



A “Next Generation” Ethics Committee

ST. JOSEPH HEALTH
SYSTEM HAS INTEGRATED
PERFORMANCE -
IMPROVEMENT FEATURES
INTO ITS ETHICS WORK



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Tools Available Online

The Ready Reference Grid, Performance Measures for Ethics Roles, Fiscal Year Work Plan, and Crosswalk (regarding informed consent), and Organizational Ethics Survey, all mentioned in this article, are now available at www.chausa.org/ethicscommittees.

It is difficult to measure the impact of the work of ethics committees in health care delivery. When, in the 1960s, traditional models of health care ethics committees were set up to offer “ethical advice” in tough clinical choice situations, they were simply not equipped with mechanisms to measure their quality-improvement impact. Various critics have identified the traditional ethics committee model’s shortcomings, and some have offered models to address the gaps.¹ I intend in this article to offer the experience of St. Joseph Health System (SJHS), Orange, CA, as it has worked to integrate ethics expertise and quality-improvement methodology in its “Next Generation Healthcare Ethics Committee” model (NG Model) for improved health care delivery operations.

In March 1999, SJHS introduced its NG Model to its local ministries (see **Box**, p. 27) with the following four principles guiding its implementation:

- Committees should be proactive, not just reactive, in their constitution and work habits.
- Committees should be organizationally integrated, not isolated, in their membership and design.
- Committees should be held accountable for performance, based on demonstrable outcomes, not just good intentions.
- Committees should be oriented by organizational core values, as well as external legal/regulatory/accreditation requirements, in their analysis of issues and activities.²

A NEW INFRASTRUCTURE FOR ETHICS INITIATIVES

Given these aims, SJHS created an infrastructure that would enable its ministries to make the transition from

the traditional ethics committee model to a NG Model. Within the NG Model, there were three basic roles:

Clinical Consultation Team Role This role was carried over from the traditional model. Clinicians at each local ministry would continue to receive—from a group trained in health care ethics principles, decision making, and site policy—clinical ethics consultations service regarding tough ethical decision-making challenges.

Systemic Team Role In this role, a second ethics team would, first, receive ethical issue trends or patterns emerging from the clinical ethics consultation service or other groups at the health care delivery site; second, identify systemic gaps from these ethical patterns; and, third, use quality-improvement methodology to create interventions to address these systemic gaps.

Executive Role A member of the hospital's executive team would be accountable for the effectiveness with which the first two roles were performed and given the authority to address administrative challenges that inhibited its work.

Although these three roles were put into operation differently at local ministries, they have been a consistent hallmark of the ethics infrastructure.

SJHS also developed two other roles that, although not explicitly part of the original NG Model, support its basic principles:

"Ethics ACE" Role Ethics ACEs (Assisting Colleagues with Ethics) are frontline staff members who utilize a Ready Reference Grid (see **Box**, p. 29) that, first, helps colleagues "frame" the ethics dilemma they find themselves faced with and, second, offer the pertinent ethical principle, legal statute, and hospital policy that will help them comprehend and respond to the dilemma. The Ethics ACE then points colleagues to the unit's nurse manager, who identifies the next steps to be taken.

Theology and Ethics Department Role The

NG Model was originally developed by SJHS's System's Center for Healthcare Ethics. Since the center's closing in 1999, the NG Model has been guided by the SJHS's corporate Theology and Ethics Department. The department's two staff members provide the education, infrastructure development, quality-improvement assessment, and tool development required by the new model.

The Theology and Ethics Department was developed in the belief that organizational transformation demands systemic change, not just education. SJHS decided that it could best serve the evolution of the ethics committee in the United States by first transforming its own ethics committees and then sharing that experience with other health care organizations.

SUCCESSSES AND CHALLENGES

The implementation of the NG Model at SJHS met several challenges.

Quality-Improvement Illiteracy Because a quality-improvement culture was relatively new at SJHS,

St. Joseph Health System

St. Joseph Health System (SJHS) is a ministry of the Sisters of St. Joseph of Orange and has its corporate offices in Orange, CA. SJHS is an integrated health care system delivery system providing a broad range of medical services. The system is organized in three regions—Northern California, Southern California, and West Texas/New Mexico—and consists of 14 acute care hospitals, as well as home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician organizations. Within SJHS, these entities are referred to as "local ministries."

—Kevin Murphy, PhD

SUMMARY

Understanding the limitations that accompany the traditional model of ethics committees, St. Joseph Health System (SJHS), Orange, CA, has been working to integrate ethics expertise and quality-improvement methodology into its "Next Generation Model" (NG Model) for such committees.

However, moving from a traditional structure to the NG Model (introduced to SJHS facilities in 1999) brought some challenges, not the least of which was a deep-rooted culture of resistance to change.

Following a 2004 audit of how the NG model was working, some common challenges were identified. To deal with those challenges, SJHS developed some tools and techniques that have helped ease the ongoing transition. These tools have helped the system's ethics committees address such issues as collaboration for the sake of organizational integration, setting goals, and measuring performance of various ethics roles.

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those who participated in the NG Model had first to be encouraged to become literate in quality-improvement methods and language. This campaign encountered the same challenges and setbacks that other writers have noted in the quality-improvement movement's history.³

Cultural Resistance At SJHS, the traditional ethics committee model had a deep-rooted culture that explicitly and implicitly resisted the NG Model. That resistance, coupled with the fact that participation in the new model was voluntary rather than mandatory, produced a formidable combined challenge to change.

In 2004, some of the cultural roots of a traditional ethics committee model were still evident in a SJHS audit of the NG Model's progress. Every organization has its own deep culture, an ingrained set of beliefs and practices regarding the organization's history, value, identity, and success. It is commonly recognized that culture will formidably shape the success or failure of any initiative implemented in any particular organization. Among SJHS local ministries, the audit revealed some common challenges inhibiting the transition and progress of the NG Model:

■ **Committee Member Satisfaction** Traditional ethics committees often hear dramatic stories concerning tough clinical choices made in the course of health care delivery. Committee participants often get great satisfaction from engaging with such stories and thinking through their resolution.

But the work involved in systems thinking and quality-improvement methodology is different from traditional ethics committee work. People who got satisfaction from the work of a traditional committee may not find the same satisfaction in committee work performed according to the NG Model, even if the new model promises better patient and organizational outcomes.

■ **Decision-Making Authority** A cultural tension can exist between a health system's corporate offices and a local care delivery site. In SJHS, implementation of the NG Model occurred in the midst of such tension.

As part of a systemwide initiative, the Theology and Ethics Department staff conducted a dialogue with the executive ethics liaisons* at the local ministries to clarify their respective responsibilities in the nurturing of the NG Model. These

dialogues helped clarify who was responsible to initiate, direct, offer insight into, or fulfill a simple consultative role. Before these dialogues were held, it was not uncommon for those responsible for implementing the new model at their entities to feel caught in a conflict between guidance offered by local leadership and that by the corporate office.

■ **Voluntary Participation** Under the NG Model, ethics chairs and committee members were to be, when performing those duties, either released from some of their primary work responsibilities or compensated for time put in beyond normal work hours. It is clear that fulfillment of this component has been challenging due to operational pressures. Some ethics committee members still see their participation as "voluntary" or "not essential."

■ **Delegation of Work** The NG Model was designed to facilitate the delegation of work among committee members. Unfortunately, it is clear that, in current practice in most local ministries, the committee's "hard work" continues to fall upon the shoulders of one or two members.

Failure to delegate tends to lead to failure to build capacity, prepare future leaders, or nurture succession planning. It does not accomplish these things because it has been shaped by certain problematic attitudes and practices. For example, some ethics committee members may resent the fact that committee work has been added to their primary workloads. On the other hand, some ethics chairs, believing that the work cannot be done well by others, may try to keep it to themselves. And some committee members may expect the chair to complete the majority of the work.

But where there is no delegation of work, there is no development of talent and succession planning. SJHS's efforts to address this problem under the NG Model have worked best in two areas. First, the corporate and local ethics leaders clarified expectations concerning ethics committee roles. Second, by looking to collaborate with groups assigned to carry out fiscal-year priorities set by local ministries, corporate and local ethics leaders are better placed to take advantage of commitment and momentum at the local level. Partly because of a lack of time on the part of ethics committee members, they have themselves worked for a closer alignment with local ministry commitments.

■ **Collaboration** The NG Model's success has resulted from the integration of ethics initiatives with the tools and approaches employed by quali-

*The "executive ethics liaison" role differs at different SJHS facilities; often it is filled by the vice president for mission and ethics or the chief nursing officer.

ty-improvement personnel. In addition, SJHS's leaders recognized that ethics leaders and ethics groups were not the system's only centers of moral responsibility. By actively looking for opportunities to work with other centers of ethical responsibility—such as quality-improvement review boards, mission leaders, and risk management personnel—the system's ethics leaders avoided turf battles and created an expectation of cooperation.

■ **Accountability** Challenges arose regarding SJHS's efforts to nurture local approaches by increasing accountability through measurable outcomes. Under the traditional model, one symptom of an ethics committee's isolation was a tendency for it to either succeed or fail without the ministry's leaders noticing the fact.

However, SJHS made progress as it began to institute systemwide fiscal-year ethics work plans, as it replaced process measures with outcome measures, as it created evaluation tools for local use, as it began to reward excellence through an annual ethics award given to the local ministry with the year's best measurable outcomes, as it further encouraged the integration of ethics committee work with the local ministry's mainstream work, and as it fostered executive awareness and support through the new model's executive ethics liaison role.

TRANSITION TOOLS THAT OFFERED TRACTION

Given the challenges described above, SJHS created a number of tools and interventions to assist in the NG Model's implementation. These tools and interventions, developed collaboratively in an effort to offer a clear vision and integrate ethics smoothly into established operational infrastructure, are:

■ **Ethics Referral Manuals and Evaluation Documents** The system developed and distributed two manuals intended to reinforce key NG Model principles in staff thinking. An *Ethics at a Glance Manual* provided a "one-stop" resource for staff members in general. A *New Member Orientation Handbook* was developed specifically to orient ethics committee members to the NG Model's uniqueness. Both manuals were designed to help all local ministries begin the transition to the NG Model at the same starting point.

Along with the manuals, the system created performance measures for each of its ethics roles, thereby providing ethics staff members with a clear picture of expectations for SJHS's consultation group, system ethics group, executive ethics liaisons, and corporate Theology and Ethics Department. Similar tools were created to facili-

tate assessment of ethics work at each local ministry. Using these tools, ethics staff members began to get a better understanding of role expectations and a clearer picture of how "success" would be defined under the NG Model.

■ **A "Best Practice"-Sharing Infrastructure** Implementation of any new model involves experimentation, learning from mistakes, and making corrections so as to better reach the desired goal. This was true of the NG Model. To encourage the sharing of discoveries and "best practices," the system conducted annual workshops in which staff members discussed issues face to face. Staff members were also encouraged to share what they had learned through e-mail.

Each local ministry was required to create a fiscal-year work plan, complete with goals and measurement indicators. The local ministries then shared these work plans, thereby enabling them to identify common interests and projects, including projects on which they might work collaboratively.

■ **Crucial Conversations** As noted above, tension sometimes exists between a health care system's corporate office and its local sites regarding decision-making authority. In 2004, SJHS inaugurated what it termed "Facilitative Dialogues" among executives in both the corporate offices and local ministries to clarify and establish working agreements on decision making and accountability roles. Such dialogues assisted implementation of the NG Model and clarified ethics roles. In a nutshell, the Theology and Ethics Department was made responsible for creating the new model and its accompanying tools, whereas local ministry ethics leaders were made responsible for the model's implementation.

■ **Collaborative Tools and Initiatives** Implementing the NG Model systemwide required collaboration efforts with other SJHS departments (legal, risk management, mission integration, per-

Tension can sometimes be found between a system's corporate office and a local facility.

The "Ready Reference Grid"

The Ready Reference Grid is a four-column grid showing the 12 ethical issues that clinicians see occurring most frequently. Aligned with each issue is the pertinent ethical principle (usually taken from the *Ethical and Religious Directives for Catholic Health Care Services*), the pertinent hospital policy, and the pertinent law of the state in which the hospital is located.

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formance improvement, among others) as well as between local ministries and the corporate office. The mantra used in this collaboration was "Ethics is not special, but essential." The following are some examples of this collaboration.

- The Legal Services Department developed a "Crosswalk" regarding informed consent policies drawn from the *Ethical and Religious Directives for Catholic Health Care Services*, Joint Commission on Accreditation of Healthcare Organizations standards, and applicable state law.

- The Performance Improvement Department developed an Ethics Improvement Project to strengthen timely and effective decisions about life-sustaining treatment in intensive care units.

- The Legal Services, Risk Management, and Performance Improvement departments developed a philosophy of mistake management and a protocol for the disclosure of mistakes.

- The Corporate Responsibility and Mission Integration departments created an organizational ethics survey for employees to help SJHS establish an internal benchmark.

WHAT'S NEXT?

If you were to ask the NG Model's authors, "What infrastructure or collaborative opportunities would you like to capitalize on in the next couple of years in order to deepen the model?" this is what they would say:

- We hope to create a more collaborative, multisite approach and culture for executing ethics performance-improvement projects.

- We hope to work with staff members at the many local ministries by serving on their committees and work groups.

- We would like to strengthen executive accountability by supporting directors and managers who experience resistance regarding ethical behavior.

- We hope to collaborate more explicitly with "next generation" models in other U.S. health care organizations and with the Institute for Healthcare Improvement, Cambridge, MA.

- We would like to obtain grants to assist in the execution of SJHS's ethics performance-improvement project at local ministries.

- We hope to help overcome the "Ethics is important but not urgent" syndrome by tying a

patient's right to informed consent to patient safety goals.

- We would like to include ethical outcome measures in the quality "dashboards" viewed by SJHS board members.

- We hope not only to integrate ethics analysis and quality improvement methodology but also, by doing so, to help create at SJHS "a community that serves, that speaks, that celebrates, and prays in such a way that others, regardless of their religious belief, encountering this community experience a revelation of life's deepest truths."⁴

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NOTES

1. For criticism of the traditional model, see Robert M. Veatch, "Hospital Ethics Committees: Is There a Role?" *Hastings Center Report*, vol. 7, no. 3, 1977, pp. 22-25; Richard McCormick, "Ethics Committees: Promise or Peril?" *Law, Medicine & Health Care*, vol. 12, no. 4, 1985, pp. 150-155; Mark Siegler, "Ethics Committees: Decisions by Bureaucracy," *Hastings Center Report*, vol. 16, no. 3, 1986, p. 22; Cynthia Cohen, "Is Case Consultation in Retreat?" *Hastings Center Report*, vol. 18, no. 4, 1988, p. 23; and David C. Blake, "The Hospital Ethics Committee: Health Care's Moral Conscience or White Elephant," *Hastings Center Report*, vol. 22, no. 1, 1992, pp. 6-11. For alternative models, see Kevin Murphy, "Re-Visioning Our Potential: Networking Ethics Mentors and Healthcare Ethics Committees," *HEC Forum*, vol. 13, no. 2, 2001, pp. 160-170; David C. Blake, "Reinventing the Healthcare Ethics Committee," *HEC Forum*, vol. 12, no. 1, 2000, pp. 8-32; Janis Rueping and Dan O. Dugan, "A Next Generation Ethics Program in Progress: Lessons from Experience," *HEC Forum*, vol. 12, no. 1, 2000, pp. 49-56; Glen I. Komatsu, "A Corporate Ethics Team: An Approach to Organizational Ethics," *HEC Forum*, vol. 13, no. 2, 2001, pp. 171-177; and Nancy P. Bancroft, "The 'Next Generation' Model," *Health Progress*, vol. 85, no. 3, May-June 2004, pp. 27-30, 55.
2. See Blake, "Reinventing the Healthcare Ethics Committee."
3. Donald Berwick, *Escape Fire: Designs for the Future of Health Care*, Institute for Healthcare Improvement's National Forum on Quality Improvement in Health Care, Jossey-Bass, San Francisco, 2004, pp. 96-123; Everett Rogers, *Diffusion of Innovations*, 4th ed., Free Press, New York City, 1995; and Gerald J. Langley, et al., *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, Jossey-Bass, San Francisco, 1996, pp. 74-91.
4. John W. Glaser, personal communication, October 2003.