider, ensuring that patients have sufficient information to make informed decisions dates back to early training in medical school. Medical students absorb lessons by watching more experienced colleagues speak with patients or their surrogate decision-makers.

When talking to a patient, doctors routinely describe potential risks, how treatments may help them and additional options or information they may need when deciding next steps. In cases where patients are no longer able to speak for

themselves, doctors rely heavily on both advance medical directives and physician orders for life-sustaining treatment. But for a chief medical officer in a senior decision-making role, it is critical to understand that there are nuances to these tools that a particular physician may not have been able to fully appreciate.

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Recently, the two of us responded to a medical/surgical floor where the nursing staff had alerted us to a concerning situation. A chart had a note from the attending physician that the patient lacked decision-making capacity. There was an advance medical directive that named the patient’s husband as her durable power of attorney for health care. The consulting surgeon had read the chart and spoken to the husband, receiving his consent on behalf of his wife to proceed with the procedure. The patient’s nurse, however, felt strongly that capacity should be reevaluated in light of conversations she had with the patient that morning. However, the consulting surgeon had already left for the operating room and was reluctant to return.

Upon arriving to the floor, the chief medical officer spoke with the patient to get a sense of her capacity while the chief mission integration officer reviewed the advance medical directive. There were several subtle elements that called the validity of it into question, one being that the first page was missing. Also, one of the witnesses on the signature page was the husband (California law does not allow for an advance medical directive to be witnessed by the appointed durable power of attorney) and the second witness had the same last name of the husband, which further called the authenticity of the document into question. Finally, the number of pages recorded by the



notary public did not match the number of pages in the advance medical directive, nor did it even come close.

When we were able to speak with the attending physician, he admitted to us that he had not personally reviewed the document, nor would he have necessarily noted those inconsistencies. Ultimately, the surgeon did reevaluate the patient and affirmed that she did have decision-making capacity. He thanked the nurse and had a very difficult conversation with the husband as to why we might not be moving forward with the procedure. Additionally, we explored in more detail with the patient who she wished to serve as her durable power of attorney in the event she did truly lose decision-making capacity.

While working within the parameters of informed consent is critical to our work, the reality is that subtle complexities can confound even the most attentive physician. Because this issue is so fundamental to the autonomy and dignity of the patient, the CMIO can be a valuable resource to partner with in this area. Physicians might also consider speaking to their facility's ethics committee or risk management team for advice.

NAVIGATING SENSITIVE OBSTETRICS ISSUES

The birth center of a hospital can be a wonderful place and can sometimes feel comparatively like the one location where good things happen in a hospital. However, things can — and do — go amiss there, and when they do, the provider is often in need of a listening ear and mutually respectful dialogue.

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To provide some consistency in how ethical issues are addressed in health care delivery throughout the country, the *Ethical and Religious Directives for Catholic Health Care* — drawn from the Catholic Church's theological and moral teachings — cover a wide range of issues, including significant attention to matters at the begin-

ning of life. An important aspect of the chief mission integration officer's job is to ensure that the local ministry acts consistently with the collective identity of the ministry within the Catholic tradition, something that relies on true collaboration with providers.

For example, the directive regarding the Catholic commitment not to directly take a life through abortion is clearly stated. But what about those times when the clinical situation is such that an indirect termination is required in order to avoid losing the lives of both mother and unborn child?

A typical situation might evolve as follows: It is late at night when a pregnant woman comes to the emergency room due to her membranes rupturing prematurely. She is 18 weeks pregnant and is devastated with the news that she may lose this pregnancy. The medical team has informed her that the onset of infection is nearly inevitable and that it will not only result in the termination of the pregnancy, but will also put her life at substantial risk.

Despite having worked with such cases in the past, and despite caregivers and providers having worked for many years within a Catholic hospital, such cases almost always invite additional concerns and discussion. Thus, it is quite common for a chief mission integration officer to arrive fairly quickly — despite the late hour — and to gather the providers and nurses together for a conversation.

In this case, the treatment team affirms their understanding that the premature rupture alone is insufficient a reason to initiate termination of the pregnancy. But few may be able to articulate the ethical rationale that grounds this course of action. Some may even voice their concern that religious beliefs are interfering with their ability to provide the best possible care.

The chief mission integration officer can reassure the treatment team that religious beliefs and medical practice are not incompatible. The principle of double effect — which recognizes that significant harm, even death, can be morally tolerated (but never embraced) when it is the inevitable secondary effect of a primary, intended, proportionally justifiable action — requires that one has a valid and current medical

reason for initiating an intervention that has such serious consequences.

When speaking directly to the physician, the chief mission integration officer attests that it is neither his intention nor within his scope to question the doctor's clinical judgment as to when intervention is needed, and only asks that the provider acts in good faith, proceeding with a morally undesirable intervention only when there are clinical grounds to do so. He goes on to list a few examples such as a rising temperature or rising white blood count and reiterates that this determination is medical rather than ethical in nature. Through this communication, the chief mission integration officer subtly invites the physician into a covenant of integrity, working together to honor a principle that is held dear in Catholic social teaching.

As a ministry, we trust that our providers are people of integrity who will collaborate to uphold these principles, and we predicate that covenant on an agreement that the provider is the medical expert who will determine when to move forward, addressing the not-so-hidden fear that "doctrine" will trump medical judgment. Through this partnership of trust and understanding, a chief mission integration officer can help to ensure a good relationship exists between the obstetrics department and hospital administration.

SUPPORTING MEDICAL TEAMS IN TIMES OF DISTRESS

One of a chief medical officer's primary responsibilities is attending to the well-being of the medical staff, something that became even more imperative during the COVID pandemic. One helpful approach is to be accessible to them by offering an open-door policy and encouraging them to reach out at any time. When a CMO meets with a physician, it is essential to listen intently and try to assist them in any way possible.

Unfortunately, a CMO is only one person and does not have eyes and ears everywhere, thus may only be aware of a portion of those in need. There is a void that potentially exists at hospitals if the CMO is attending to the medical staff alone.

At Providence Holy Cross, the chief mission integration officer fills this void successfully, even without being asked. Although he is not a medical doctor, over time, he has gained the trust of physi-

cians, and several members of the medical staff have a long-standing relationship with him as a confidant and sounding board.

Together, the chief medical officer and chief mission integration officer offer two access points for medical staff to reach out to when they need someone to talk to. Although rates of physician burnout have been higher than ever these past few years,⁶ we are optimistic that our unified approach at Providence Holy Cross likely contributes to our ministry having one of the highest rates of physician well-being across all of Providence in a 2020 survey.⁷

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CONCLUSION

By working as true partners, a CMO and CMIO can address some of the most challenging issues faced in health care. At Providence Holy Cross, we have found through pairing our unique — but complementary — skill sets, we can navigate even the most complex issues faced today.

We have found our collaboration to be invaluable. It is likely that others have found the same to be true. But for those who have not yet capitalized on the potential of this relationship, we suggest that what is true in both medicine and ministry is certainly true in our experience: when people with good intentions join their talents together, the results are not merely additive, but truly transformative.

REX HOFFMAN is chief medical officer of Providence Holy Cross Medical Center in Mission Hills, California. **D.W. DONOVAN** is chief mission integration officer of Providence Holy Cross Medical Center.

NOTES

1. "Coronavirus (COVID-19) Update: FDA Issues Emergency Use Authorization for Potential COVID-19 Treatment," U.S. Food & Drug Administration, May 1, 2020, <https://www.fda.gov/news-events/press->

announcements/coronavirus-covid-19-update-fda-issues-emergency-use-authorization-potential-covid-19-treatment.

2. "Important Information About Veklury," U.S. Department of Health & Human Services, <https://aspr.hhs.gov/COVID-19/Therapeutics/Products/Veklury/Pages/default.aspx>.

3. John H. Beigel et al., "Remdesivir for the Treatment of Covid-19 – Final Report," *The New England Journal of Medicine* 383, no. 19 (November 2020): 1813-26, <https://www.nejm.org/doi/full/10.1056/NEJMoa2007764>.

4. "California Health and Human Services Remdesivir Distribution Fact Sheet," California Department of Public Health, May 29, 2020, [https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Remdesivir-](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Remdesivir-Distribution-Fact-Sheet-.aspx)

[Distribution-Fact-Sheet-.aspx](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Remdesivir-Distribution-Fact-Sheet-.aspx).

5. D.W. Donovan and Rex Hoffman, "Providence Holy Cross Outlines Steps for Ethical Distribution of a COVID Medication," *Health Progress* 101, no. 4 (Fall 2020): 57-60, <https://www.chausa.org/publications/health-progress/archives/issues/nurses/providence-holy-cross-outlines-steps-for-ethical-distribution-of-a-covid-medication>.

6. Joy Melnikow, Andrew Padovani, and Marykate Miller, "Frontline Physician Burn-out during the COVID-19 Pandemic: National Survey Findings," *BMC Health Services Research* 22, no. 1 (March 2022): <http://doi.org/10.1186/s12913-022-07728-6>.

7. "Southern California AMA Medical Staff Survey Results — Providence Report," Providence Holy Cross Medical Center, 2020.

QUESTIONS FOR DISCUSSION

Chief Medical Officer Rex Hoffman and Chief Mission Integration Officer D.W. Donovan at Providence Holy Cross Medical Center in Los Angeles describe the importance of partnerships and knowing where one job ends and another begins as the roles relate to challenging medical and ethical decisions in health care environments.

1. If you are in a chief medical officer or chief mission integration officer role, do you make time to talk about how and when you communicate with each other? When more people need to be a part of a conversation, is a good, prompt system in place that allows for that?

2. Does your health care organization have clear guidelines in place to avoid bias in complex decision-making? Is there a clear understanding of foundational standards and the timing and process of decision-making? What can be done to make sure you're communicating with patients and their loved ones in a way that is empathetic, clear and provides them with the information and support they need?

3. How can senior leaders do a better job making sure other employees understand the responsibilities of chief medical officers and chief mission integration officers and how they can convey questions or concerns to them?

Upcoming Events

from The Catholic Health Association

Virtual Program:

Community Benefit 101
Oct. 25 – 27 | 2 – 5 p.m. ET

Diversity & Disparities Networking Zoom Call
Oct. 25 | 1 – 2 p.m. ET

Global Health Networking Zoom Call
Nov. 2 | Noon – 1:30 p.m. ET

Virtual Seminar: Mission Leadership
Nov. 7 and 9 |
Noon – 4 p.m. ET

Faith Community Nurse Networking Zoom Call
Nov. 15 | 1 – 2 p.m. ET

United Against Human Trafficking Networking Zoom Call
Nov. 16 | Noon – 1 p.m. ET



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