# The Emerging Role of Ethics: A Sponsorship View

## Implementation of Ethics Throughout Catholic Health Care Promotes Values-Based Actions

The story of Catholic health care is one of innovation and adaptation, and one in which ethics has had a featured place. In response to changes in the church, in religious life and in health care, Catholic health systems grew dramatically during the 1970s and 1980s in the United States. Building on a long tradition of care, independent Catholic hospitals and nursing homes increasingly came together to form stronger and more integrated systems.

In order to ensure vital community presence and service, sponsoring religious congregations recognized the importance of maintaining an intentional ministerial focus during these changing times. Catholic hospitals came to form systems, and sponsors built formal methods for nurturing the unique dimensions to religiously motivated health care. Leaders created structures to ensure mission integration, pastoral care, care for poor and underserved persons, and dynamic community outreach.

In line with these important dimensions of Catholic identity, founders of new systems also put ethics structures and processes into place. The emerging role of ethics in Catholic health care provides one important frame for understanding the sponsors' commitment to ministerial identity, organizational values and charitable mission.

This article outlines themes in the recent history of ethics in Catholic health care, and some specific experiences of ethics practice at Bon Secours Health System.

### Reinforcing Existing Foundations

As Catholic systems developed, existing institutional ethics structures were reinforced to address issues and decision-making related to advances in medical technology and to support an expression of Catholic identity. In line with the development of ethics committees in hospitals throughout the United States, Catholic systems ensured that their institutions maintained committees for evaluating ethical dilemmas related to delivery of care.[1] Of course, many Catholic hospitals already had ethics structures in place. The evolution of Catholic health care systems provided an opportunity for wider sharing and uniformity of best practices and for engaging in ministry-wide ethics reflection.

Many noteworthy legal cases in the 1970s and 1980s regarding treatment decisions, including the highly publicized Karen Ann Quinlan case in 1976, and related governmental recommendations, supported institutionalization of ethics committees.[2] Professional organizations, including the American Hospital Association and Catholic Hospital Association, also strongly endorsed the role of institutional ethics structures.

### Expressing Catholic Identity

In establishing ethics structures, Catholic systems also sought to express and reinforce Catholic identity. Emerging systems understood that ethical commitments have an explicitly theological source and focus, and that promoting sound ethical decision-making is a matter of engaging the tradition. Attuned to Catholic moral theology, these systems sought to shape ethical dialogue in a distinctive way. Dialogue here acknowledges the role of ethical principles, but has foundations in an understanding of natural law and the human person.

Beginning with an understanding of the person in the community, and focusing on the virtues that advance thoughtful decision-making, Catholic health care ethics is personal, social and

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theological.[3] Serving in communities with diverse religious and cultural perspectives, Catholic systems seek respectful dialogue on matters of ethical importance. The traditional Catholic understanding of natural law supports such a conversation. The natural drive of human reason to seek the truth, and a natural inclination to do good, provide a starting point.

During the evolutionary period, there was also focus on application of the *Ethical and Religious Directives.*[4] Based on guidelines developed by the Catholic Hospital Association in 1948, the 1971 document, then titled *Ethical and Religious Directives for Catholic Health Facilities,* was published by the United States Catholic Conference. Newly formed systems routinely engaged Catholic moral theologians to assist in understanding and applying the directives. Some hired full-time ethicists to oversee the work of theologians and of ethics committees that assist the organization in applying the directives.

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Although, from a sponsorship perspective, ethics was viewed as an important dimension of a system's Catholic identity, much day-to-day work focused on clinical ethics at the facility level. Educational programs were created to develop the skills of ethics committee members. In this period, ethics policies tended to be facility based. An integrated system-wide approach with a focus on organizational identity was not the norm.

As the number of system ethicists grew, attempts were made to establish more consistent ethics structures and practices, to increase the scope of education, and to develop some system-wide policies. By the 1980s, system ethicists and consultants routinely came together in both formal and informal meetings to discuss emerging trends and issues and to share best practices. Systems developed guidelines for forming and developing ethics committees and consultation practices, and work on competencies for ethicists and committee members began.[5] At this time, ethics was seen as the province of academically trained ethicists, and ethics dialogue as expert-driven.

As in many other systems, ethics was viewed at Bon Secours Health System as an essential element of mission integration. The place of ethics in the organization was formally protected in two sponsor-approved policies related to Catholic identity and mission interests. Like others during this foundational stage, there was certainly variation in the way ethics work was carried out in local ministries. From early on, however, a commitment was in place to provide oversight and adequate resources. A system ethicist was hired during the system's formative years to advance clinical ethics practice, define organizational values, and even to lead what might be seen as a prelude to organizational ethics. Work on values-based decision-making, and education for providing a sponsorship and mission perspective on business practices were part of the ethicist's responsibilities.

## Looking at the Next Generation

The next stage of ethics in Catholic health care involves the intersection of two important developments: the 1995 revision of the *Ethical and Religious Directives for Catholic Health Care Services* and emergence of the next generation model. Each had a unique influence on the way in which Catholic systems understood their ethical responsibilities and their social and religious commitments.

After a lengthy and inclusive consultation process, the United States Catholic Conference published a revised version of the directives in 1995. This edition thoughtfully articulated the ministry's social responsibility and included for the first time a section on forming new partnerships. The consultation process itself and the publication of the revised directives provided an opportunity to engage Catholic health care leaders in dialogue about moral commitments and ways of advancing Catholic identity in an environment increasingly requiring collaboration with other-than-Catholic organizations.

In addition to the revised directives, this stage saw increasing concern about the role and effectiveness of ethics structures. From early on, questions arose about the ability of hospital ethics committees to deal effectively with complex decision-making. In addition to important questions

about the skills needed for committee members, critics suggested that existing structures might actually impede ethics integration, decision-making and organizational effectiveness.[6]

Among responses to these concerns were the establishment of core competencies for ethics committee members, empirical studies on case consultation outcomes, and proposals for a "next generation" model of health care ethics committees. Core competencies, focused on ethical assessment, facilitation and interpersonal characteristics, were put forward by the American Society for Bioethics and Humanities.[7] The purpose of ethics committees and the case consultation process here is to assist with mediation and help promote principled decision-making.

Also addressing concerns about committees, the next generation model goes beyond dealing with difficult decisions. Employing quality improvement techniques, the model calls for identifying patterns of ethical concern, proposing solutions, monitoring outcomes and ensuring focused executive involvement and ownership.[8] Both the competencies and next generation model gained some foothold in Catholic health care and have prompted continued reflection on the purpose and desired outcomes of ethics committees and their relationship to executive leadership.

From a sponsorship perspective, these developments served to strengthen commitments to ethical structures and processes and to raise questions about their robustness and integration into the life of the ministry. In this, it became clearer that, although technical theological and ethical expertise provides important support for ethics practice, it is insufficient. Work on competencies, the quality improvement focus of next generation ethics, and the revised directives all pointed to the need for integrating ethics into the fabric of the organization.

## Developing Organizational Ethics

The third wave of development occurred in response to increased interest in business or organizational ethics in health care. In 1995, the Joint Commission for Accreditation of Healthcare Organizations included new standards on "organization ethics" as a requirement for accreditation. These standards focus on a number of specific ethical issues, such as those related to billing, marketing and conflicts of interest. Equally importantly, the joint commission outlined a number of dimensions for supporting an ethical climate in an organization. Well understood mission and values, practical behavioral expectations, sound practices related to salary and promotion, and ongoing education are just some of these components.[9]

A significant increase in academic and professional reflection on organizational ethics followed introduction of the new standard. Building on conventional business ethics and professional codes, organizational ethics in heath care goes beyond them. The themes of organizational ethics resonate well with some of the classic values and concerns of the Catholic health ministry. Emerging from a tradition of service and community presence and commitment, Catholic health care is concerned principally with care for people and community health.

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Relating the nature and purpose of a health care organization to observable behaviors and practices is a dimension of organizational ethics that also fits well with the Catholic tradition. Insofar as it is concerned with caring for people, the *business* of health care has unique contours. In providing a necessary service, health care organizations are bound by important social obligations.[10] Health care, in every form, is more than a commercial enterprise. With this understanding, intentional cultivation of ethical discourse and communities of ethical practice is an obligation of health care leaders.[11]

The emergence of organizational ethics provides an affirmation and a challenge to Catholic health care. Putting the charitable mission of the organization at the center of ethical reflection affirms the heritage of religiously motivated care. At the same time, the challenge is to carry forward this tradition in an environment that sometimes promotes unhealthy competition, individual and corporate gain, and a view of health care as a commodity rather than a necessary service. The question naturally arises: Can we continue the ministry with integrity, and not just goodwill, in a climate that may not be supportive?

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From a sponsorship point of view, this ethical struggle is well worth the effort. Organizational ethics, thoughtfully undertaken, promotes dialogue about how values are practically applied in the workplace. Quality of care, human resource practices, resource allocation, investments, marketing and communication and environmental responsibility are all in the mix. Health care ethics here is directly linked to organizational mission, and, more importantly, to its practical manifestation.

The 2001 edition of the *Ethical and Religious Directives for Catholic Health Care Services* also had a bearing on this stage of development. Based on significantly less consultation than the preceding revision, this version of the directives includes changes related to the formation of new partnerships and replaces an appendix on principles governing cooperation with additional directives. While acknowledging that partnerships may provide opportunities for the ministry to serve, the directives also warn against dilution of Catholic identity and potential promotion of questionable practices.

Having important responsibility for the advancement of mission, values and identity, sponsors understood that this change in the directives encouraged a deliberative and thoughtful approach to new ventures. A clear implication of the revised directives is ensuring that partnerships with non-Catholic facilities include appropriate reserved rights, board representation, and distinguishing marks of Catholic health care, such as charity care, holistic and pastoral care and community focus.

During this stage of development, Bon Secours Health System created a system-wide ethics quality plan, which required reasonable standardization of structures and practices in clinical and organizational ethics, and defined approaches to ethics leadership and education. In addition, based on earlier system practices, a "mission due diligence" process was put into place for assessing the organizational culture of potential partners as reflected in their mission, leadership style, employee relations practices and social commitments, and for evaluating compatibility with those of our organization.

## Assessing Emerging Trends

As the ministry continues to develop, so too does the contribution of health care ethics. From a sponsorship perspective, among the many issues that will shape ethics dialogue in the future are health care justice and public policy, ministry leadership and board formation in light of emerging sponsorship models, and succession planning for ethicists and their emerging roles. Here is a closer look at each area:

**Health Care Justice & Public Policy** The virtue of justice is concerned with respect for the rights of persons, and promotion of right relationships and the common good. Within the Catholic tradition, health care justice raises important questions about systemic health care reform, allocation of limited resources, medical research, and special concern and outreach for persons who are poor and underserved.

Engaging in public dialogue and advocacy for systemic health care reform and for universal access to care continues to be a priority of Catholic health care. In the important debate about the appropriate balance of incremental and systemic change, the voice of the Catholic health ministry needs to be heard.[12] Despite the complex nature of health care delivery and financing in the United States, ensuring adequate care to all is clearly an obligation of justice.[13] Being present, engaged and persistent in helping to find solutions is an important expression of the ministry's ethical commitments.

As part of this commitment to social justice, Catholic health care ethics also has a potentially important role to play in influencing practice patterns and models of care delivery. A current focus

on specialty care and concerns related to overtreatment, including questionable tests and surgeries, highly aggressive treatments and related deaths, is a matter for increased scrutiny and ethical dialogue.[14] Ensuring that persons have a medical home for primary, preventative and chronic care may be overshadowed in the current environment by reimbursement and practice models that reinforce less conservative, and potentially more dangerous, approaches.

Related to this, the increasing prevalence of so called "consumer-driven" and "retail" models of health care should prompt deeper analysis. An approach that suggests health care is a commodity rather than a necessary service is of ethical concern and conflicts with the Catholic tradition of care. Such models have the potential of limiting access to primary care, and shortchanging those who are most in need of well-integrated services.

Research ethics will continue to be an important area of focus. As medical research is increasingly being conducted in community hospitals, Catholic systems will need to ensure that satisfactory institutional review board processes are in place, and that respect for the dignity of the person and commitment to the common good remain components of ethical analysis.

**Ministry Leadership & Board Foundation** As sponsorship of Catholic health ministries moves beyond traditional boundaries, ministry leadership formation assumes an important role. In order to ensure a lively continuation of the mission, leaders and board members will need to be prepared in key dimensions of the Catholic tradition, including moral theology, Catholic social teaching and spirituality.

Because ethics practice should not be the exclusive province of academically trained ethicists, an understanding of the tradition and practical development of moral sensitivity should also be part of a comprehensive formation program. This need is particularly important, not simply to build technical expertise, but in order to form communities of discerning leaders.[15]

The religious motivation that is at the heart Catholic health care needs to be evident in the decisions that are made, and in the *manner* of decision-making. Thoughtful ethical discernment, therefore, needs to be a defining characteristic of the ministry.

**Ethicists in the Future** It is important to consider the sources, formation and role of ethicists in the future. Appropriate philosophical and theological training, preferably including a sound understanding of the Catholic tradition, should be expected.

In line with overall ministry formation, special attention should be given to affective and spiritual formation, and to the integration of ethics leaders into the broader leadership community. Because ethics leadership requires technical expertise *and* the ability to influence, participate in and facilitate decision-making, ongoing coaching and mentoring by successful ethicists and non-ethics leadership peers should also be available.

Ethicists will be most effective in promoting reflection and thoughtful decision-making if they are respected by other leaders for their knowledge of ethics and the Catholic tradition, and for their understanding of the practical realities of health care leadership. Like sponsorship and mission leaders, ethicists should have a good working knowledge of health care operations, finance, planning and human resources.

In carrying out the ministry in the name of the church, sponsors have an obligation to ensure that ethics practice is integrated deeply into the life of the organization. It should never be viewed as an interesting but peripheral activity. In this, ethicists should have routine, formal and significant interaction with executive leaders and should work in concert with sponsors and mission leaders in advancing Catholic identity in a thoughtful and inclusive way. A reasonable and important question for today and tomorrow is: Should an ethicist or theologian be a member of the executive team in order to influence decision-making, model ethics reflection and contribute to organizational direction?

## Continuing the Tradition

Precisely because the story of Catholic health care is part of the story of the church, ethical reflection involves an engagement with the tradition and an ongoing discovery of the truth which tradition reveals. Ethics is a way of looking at and understanding the world. Ethical discernment is a creative activity, an exercise of moral imagination, based on God-given gifts.[16]

The role of ethics in Catholic health care, from

a sponsorship perspective, is one that both safeguards tradition and creates it. Like emerging sponsorship models themselves,[17] ethics practice provides a means for creating communities of concern and meaning. Although ethics in Catholic health care certainly helps with complex clinical and business decisions, it is also, and importantly, about cultivating an environment in which meaningful conversation about values can occur, and from which values-based actions arise.

Ethics practice matters to sponsors precisely because it contributes to organizational integrity, and is a profound and creative expression of our living tradition. ■

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## NOTES

1. See Francis Bernt et al., "Ethics Committees in Catholic Hospitals," *Health Progress* 87, no. 2 (March-April 2006): 18-25.
2. Judith Wilson Ross et al., "History of the Bioethics Movement" in *Handbook for Hospital Ethics Committees* (Chicago: American Hospital Association, 1986), 6-8.
3. See Kevin O'Rourke and Dennis Brodeur, *Medical Ethics: Common Ground for Understanding* (St. Louis: Catholic Health Association, 1986), and Benedict Ashley, Jean deBlois and Kevin O'Rourke, *Health Care Ethics: A Catholic Theological Analysis*, 5th ed. (Washington, D.C.: Georgetown University Press, 2006) for a consideration of the theological dimensions of Catholic health care ethics.
4. *Ethical and Religious Directives for Catholic Health Care Services*, 4th edition (Washington, D.C.: United States Conference of Catholic Bishops, 2001) is the current authoritative version. Available online at www.usccb.org.
5. Margaret John Kelly and Donald G. McCarthy, ed., *Ethics Committees: A Challenge for Catholic Health Care* (St. Louis: Catholic Health Association, 1984).
6. See Kevin Murphy, "A 'Next Generation' Ethics Committee," *Health Progress* 87, no. 2 (March-April 2006) 26-30, for a summary of some relevant literature and an overview of one system's experience.
7. *Core Competencies for Health Care Ethics Consultation* (Glenview, Ill.: American Society for Bioethics and Humanities, 1998).
8. Judith Wilson Ross et al., *Health Care Ethics Committees: The Next Generation* (Chicago: American Hospital Association, 1993).
9. Joint Commission on Accreditation of Healthcare Organizations, *Ethical Issues and Patient Rights Across the Continuum of Care* (Oakbrook Terrace, Ill.: Joint Commission Resources, 1998).
10. Leonard J. Weber, *Business Ethics in Healthcare: Beyond Compliance* (Bloomington, Ind.: Indiana University Press, 2001), pp. 4-7.
11. Carol Taylor, "The Buck Stops Here," *Health Progress* 82, no. 5 (September-October 2001): 37-40.
12. John W. Glaser, "'Covering the Uninsured' is a Flawed Moral Frame," *Health Progress* 87, no. 2 (March-April 2006): 4-9.
13. Philip S. Keane, *Catholicism and Health-Care Justice* (New York: Paulist Press, 2002), esp. 5-18.
14. See Shannon Brownlee, *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer* (New York: Bloomsbury USA, 2007), and Elliott S. Fisher, "Medical Care — Is More Always Better?," *The New England Journal of Medicine* 349, no.17 (Oct. 23, 2003): 1665-1667 for a consideration of the dynamics of unnecessary treatment.
15. John W. Glaser, "The Community of Concern," *Health Progress* 83, no. 2 (March-April 2002): 17-20.
16. Philip S. Keane, *Christian Ethics and Imagination: A Theological Inquiry* (New York: Paulist Press, 1984), 99-105.
17. See Francis Morrisey, "Toward Juridic Personality," *Health Progress* 82, no. 4 (July-August 2001): 27-31, and *Core Elements for Sponsorship: A Reflection Guide* (St. Louis: Catholic Health Association, 2006) for ways of thinking about contemporary dynamics of sponsorship.