ETHICS & MEDICS

FEBRUARY 2020 VOLUME 45, NUMBER 2

A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

Also in this issue: "Community Outreach and Ethics Services" by Jason Lesandrini and Joseph Bertino

Ethics Education of Medical Staff and Associates

Erica Laethem

Ethics education is an essential function of a robust health care ethics service and an expectation of the *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*).[1] It is primarily through education that ethics committees influence organizational culture, contribute to the formation of conscience, and foster a moral community in which health care professionals do the right thing for the right reason.[2] Therefore, ethics education should be proactive, not merely responsive to issues as they arise. In addition to imparting knowledge for the sake of good outcomes, a vibrant ethics education program aims to create transformative experiences that help medical staff and associates grow in competency and virtue for the sake of human flourishing—of the professionals themselves and of those they serve.

Catholic health care organizations vary considerably in structure and resources, and there is no one-size-fits-all approach to ethics education. Still, a standard of excellence can be identified: "Excellence in ethics education is the habit of building and strengthening the competency of various audiences within the organization to recognize and address ethical issues successfully and to carry out their responsibilities in an ethical manner. In addition, it entails the ongoing development of ethical competencies to deliver ethics services."[3] This approach to ethics education ought to be both instructive and formative, conveying knowledge and building morally good habits.[4]

Attributes of Ethics Education

Ethics education should be mindful that those who advance the mission of Catholic health care come from diverse cultural, professional, religious, educational, and socioeconomic backgrounds and represent a range of roles and learning styles. Therefore, efforts should be made to define and translate the ethical jargon (e.g., cooperation, scandal, and ordinary/extraordinary means) into understandable terms, particularly those concepts with precise meanings in theological ethics that differ from colloquial English. For professionals, revisiting ethics codes and oaths is a way to call forth the conscience of the professions and to uncover a conceptual bridge of compatibility between professional, clinical, and organizational ethics.

Ethics education should reflect Catholic teaching's foundational tenet that faith and reason are compatible and complementary. Whether philosophical or theological methods are used, efforts should convey the reasoning behind concepts so that professionals might understand them through the intellect; at the same time, ethics education should reflect an openness to the Transcendent and to the transcendent and spiritual dimensions of the person.

Accordingly, while ethics education should accurately reflect the elegance and nuance of Catholic moral tradition, it need not be bound to an exclusively theological approach. Commonly taught frameworks—such as principlism, which identifies respect for autonomy, beneficence, non-maleficence, and justice as the principles of biomedical ethics[5]—offer valid principles but tend to be reductive and insufficient as a framework for the health care ministry. The "animating principle" of Catholic health care is Christian love;[6] thus ethics approaches ought to be rooted in love. Ethics education in a Catholic organization may be enriched by aspects of virtue ethics, personalism, deontology, Catholic social teaching, professional ethics, feminist and narrative approaches, and the wisdom tradition, among others.

Ethics education should be relevant and applicable. It should avoid portraying ethics as an esoteric activity or as a discipline that applies only in cases of moral conflict. By illustrating how ethics plays a role in quotidian life, education serves to form the virtue of practical wisdom or *phronesis*, as Aristotle referred to it: "Virtue determines the end; practical wisdom makes us do what is conducive to the end."[7] In addition, ethics education should demonstrate how these concepts apply to concrete circumstances.

Ethics education should be cautious not to treat ethics reductively, as mere compliance with moral norms or even with the *ERDs*, as essential as these norms may be. Such an approach can lead to an ethics of minimums, the

Erica Laethem, BeL, is the regional director of ethics at OSF HealthCare in Rockford, Illinois.

disempowerment of moral agency, and the implication that the aim of the moral life or the identity of the organization is found in negative moral precepts. Although medical staff and associates do need to know which actions they must avoid, an approach that overemphasizes negative moral precepts and "thou shall nots" risks obfuscating the great "thou shall" of Catholic health care: to extend the charity of Christ by continuing his healing ministry.[8]

Strategy and Content

Ethics education—whether a curriculum for the entire organization or for particular programs—should be intentionally and strategically designed. To inform objectives that support strategic goals, planners should identify audiences and assess needs. Audiences may overlap and include employed and non-employed staff with privileges, clinical and non-clinical associates, leaders, providers, nurses, pharmacists, rehabilitation therapists, residents, and students.

To focus priorities and identify opportunities to integrate ethics education into existing structures, a needs assessment and feasibility study are useful.[9] A needs assessment could involve surveys, qualitative and quantitative analyses of trends in ethics consultations, feedback from rounding, focus groups, and literature reviews. A needs assessment might also include professional ethicists' observations of strategic ethics-related priorities for the health care ministry that would not necessarily be captured by other forms of assessment. Feasibility may be gauged by identifying available resources and avenues for education, including existing structures, reliable developers of ethics content, presenters, continuing education credit applications, a budget, and administrative and logistical support.

These assessments inform the development of objectives within the strategic plan. Objectives should be measurable so that progress can be tracked. Ethics learning may be measured in terms of both increased knowledge and improved behaviors or outcomes. The plan should also identify timelines for accomplishing objectives.

Once objectives are articulated, strategies and tactics can be developed. Strategies are high-level plans for achieving objectives, and each strategy identifies a set of tactics. Tactics define strategies by identifying specific ways they will be executed. Tactics include lecture series, retreats, annual reviews, computer-based learning modules, simulation laboratories, brown bag lunches, webinars, podcasts, rounding tools, daily "huddle" notes, posters, smartphone applications, pocket cards, and so on. Whenever possible, ethics education should be woven into existing educational structures.[10]

Whatever the tactic, content should be informed by best educational practices and adapted to needs. Transmitting information about ethics is necessary at times; however, learning research has shown that the "information transmission" approach is limited in its effectiveness. Learning researchers Harold Stolovitch and Erica Keeps identify six universals about what helps people learn better:

1. "*Why*. If you know why you are supposed to learn something and see personal benefits, you learn better."
2. "*What*. If you know exactly what you are supposed to learn, you learn better."
3. "*Structure*. If instruction is well organized and structured in a way that is meaningful to you, you learn better."
4. "*Response*. If you actively respond and practice during learning, you learn better."
5. "*Feedback*. If you receive timely, specific, meaningful feedback on how well you do during learning, you learn better."
6. "*Reward*. If you feel good about what you are learning and feel rewarded for it, you learn better."[11]

Strategically designed ethics education has the potential to shape organizational culture and to foster a flourishing moral community where medical staff and associates from diverse backgrounds are united by a common mission and ethical commitments. Animated by love and grounded in reason, ethics education serves to advance the well-being of all who carry out and are touched by the continuation of the healing ministry of Jesus.

Notes

A version of essay appeared in Edward J. Furton, ed., *Catholic Health Care Ethics: A Manual for Practitioners*, 3rd ed. (Philadelphia: National Catholic Bioethics Center, 2020), 5.27–5.32.

1. US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: USCCB, 2018), dirs. 5, 37.
2. Edmund Pellegrino, "The Medical Profession as a Moral Community," *Bulletin of the New York Academy of Medicine* 66.3 (May–June 1990): 225–226. Here *moral community* is defined as "a moral community is one whose members are bound to each other by a set of commonly held ethical commitments and whose purpose is something other than mere self-interest."
3. Catholic Health Association (CHA) of the United States and Ascension Health, *Striving for Excellence in Ethics: A Resource for the Catholic Health Ministry* (St. Louis, MO: Catholic Health Association of the United States, 2014), 31.
4. Charles Bouchard, "Are We Part of the Problem or Part of the Solution? Clergy Sexual Abuse and Catholic Health Care," *Health Progress*, November–December 2018, 21, https://www.chausa.org/docs/default-source/health-progress/01f915bec5f945c1bf7bfa8f58d8f77b1-pdf.pdf?sfvrsn=0.
5. See Thomas L. Beauchamp and James Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2012).
6. USCCB, *Ethical and Religious Directives*, general introduction.
7. Aristotle, *Nicomachean Ethics* 1145a5–6, in *The Complete Works of Aristotle*, Bollinger Series, ed. J. Barnes (Princeton, NJ: Princeton University Press, 1984).
8. See USCCB, *Ethical and Religious Directives*, general introduction.
9. CHA and Ascension Health, *Striving for Excellence in Ethics*, 32.
10. CHA and Ascension Health, *Striving for Excellence in Ethics*, 32.
11. Harold D. Stolovitch and Erica J. Keeps, "Six Universals from Learning Research" (workshop, Chicago, IL, November 2016), based on their book: Harold D. Stolovitch and Erica J. Keeps, *Telling Ain't Training*, 2nd ed. (Alexandria, VA: American Society for Training and Development Press, 2011).

Community Outreach and Ethics Services

Jason Lesandrini and Joseph Bertino

Three core functions of health care ethics committees are consultation, education, and policy development. While these are entrenched in most ethics committees, those committees that have moved into a next-generation or integrated ethics committee model have identified a need to work in a more preventative manner.[1] Therefore, committees should think about how they function in, and subsequently integrate ethics work into, their communities. Proactively doing so promotes approaching ethical discrepancies among community members in a beneficial and time-conscious manner.

By extending its resources to the larger community, the ethics committee can adhere to the larger mission and values of Catholic health care. Engaging in community stewardship bolsters patient- and community-centered care in a manner that is respectful, mission-driven, and just. Moreover, this approach contributes to the underlying goal of defending human dignity, promoting the common good, and advocating for vulnerable individuals.[2] The following recommendations are based on the experience of WellStar Health System in Atlanta, Georgia.

Local Universities

Ethics committee members can often obtain adjunct faculty status at local universities and medical schools to teach ethics courses, give guest lectures, or provide continuing education. A primary benefit of this relationship includes providing practical experience rather than strictly academic information.

Connections with local universities can lead to internships, shadowing opportunities, and mentorships, which provide students with experience (e.g., clinical and theoretical research, education, and policy development) and a closer relationship with their local health care organization. Relationships with the community through an academic venue can offer ethics committees a chance to offload some of the necessary work. Although some view a student's assistance as limited, having someone from the academic community can be extremely beneficial if the needs of the committee align with the student's expertise.

Jason Lesandrini, MA, is the assistant vice president of ethics, advance care planning, and spiritual health at WellStar Health System in Marietta, Georgia. Joseph Bertino, PhD, is a clinical ethicist at WellStar.

Vulnerable Populations

Ethics departments also have an advocacy role, especially with patients who have no support system, surrogate, or evidence indicating their treatment preferences. Our department receives at least one referral per week from care coordinators or physicians regarding a patient who cannot communicate treatment preferences. Frequently the state must appoint a guardian who can speak on the patient's behalf. Yet most state-appointed guardians are ill-prepared to take on the role of surrogate decision maker and frequently defer decision making to the clinical team. To assist patients in such vulnerable times and to prepare their guardians or surrogates, our department works with local probate courts to train court-appointed guardians to make medical decisions on behalf of their wards. Our connection to the probate courts arose through our faculty appointments—a professor at a local university was also a probate judge in a county served by our health system.

Most guardians lack the skills to navigate surrogate decision making in a manner that promotes the patient's values. Therefore, we implemented the program developed at Washington Hospital Center in Washington, DC.[3] For every patient who comes into the hospital setting with a guardian, an ethics consult is requested. The guardian is provided a brochure on the expectations of surrogate decision making on behalf of the patient. The brochure describes the three standards for decision making on behalf of another: patient's explicit preferences, substituted judgment, and best interests. The guardian is provided with the phone number for the ethics consultation service to assist with decision making if he or she desires such assistance.

Our ethics consultation service has responded to numerous requests for consultation regarding the extent of surrogate decision making for prisoner populations. As all recognize, potential conflicts arise when someone in a position of power makes medical decisions for a patient at a vulnerable time. Determining appropriate decision makers for prisoners often involves complex social dynamics that thwart discovery of a patient's wishes or values. An ethics committee's involvement with prisoner populations can educate staff from the corrections system about appropriate decision makers and how decision making should proceed. For example, we have experienced numerous cases where a warden told the clinical team that he or she would make decisions on behalf of a prisoner patient. As with guardians of other patients, we engaged the warden and clinical staff at the prison system to inform them about the responsibilities of health care institutions and surrogate decision makers.

Clubs and Community Organizations

Ethics committees have community outreach opportunities, especially to partner with local churches, civic clubs, assisted-living facilities, and community-based health and well-being classes to provide ethics education (e.g., advance directives, informed consent, and value-based preferences), advance care planning, etc.

THE NATIONAL CATHOLIC BIOETHICS CENTER

6399 Drexel Road, Philadelphia, PA 19151–2511 www.ncbcenter.org

ETHICS & MEDICS

VOLUME 45, NUMBER 2
FEBRUARY 2020

An ethics committee can bring recurring problems to the local government relations staff. Opportunities frequently arise to connect with national and state-level representatives to update, improve, or propose legislation. Some state laws surrounding surrogate decision making—such as discharge planning, general medical or surgical treatment, and psychiatric treatment—create delays in care for patients or challenges for the clinical team in making decisions.

In addition to working with government relations staff, ethics committees might collaborate with local health care ethics consortiums and other organizations, such as local chapters of the Alzheimer's Association or the American Society for Parenteral or Enteral Nutrition. We recently worked with the ASPEN to discuss the ethical issues involved in hand-feeding patients with advanced dementia.

Collaborating with the Local Diocese

Specific cases and concerns regarding the Catholic moral tradition may require involving the local diocese. Meeting with the local ordinary or his representative can provide tremendous insights into a health care organization's larger community. As figures of authority in the Church, bishops are responsible for teaching Catholic doctrine within their jurisdictions. Moreover, bishops are moral representatives of the Church who can create meaningful dialogue within the community. Regular meetings with representatives from the local diocese can aid an ethics committee's efforts to provide value-based accommodations to patients. These meetings can help align a health care system's mission with the values of the Church as a whole, as well as those specific to the diocese and its larger community. Including a local ordinary or his representative as an ad hoc committee member provides the ethics committee with an opportunity to both educate and learn from a diocesan representative.

Collaborating with the diocese can be an opportunity to clarify concerns surrounding the *Ethical and Religious Directives for Catholic Health Care Services*. Regular meetings build lasting relationships centered on topics of mutual interest, such as caring for the poor or contributing to the common good. Ongoing dialogue on ethical topics helps build trust and expertise for all involved. A strong relationship also makes conversations about difficult topics easier. If an ethics committee or its representative interacts with a local ordinary only when difficulties arise, the relationship is less likely to be successful. Thus, proactive meetings and collaborative interactions with the local ordinary can serve as a mechanism that promotes preventive ethics and clarifies specific topics for patients.

Finally, novel mechanisms exist wherein ethicists can collaborate with a diocese and its larger population in educational venues, for example, by giving guest lectures to high school classes. These venues allow ethicists and health care advocates to provide young audiences with values-based information surrounding health care and decision making. In recent years, it has become commonplace for Catholic high schools to offer philosophy courses for juniors and seniors. These too serve as beneficial venues for ethicists to educate young members of a given diocesan population. Similarly, opportunities for ethicists and ethics committee members to speak at diocesan retreats can offer a venue for hospital personnel and community members to collaborate.

Notes

A version of this essay appeared in Edward J. Furton, ed., *Catholic Health Care Ethics: A Manual for Practitioners*, 3rd ed. (Philadelphia: National Catholic Bioethics Center, 2020), 5.49–5.54.

1. Ellen Fox et al., "IntegratedEthics: An Innovative Program to Improve Ethics Quality in Health Care," *Innovation Journal* 15.2 (January 2010): 1–36; and Kevin Murphy, "A 'Next Generation' Ethics Committee," *Health Progress* 87.2 (March 2006): 26–30.
2. US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: USCCB, 2018).
3. Virgina A. Brown and Nicole L. Greenidge-Hoskins, "Process Improvement Projects to Assist Attorney Guardians in Making Ethically Optimal Medical Decisions for Their Hospitalized Charges," *Journal of Hospital Ethics* 2.1 (October 2010): 27–33.

Ethics & Medics is a publication of The National Catholic Bioethics Center. Regular annual subscription rates for twelve issues include both the print version by mail and online access at www.ncbcenter.org/em: United States, $28; foreign $38; institutional $55. Individual copies are available for $3 each. To subscribe, please write to The National Catholic Bioethics Center, PO Box 596, Wynnewood, PA 19096, e-mail orders@ncbcenter.org, or phone (215) 877–2660. Publisher: John M. Haas, STL, PhD. Editor: Edward J. Furton, MA, PhD. ISSN 1071–3778 (print), ISSN 1938–1638 (online). To submit an essay or request submission guidelines, please e-mail submissions@ncbcenter.org.