MAKING ACCESS A PRIORITY

Ethics Has a Vital Role in Fostering Collaboration in Health Care

BY FR. JOHN F. TUOHEY, PhD

In 2004, the Portland, OR, *Oregonian* published a letter to the editor from the directors of the various ethics programs of the state's health care systems. I was among the signers, representing Seattle-based Providence Health & Services in Oregon. In the letter, we said that we planned to bring together the Portland area's top health care leaders and ethicists to discuss how we might better coordinate our independent efforts to care for Oregon's increasing number of uninsured and underinsured citizens.

Portland's health care leaders and ethicists were already accustomed to working with each other in other settings. We intended to bring them together in the context of ethics, rather than that of business or public policy. We hoped to change the relationships among area health care organizations so that we might begin to see ourselves as each other's stakeholders in the provision of health care to our community. As mutual stakeholders, we would need to be engaged in each other's operational decisions concerning budget cuts in the Oregon Health Plan, the state's Medicaid program, as well as other health care programs. Such engagement would be something quite new for us.

The issue we intended to discuss in the meeting was access to health care, particularly access by the poor. Because Oregon health care systems would have fewer dollars to spend than in previous years, each of them was being forced to make difficult decisions concerning services provided, especially to the uninsured and the underinsured. We who signed the *Oregonian* letter thought that if our organizations could see *each other* as stakeholders in those decisions, as groups of people who would be affected by the decisions of other groups, we might make decisions differently. More importantly, we might make them in a way that was ultimately better for those who needed care but are the least able to afford it. Our thinking was that if our organizations would begin to make their operational decisions *together*, rather than independently, those decisions might better benefit those whose access to care was threatened.

An example intended to illustrate the importance of such working together was offered by Susan Tolle, MD, director of the Center for Ethics in Health Care at Oregon Health & Science University (OHSU), Portland. What if, Tolle asked, OHSU were to consider reducing or even ending service provided by its Poison Control Center? In that case, she pointed out, the state's other major health systems—Providence Health & Services-Oregon Region; Legacy Health System, Kaiser Permanente Northwest; and PeaceHealth—would have an interest in that decision. They might well want to act as stakeholders in making the decision. Ultimately, the independent decisions of one system impact the others, which in turn impacts access to care. Might not access be better preserved if some system decisions were made with regard to their impact on other systems, if we saw each other not as competitors but as stakeholders?

A Frank Discussion

This was our thinking. Having put ourselves on public notice, we proceeded to make the meeting of area health care leaders and ethicists happen. Fortunately, all of the health care leaders in the state agreed that a meeting of this sort would be helpful. As a result, 10 of us system representatives gathered in late 2004 at the Providence Center for Health Care Ethics, on the campus of

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The meeting's conversation was frank and sometimes took on an edge. Even so, we remained focused on the key issue: How can health care systems, more familiar with competition than with sharing strategic plans, deal with each other to facilitate access for the most vulnerable in our society?

A number of very interesting ideas were raised. Unfortunately, none of us knew how our organizations' budget numbers were going to play out. It was therefore hard for us to begin to think about strategizing together in a concrete way. Nevertheless, everyone agreed that perhaps a different way of working with each other, within the context of ethics, might be a good way to proceed once the facts were in.

That, unfortunately, is as far as we got. Budget numbers from the state and federal level are never as clear as one would like. The number of people losing insurance, both private and public, continues to grow. Because it does, it is very difficult for health care organizations to budget accordingly. With everything in flux, we who had participated in the initial meeting decided to wait for what essentially was a moving target to settle before getting back to our plan for interorganizational ethical discernment concerning access to care.

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New Model Needed

Nearly three years later, as we continue to grapple with expanding markets and budget shortfalls, I tend to think that we, as ethicists in Oregon, failed to take advantage of the time available to us as we waited for specifics. And, in doing that, I would have to say that we failed the state's poor as well. Instead of waiting, we ethicists should have offered our leaders the tools they would need if we were to succeed in changing our fundamental ways of relating to each other. We should have:

- Articulated precisely why a conversation about access should take place within the context of ethics
- Presented a new model within which to make new decisions, rather than assuming the current business or operating model would suffice
- Made explicit the moral imperative for moving in this new direction

We failed to realize that the model for business decision making that governed our interorganizational relations was both inadequate and an obstacle to the changes we were hoping to make. As a result, we did not offer a new model. We should have. Also, I think we just took it for granted that everyone involved would agree that access to care for the poor is important, and that, because everyone agreed, we would not need to articulate an imperative for what we were proposing.

In this, we were mistaken. Rather than wait for fiscal clarity, we ethicists should have offered our leaders a clearly stated imperative for moving from competition to collaboration, and a new ethical model for that move. Perhaps we and others can use our failure to learn how to do better in the future. This essay is an attempt to do that.

Why Ethics?

Why an ethical dialogue among our systems? Ethics, I would argue, can and should be the primary context within which health care organizations make the kinds of decisions they are challenged to make. Ethics is, I suggest, the *only* context in which genuine interorganizational collaboration can improve access to health care by the general public.

The term "ethics" comes from the Greek *ethos,* meaning a stable or a barn. The ethos provided the context and structure for the life of the herd. In using this term in a human context, the Greeks made of ethos or ethics the context or framework that people need if they are to come together as community. Ethics is, then, fundamentally, about the relationships that are necessary for community. Ethics is the science or art that defines the parameters of our human relationships and gives us insights into our obligations toward one another. As Br. David Steindl-Rast says, "Ethics is how we behave *when we decide we belong together.*"[1]

In saying that we wanted to make ethics the context within which corporate relationships are discussed, we meant that we wanted each system to base its business decisions not primarily on its own corporate needs (the traditional model for doing business) but, rather, on its relationships with and obligations toward other health care systems. We needed to equip our systems with an operating model rooted in "relationship build-

ing." In such a model, the primary concern is with mutual responsibilities and the imperatives incumbent upon the people involved to act as caring persons, caring *about* each other. The measure of corporate success is found in the quality of those relationships. In such a model, one looks to the level of trust, openness, and respect present in relationships.

On one hand, this should come quite naturally to those of us who work in health care. After all, health care is built on relationships. Health care is rooted in our caring about and for others in need.

The reality is, of course, that while health care *itself* may be all about caring, health care *delivery*, externally and structurally, has taken on much more of a corporate nature. By virtue of its size and complexities of services, even Catholic health care has structured itself on a typical corporate model that is not always compatible with relationship building. We, too, often have an inherent inclination toward self-interest in our drive to take care of patients: We, too, concern ourselves with expanding our markets, for example. Like others, Catholic organizations strive for success, and our measures of success are often found in the business model of benchmarking, return, and efficiencies.

One alternative to the business model is "enlightened self-interest." Organizations based on that model seek to take a broader view of their interests. However, I am not sure that enlightened self-interest is a good model for health care. If self-interest means "It's all about me," enlightened self-interest may be described as "Being about you is all about me." Self-interest, however "enlightened," remains self-interest at heart. It cannot provide a model that fits the ethical context of health care, a model that facilitates the level of collaboration health care requires. Ultimately, I think we must say that, since the topic here is improving access to health care for others, any model rooted in self-interest, no matter how enlightened, is going to fall short of the mark.

Three Commitments in Doing Business

In her book, *Good Intentions Aside: A Manager's Guide to Resolving Ethical Problems,* Laura Nash writes that three commitments lie at the foundation of all business decisions.[2] They are:

- Purpose
- Driving assumptions
- Means or measures

Nash describes how these commitments play out in two business models—the *self-interest model,* which, I believe, is the basic model in health care, even Catholic health care; and the *covenant model.* It is the covenant model that we Oregon ethicists should have proposed to our systems' leaders as a way to allow ethics to shape corporate relationships.

The Self-Interest Model In this model, *purpose* refers to the "bottom line"—that is, to a maximized return on investment. For-profit corporations are not the only organizations that follow this model. Wherever one works, one hears the phrase "It's all about the bottom line." Even though not-for-profit organizations do not accumulate profits—they call them "margins"—those margins are very important and those organizations have every intention of achieving and maximizing them. And

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they are right to do so. Margins make it possible for not-for-profit health care organizations to grow, expand services to people, and engage in medical research.

Still, no matter however worthy the outcome or enlightened this interest in the bottom line, the not-for-profit organization's purpose can remain maximizing returns. To the extent that this purpose prevails over others, decisions about collaboration with other organizations will have a competitive edge to them. Organizations will be competitors, not mutual stakeholders.

The *driving assumption* behind this self-interested purpose is that maximizing profits is the way to ensure ultimate success. There are few in Catholic health care who have not heard the expression "No money, no mission." Its underlying premise is that a health care organization that does not maximize its returns will not be able to pursue its mission of providing high-quality health care, especially to the poor and vulnerable. The *purpose* of achieving the bottom line to maintain the ministry *drives* the *assumption* that the bottom line is necessary for the continuation of the ministry.

The importance of preserving good credit and a high bond rating can be an important part of

this driving assumption. Business decisions can be made with an eye more on the organization's bond rating than on its mission. To the extent that this driving assumption prevails, decisions about collaboration with other organizations will have a competitive edge.

Self-interest is also evident in *means and measures,* the way an organization moves toward its goal. In the self-interest model, means and measures reflect tangible efficiencies. For example, patient length of stay becomes as much a key measure of success or failure as does outcome. The principle of wise stewardship is equated with practical cost-effectiveness.

A recent *JAMA* article described a study seeking to show the effectiveness of an ethics consult as demonstrated through the measure of shortened length of stay.[3] It seems to me not entirely impossible that a good ethics consult could, in fact, *lengthen* a patient's stay. In a case like this, the measure prejudices the consult. To the extent that a measure of efficiencies prevails, decisions about collaboration will have a competitive edge.

The Covenant Model In contrast to the self-interest model, Nash offers what she calls the "covenant model." As the name suggests, this model has to do with fidelity to relationship. As the great health care ethicist Paul Ramsey wrote in his 1970 groundbreaking work, *The Patient as Person: Explorations in Medical Ethics,* "covenant" derives from the Hebrew concept of *hesed*.[4] *Hesed* entails an absolute commitment to fidelity, according to which the question concerning relationship is never *whether* to relate with another but, rather, *how* to be in relationship with another.

But the biblical tradition out of which the term "covenant" comes also has to do with identity. One aspect of covenant often overlooked, even by Nash, is the fact that when one enters into a covenant with another, one's own identity is changed. We become who we are in and through the covenants/relationships we make. Fidelity to covenant is more than fidelity to another or others. Fidelity to covenant also entails our being faithful to who we have become through those relationships. This is the model that we ethicists should be promoting with health care leaders, the model we should be bringing to them now for future endeavors.

In the covenant model, purpose is not the "bottom line." It is what Nash calls the "social contract," and it serves as a justification for the organization's existence. In this model, an organization's purpose or reason for existence is the service commitment it makes to the broader society. Publicly traded corporations are increasingly adopting the covenant model. They are doing so because they realize that the accumulation of capital, of corporate profits and investor returns, is not in itself sufficient justification for being in business. They see that they should also be providing some *social* benefit.

Such corporations understand that society as a whole should be better for the existence of a business enterprise. This is the social contract: the commitment to use a business for the betterment of society. Avon Products is a good example of a for-profit organization that understands the social contract. Avon has committed itself to use a percentage of its profits, drawn overwhelmingly from sales to women, for research and education in breast cancer, one of women's principal health concerns. Avon's leaders understand that providing a return to the investor for making "Skin So Soft" products, which keep mosquitoes away (as the company's ads claim), is not a good enough reason to tie up one group's assets and capital and to ask another group to work a 40-hour week. Some social justification is needed as well. In the covenant model, a company exists to fulfill a social contract.

A cynic might say, "The fact that Avon is donating money to cancer research is just another marketing gimmick!" And, of course, such donations *do* make good advertising. But we need not be cynical about it. The fact that Avon's gambit works as good advertising speaks to the driving assumption in a covenant model. In the covenant model, the driving assumption is not "No money, no mission" but, rather, "Keep the mission, and the mission will keep you."

Fidelity to the mission will ensure the success of the mission. This has been demonstrated in the marketplace. There was a time when socially responsible investing was seen as the "stepdaughter" of Wall Street—it was a nice idea as long as the investor wasn't interested in making much money. Today, however, portfolios comprising the stock of corporations committed to social responsibility—corporations with a strong social contract—are as successful as those operating on a pure self-interest model. Sometimes they are *more* successful. Catholic health care organizations that limit their investing to socially responsible stock portfolios see this all the time. If we keep to the mission, the mission will keep us.

But what about means? Means have to do with the quality of a relationship. In health care, success is measured in terms of patient satisfaction. Satisfied patients will return to conscientious facilities and recommend them to others. They will do so not simply because those facilities are doing well, but because they are *being good.* A health care organization's goal should be making sure that others view it as a reliable

steward not only of its resources but also of its core values.

A perfect example of such stewardship is a willingness to disclose medical errors and "near misses." Forthrightness and honesty ensure trust even in the face of error. This was well illustrated by St. Agnes Medical Center, Philadelphia, in 2001. When administrators discovered that an error had been made in the dosages of an anticoagulant medication for hundreds of patients, they announced it in a press conference. St. Agnes administrators visited the homes of the patients affected, including those of patients who had died, possibly as a result of the error. The hospital was fined because of this error. But, as a result of its concern with preserving the quality of patient relationships in the midst of error, the money St. Agnes was fined in law turned out not to be a fine in fact. The judge in the case permitted the hospital to use the money to develop new processes to help prevent similar errors in the future. Meanwhile, the community's respect for the hospital did not waiver. Maintaining the quality of a relationship through trust, honesty, reliability, and fidelity is the ultimate means to—and measure of—success.

Covenant Model as Business Model in Health Care

The interesting thing to note, of course, is that when it comes to patient care, Catholic health care organizations *do* operate according to the covenant model. All of our institutions, whatever their mission statement or sponsorship, demonstrate a commitment to a high-quality relationship with their patients and clients. The question we face is whether we can operate on the same model in other areas of business, in our collaborative relationships with our "competitors," for example.

The reality is that, in collaborating with other systems, we more often than not operate according on the self-interest model, however "enlightened" that self-interest may be. When it comes to providing health care, we "walk our talk" of commitment to the community, our service areas, and our patients. However, when it comes to dealing with another organization, the "walk" is often a reflection of the "talk" of market, niche, and market share. Interests become competing, rather than mutual. When this happens, access to care by the most vulnerable may be impaired.

Where we Oregon ethicists fell short was in not providing an explicit model that would help our leaders move beyond competing self-interests, and beyond even mutual interests, to an *intersection of interests.* The covenant model, at which we are so adept with our patients, should have been offered to our leaders, in an explicit way, as the basis for intersystem collaboration. Then, when the budget realties became clear, our leaders would have known how to use that information in a new way. As long as health care organizations interact with each other according to the traditional corporate model of self-interest, they will collaborate only in those areas where they have, at best, enlightened self-interests: for example, advocacy for broader coverage and reasonable reimbursement.

Where it really counts, in areas in which access to care is the issue, we tend to compete out of self-interest (rather than collaborate) because of intersecting interests. I suspect that this is not the case in Oregon alone. The challenge—to bring leadership a new business model for relating to other organizations—faces all of us who work as ethicists.

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A Moral Imperative

If we have a rationale for using ethics as the context for intersystem collaboration, and we have a new covenant model for this collaboration, from whence comes the moral imperative for action? Why should we work to change the prevailing context and model for collaboration? In order to respond to this final question, a correction in our initial mind-set is necessary. In Oregon, we set out to ask our organizations to see each other as each other's stakeholders. In retrospect, I would now say that was a mistake. To some extent, that mind-set reflects a self-interest model. The fact that we are each other's stakeholders is not in itself a sufficient argument for the adoption of a new way of doing business.

The moral imperative for health care organizations to collaborate, truly collaborate, is rooted in the fact that, in the end, it is not just that such organizations are each others' stakeholders; they share the *same* stakeholders: the people of the community. The question is not simply seeing each other as stakeholders, as we ethicists origi-

nally thought, but, rather, in seeing that we all have the same stakeholders. This fact has, I suggest, a profound ethical implication for collaboration. None of our organizations has a claim to exist apart from our social contract; our justification of existence is found in that contract—to leave society better off for the fact of our existence. The social contract is related to the provision of health care to the community at large. Communities are not delimited by niches or markets. By definition, a social contract is made with the whole society, even with communities outside an organization's service areas or market. Every health care facility and system has the same social contract with that same society.

Competition among health care organizations, however unintended it may be, will not promote access to that care by all people in society. In fact, quite the contrary. When self-interest leads to competition, that competition leads to a focus on the narrow self-interest of the organization and its "service area," not the community. As a result, the organization fails in its social contract, however wonderfully its serves its particular niche or market. It may be a wonderful provider to its patients, but if access to the community at large is not enhanced, the social contract is broken. To the extent that a health care organization fails in its social contract, it ceases to enjoy a justification for existence.

The fact that Catholic health care is a ministry of the church is not sufficient reason for existence. Indeed, I would say that the fact that we are a ministry of the church compels us to fidelity to the social contract, not simply to success in our service areas and markets. All hospitals and systems contract with one and the same society; they have one and the same stakeholders. Health care's very justification for existence—society—is also the moral imperative for competitors to be collaborators with each other in serving the health care needs of that society.

The Common Good

One further point might be made concerning the Catholic social tradition. In this tradition, we speak of "the common good." The common good is often misunderstood as providing the greatest good for the greatest number. If that were the case, Catholic health care could simply carry on as at present, pursuing its own enlightened self-interest. In time, perhaps, the greatest good would eventually trickle down to the greatest number.

In the tradition, however, the common good refers to the sum of those conditions necessary for *all* individuals and groups to achieve personal and social fulfillment. It is a condition that each and every one of us must enjoy, not simply the greatest possible number. Health care is one of those conditions of the common good. Health care is a sine qua non of the fulfilled life of every individual. Access to health care, as part of the common good, is not a debatable point. Whatever obstacles may stand in people's way, the fact that health care is part of the common good impels us to overcome those obstacles. When those obstacles are one's own corporate self-interests, the urgency is all the greater.

The Task of Ethics

This, then, is our task as ethicists if we are to work with our organizations to improve access to health care of the poor and vulnerable. And it is not just a task for ethicists in Oregon. All ethicists—Catholic and not, for-profit and not—need to be able to articulate to our leaders the why and what of true collaboration. The context for our collaboration needs to be ethics. Ethics is about understanding the parameters and obligations of relationships. It is also about concerning ourselves with the *quality* of those relationships.

If we are to collaborate in an ethical context, those of us who work in health care need to take a lesson from our models for patient care, exercising those principles in our interorganizational relationships. We need to move from a corporate model of self-interest, however enlightened, to a covenant model. We need to be "covenanted" with each other, as hospitals and systems, in the same way we are "covenanted" with our patients. And the imperative for doing this? We have the same stakeholders. We are not here to care for our patients alone; we are all here to care for all society. This is our moral imperative: to move from competition to collaboration. ■

NOTES

1. My emphasis. See www.gratefulness.org/brotherdavid/bio.htm. I am grateful to Sr. Karin Dufault, SP, RN, PhD, for this quote.
2. Laura Nash, *Good Intentions Aside: A Manager's Guide to Resolving Ethical Problems*, Harvard Business School Press, Cambridge, MA, 1993.
3. Lawrence J. Schneiderman, et al., "Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting: A Randomized Controlled Trial, *JAMA*, vol. 290, no. 9, September 2003, pp. 1,166-1,172.
4. Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics*, Yale University Press, New Haven, CT, 1970.

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