• What happens when your institutional leaders make decisions not in keeping with the stated vision, mission, and core values? Does the institutional culture/ethos support holding one another accountable (up-down, down-up, and sideways) to the mission? What are your obligations (and related options) when institutional leaders are morally bankrupt?

• How is your team most likely to respond when experiencing a problem concerning patient safety or quality care? Do you try to ignore the discomfort and pretend there is no problem? Believe you are powerless to effect a solution? Commit your best energies to resolving the problem?

The **box** on p. 38 offers a set of questions to guide ethical reflection and discussion on institutional integrity and moral leadership.

Evaluating Moral Leadership

We cannot presume institutional integrity and moral leadership in our health care ministry; now is the time to hold ourselves accountable in this regard. Board members are exquisitely prepared to evaluate an institution's or system's finances and are adept in holding senior management accountable for market share and financial performance. Boards seem less skilled in raising questions about moral integrity and the trust an institution engenders from its patients, employees, and the public. The **box** on p. 39 concludes with a sample survey tool of institutional integrity and moral leadership. ■

NOTES

1. Ralph L. Potter, "From Clinical Ethics to Organizational Ethics: The Second Stage of the Evolution of Bioethics," *Bioethics Forum*, Summer 1996, pp. 139-148.
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SUGGESTED READINGS

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Organizational Ethics Case Study: The Bon Secours Richmond Contract Renewal

The personnel of an organization make scores of decisions daily, often in direct response to the needs of a customer or to make operational improvements. Virtually all decisions have financial consequences for the organization and, on careful examination, reflect the values of that organization and staff. Most of these decisions take place in the context of a situation with discrete parameters, recognizable consequences, and frequently a well-established culture and value system that suggests the appropriate course of action. These "habits" guide the routine of the organization. Occasionally, however, significant events call for a decision that may profoundly

affect relationships among those served, the culture of the organization, and the very nature and mission of the organization. Mergers, layoffs, and legal actions are examples of situations with significant consequences that suggest a more complex and structured discernment process.

For Catholic health care providers today, the challenge of discerning the proper course of action is all the more exacting because of the nature of the activity and the values inherent in a religious organization. In the fall of 1999, Bon Secours Richmond Health System* faced a vexing decision regarding its contract with the local Aetna health plan. The situation described here is not intended to be a model for complex ethical decision-making in a Catholic health care organization, but rather to invite discussion of the values and structures needed to ensure a comprehensive discernment.

The Case

In the 1990s, Bon Secours Richmond Health System had established contractual relationships with every health care insurer in central Virginia. The system's St. Mary's Hospital had sought, in addition to an excellent reputation for compassionate and high-quality services, to be one of the lower-cost providers for central Virginia. Although insurers early in the decade contracted with all area hospitals for their indemnity and PPO products, many tried to control costs by limiting their HMO enrollees to selected hospitals. Providers accepted lower reimbursement terms in exchange for an increased volume of patients to their facilities. The financial risks associated with indemnity and PPO products are borne, in large part, by individuals or self-insured businesses. The insurer under an HMO product assumes financial risk and reward.

Bon Secours facilities maintained a charge structure 25 to 40 percent lower than that of other area hospitals, for two reasons: concern for the cost of health care in the community, particularly for the out-of-pocket expenses of patients, and because such a business strategy enabled the organization to capture greater market share. This allowed for a lower per-unit expense and an acceptable bottom line. Bon Secours was, in fact, the preferred provider of health plans for their HMO product. The "win-win" was more business directed to Bon Secours hospitals for a lower cost to insurers.

The dilemma for health plans in the mid to late 1990s was how to increase their business. The choices were fairly simple: either merge with or buy out competing plans, or "open" their limited HMO networks to resemble their PPO product that gave consumers a greater choice of providers. Several plans did both.

The merger of US Healthcare and Aetna led to significant changes in the Richmond market. When Aetna subsequently acquired the central Virginia business of Prudential and NYLCare, further efforts to reduce payments, in line with Prudential's capitated contract, became matters for negotiation. The "new Aetna" proceeded to allow patients to use previously excluded hospitals—but it continued to pay Bon Secours rates predicated on the basis of a limited network arrangement, even though the contract specifically called for higher payments in the event network changes were implemented. Initially, Aetna did not disclose to Bon Secours changes in its network of providers and afterwards declined to make payment adjustments. Failure to adjust payments over the preceding 18 months and routine claim denials resulted in a several million-dollar payment shortfall to Bon Secours.

The local Bon Secours chief executive established an internal strategy team consisting of managed care, finance, hospital administration, and sponsorship senior team members. The responsibility of this group was to produce data enabling the team to understand the impact of various potential scenarios, establish negotiating parameters, and evaluate from several perspectives the responsibilities and consequences to Bon Secours for this contract. The local system also worked with corporate staff to establish the approach and acceptance of any final decision.

The management team determined that whether Bon Secours lost the contract or agreed to a new pricing structure, significant risks were apparent. If Bon Secours failed to retain its Aetna business, which represented 8 percent of revenue, the loss of income would place both capital improvement needs and wage increases in jeopardy. But to agree to such a significant discount in the current business to the point required by Aetna would adversely affect the stewardship of resources for the local system. Within a year, Bon Secours could expect other major health plans to pursue a similar rate structure. In addition to foregoing employee raises and equipment replacement, Bon Secours could likely face decisions about the level and quality of care delivered to its patients.

In a mid-September letter to Aetna, Bon Secours was willing to agree to a price reduction for the PPO contract that would address the needs of local self-insured employers. The HMO rates, in which all savings accrued to the benefit

*Bon Secours Richmond is the leading not-for-profit health care system in central Virginia, consisting of three acute care facilities, with a fourth under construction, two senior living communities, physician practices and services, as well as home care and hospice care. It is part of Bon Secours Health System, Inc., a national health system sponsored by the Sisters of Bon Secours.

of the insurer directly, were unacceptable. Thus, at the end of December 1999, Bon Secours' agreements with Aetna were terminated.

Discussion

Bon Secours could have decided that the viability of the local system took precedence over all other considerations. And indeed, the organization did conclude that to accept such an agreement would eventually set the local system on a course of continuous decline. But before reaching such a conclusion outright, an ethical reflection suggests examining the decision in light of several, at times competing, values. CHA's annual "Foundations of Catholic Health Care Leadership" educational program provides such a guide.

If care is compromised through inadequate staff, delayed care, or aged equipment, then an organization risks failing to address the moral claims of its patients.

The wider questions raised by the situation included:

- Who are the stakeholders for such a decision?
- What risks or issues are raised for Bon Secours' physicians and their patients by terminating the contract?
- What standard of care is Bon Secours obligated to provide?
- What work environment, in terms of equipment and facilities, is needed to care for patients?
- What obligations to its employees does the organization have?
- What community or mission services are put in jeopardy by accepting this contract?
- What stake does the wider community have in this decision?
- What options do employers have for health care services?

Promotion of Human Dignity Health care organizations exist to promote and improve the health of patients. If care is compromised through inadequate staff, delayed care, or aged equipment, then an organization risks failing to address the moral claims of its patients. The "stakeholders" with the strongest claim on the conduct and performance of a health care enterprise are the patients and their family members. Good quality care is the essential and tangible reflection of a provider's intent to honor the dignity and promote the well-being of the person. Moreover, although all providers are expected to go beyond corporal concerns and attend to patients' emotional and spiritual needs, faith-based providers have an expressed accountability to patients and families to provide the necessary services that address these needs.

For health care providers, the essence of a contract negotiation is the ability to have sufficient resources to fulfill responsibilities and satisfy future needs. Whenever resources are limited, leadership must evaluate to what extent the ramifications of those scarce, or diminishing, resources are likely to cause a reduction in compassionate quality care.

The perpetual task of administration is to increase business and achieve expense savings. When revenue is declining, pressure to reduce costs is that much greater. Most executives and their teams try to reduce the nonclinical components of the cost equation (travel, marketing, purchased services, support functions, etc.) while seeking to preserve the necessary resources to administer excellent care. When the savings required are in the millions of dollars, the areas of focus include the postponement of technology and plant investments and, invariably, labor savings through staffing levels and redesigned care models. Significant contract changes can place an organization on the slippery slope that views health care as a commodity and the patient as the "customer" who is entitled to purchase only so much service.

Care for Poor and Vulnerable Persons Beyond direct patient care and the walls of the hospital are populations whose health status is disproportionately at risk by virtue of genetic, social, and economic conditions. Because Catholic and other faith-based providers recognize that "being with" and caring for the least valued among society brings the Gospel to life, preservation of these mission activities and services is an ethical priority for the institution. No one organization can address all the needs of the most vulnerable. Every organization must match its capabilities with the appropriate needs of the community. A Catholic provider's presence and witness within a community, however, cannot be exchanged for a need to preserve the "core business." Second, faith-based providers should not be baited by "the marketplace" into either establishing different standards or tiers of health care delivery based on economic ability or social standing, or selectively pursuing preferred payer populations. Because the market seeks to eliminate or avoid activity that has no economic value, mission-driven institutions must continuously be vigilant that their decision making gives consideration for the needs of those with limited resources.

Promote the Common Good Several additional members of the community are affected by the termination of a payer contract. Perhaps the greatest

level of disruption occurred for ambulatory patients of Bon Secours' physicians who had only one health plan option (Aetna) through their employer. Several hundred people had to transfer medical records and establish new primary care relationships. A historical bond with a physician is a significant part of a person's health maintenance, and trust developed over time is not readily transferred to a clinician who has little familiarity with the person and his/her conditions, thoughts, and perceptions. Ongoing payer participation not only provides a stable and predictable business climate, but may be essential to the community's access of one of the more significant components to good health: an effective relationship with a health care provider.

The "common good" depends frequently on the particular circumstances of the situation. In light of the common good, what obligations to the community would Bon Secours have had if it had not been the lower-cost provider? Or, in another circumstance, the sole acute care provider in the community?

Finally, business and citizens in the community always evaluate the reputation of a provider in light of change. Communication with constituents throughout the community is not only good public relations, but is also an obligation of an organization seeking to act faithfully.

Structures

Before this event, the management team did not have a formal organizational process for evaluating and reflecting on the ethical import of its managed care contracts. The long-standing policy of having agreements with all health plans became instead an opportunity to establish a more formal structure for understanding the impact of contracts on the organization's obligations to patients, community, staff, and its own future. Fortunately, the vice president for sponsorship and other senior team members were cognizant of placing the discussion in the context of the principles and values affirmed by Catholic health care. Nonetheless, the "habit" of reflecting in an inclusive, multidimensional manner requires a planned approach within an established forum, or else it is likely to remain ad hoc and dependent on the gifts of individual leaders.

As Sr. Carol Taylor's article indicates (p. 37), moral agency requires developed competencies. The ongoing education and formation of executive leadership should enable an organization to assimilate ethical concerns and obligations to stakeholders into the decision-making process. Frequently these elements emerge as a result of a significant issue or crisis. However, routine discussions around budget, capital priorities, risk management, and internal audit functions (to name a few) are opportunities to use instruments, such as those presented by Taylor, to discern the moral good and reaffirm the mission and vision shaping our activity as faith-based providers in health care.

Communication with constituents throughout the community is not only good public relations, but is also an obligation of an organization seeking to act faithfully.

Postscript

For the past year and half Bon Secours has not been a provider in the Aetna network of central Virginia. The health system has been able to replace a majority of the business, in part from the transition of many thousands of enrollees into other health plans that include the Bon Secours' facilities within their networks. Health care remains both a local and relational experience for most of the population. One's personal physician and the experience of compassionate care still render considerable influence in the selection of health coverage. And although the outcome proved more financially positive than Bon Secours' leaders originally anticipated, the benefits to the organizational culture, perception, and commitment to the community brought renewed strength and sense of purpose. ■

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