

# QUALITY AND THE “EFFICACIOUS WORK OF GOD”

In a previous column (“A Tale of Two Reports,” *Health Progress*, May-June 2004, pp. 6-9, 61), I reflected on two Institute of Medicine reports, *Insuring America’s Health* and *Crossing the Quality Chasm*, pointing out the essential relationship between the issues of access and quality.<sup>1</sup> I also pointed out how, as ministry gathered and engaged, we are addressing both of these topics. Finally, I highlighted some of the ethical resources that are available to assist and guide us in our efforts.

After writing that column in early February, I joined our then board chair, Rich Statuto, in making visits to and engaging in discussions with the leadership of several of our systems. As always, I was impressed by the passion and vision of these ministry colleagues. I also was struck by how, in one way or another, the issues of access and quality were raised. And, as regards quality, I was struck by how each system was taking its own unique approach to advancing the quality agenda. Clearly, the history, philosophy, and resources of each system influenced what its leaders determined to be their approach to advancing the quality agenda.

In several of these discussions, a new theme or topic for reflection emerged. Though expressed in different ways, the theme went something like this: How should our being Catholic distinguish our quality efforts? There was a concern that our efforts needed to be pursued for more substantial

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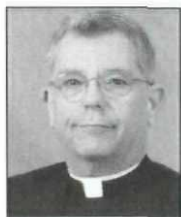
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PLACE, STD

reasons than merely preserving market share or avoiding legal and regulatory sanctions. This line of reflection was taken to a new level when, on several occasions, it was suggested that what was needed was a *theology of excellence*. To be honest, I was a bit taken aback by the proposal. The proposal appealed to me at an intuitive level, but, at a rational level, it was not at all clear to me how one might begin to construct such a theology.

As a result of this perceived complexity, I put the matter on the “back burner.” However, over the course of the intervening months the question has surfaced again and again in various venues: Is there anything distinctive about our quality efforts?

The question of distinctiveness is not a new issue. For example, Cardinal Joseph Bernardin addressed it nine years ago this October in his pastoral letter, *A Sign of Hope*. When viewing the question of distinctiveness from the perspective of the patient, he proposed that: “Our distinctive vocation in Christian health care is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life.”<sup>2</sup>

I continue to believe that, from a theological perspective, providing the possibility of hope in the midst of the chaos that is so much a part of sickness and dying should be a distinctive aspect of Catholic health care. Our public perception research also indicates that those we serve appreciate this differentiation. People describe Catholic hospitals as “more caring” in their approach to patients. In a 2003 nationwide phone survey, six out of 10 respondents listed compassionate care as a top-tier quality-care issue—and added that the primary difference they perceived between Catholic hospitals, on one hand, and community or university hospitals, on the other, was the



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compassion offered at Catholic facilities. As one focus group participant put it, "[Catholic hospitals] also care about you as a person, not just as a patient." And when focus group participants consider other aspects of the care continuum, they immediately connect Catholic care at nursing homes or long-term care facilities with greater compassion and a more caring staff. They describe a nurturing environment that tends the emotional and spiritual needs of individuals as well as their physical needs.

One might well ask, however, Can a sense of hope be provided if patients, their families, and our communities cannot trust that the health care we provide is safe and effective? In other words, without a bond of trust can we be a "sign of hope"?

#### BOND OF TRUST

As I move into the reflection that follows, I want to emphasize its tentativeness. In many ways, what follows is an attempt at "first impression" theologizing. My hope is that these reflections might encourage others to a richer and more helpful theological grounding—or, to say it another way, to a better appreciation of the theological imperatives that should guide and inform us as we build and nurture a bond of trust between patient and provider, whether that provider be a single clinician or the health care institution.

In organizing a response to the question "Can we be a sign of hope without a bond of trust," I would suggest that it will be helpful to return to a distinction I introduced in my column in our last issue.<sup>3</sup> Reflecting on ministerial leadership, I proposed that the "how" of Catholic health care can be distinguished from its "why," even though these two dimensions are essentially interrelated. The "why" of the ministry—its purpose—is noted by the transcendence of proclaiming the presence of the Reign of God through healing. The "how" of being about that healing is quite incarnational: It is practicing both the art and science of 21st-century health care. I introduced this distinction because I wanted to propose that the theological grounding for creating and maintaining a bond of trust might not be the same for both the "why" and the "how" of Catholic health care.

#### THE "HOW": OUR SERVICE

In recent years, we have come to speak of Catholic health care as having two foci: service

and transformation. In many ways, our service is provided through the "how" of modern health care delivery, characterized by its many technological and pharmacological advances. When reflecting theologically on *how* health care is provided and on what is necessary for there to be a "bond of trust," the Catholic tradition has much in common with secular ethics. For example, the imperative "Do no harm," expressed theologically as "beneficence," would "involve the obligation to present and remove harms and to promote the good of a person by minimizing the risks incurred to the patient and maximizing the benefits to them and to others. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others."<sup>4</sup>

Similarly, the virtue of justice would require that each person be given his or her due as well as that they be treated fairly and equitably. Clearly a patient would expect that, in health care delivery, he or she is "due" (entitled to receive) safe, high-quality services. A grounding for these requirements would be the inalienable dignity of each person.

As rich as the categories of beneficence, justice, and human dignity are, the Catholic tradition would enrich them further with the category of the common good, which is understood as the sum of these conditions necessary for individuals (and communities) to flourish. Similarly, the categories of distributive justice (the fair, equitable, and appropriate distribution of resources) and social justice (the establishment and defense of economic, political, and social structures that uphold the dignity of all) would be considered.<sup>5</sup>

In a way, these theological categories provide the ethical building blocks for what is necessary if the "how" of Catholic health care is to make possible a sense of trust: doing no harm, treating fairly, empowering dignity, making possible human flourishing, distributing resources equitably, and advocating just social structures. However, I and many others would argue that these categories are not uniquely Catholic, but, rather, are "natural" to the proper provision of health care wherever and by whomever it is provided. In a way, they are essential to providing well-ordered health care; without them, trust is not possible.

As true as that assertion might be, it also is true that in a way these categories can be seen as being somewhat minimalist. Returning to *Crossing the Quality Chasm*, I note that one of its most

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provocative observations is that the higher quality of care it proposes cannot “be achieved by further stressing current systems of care.”<sup>6</sup> “In some cases,” the report goes on, “achieving this ideal will require crossing a large chasm between today’s system and the possibilities of tomorrow.”<sup>7</sup> This proposition invites us to wonder whether these ethical elements just outlined are sufficient to motivate or compel the crossing of that chasm. Similarly, can there be a real bond of trust without crossing the chasm?

I believe one could argue that the answer to both of these questions is a resounding “no.” As important and helpful as these categories are, they lack a sense of moral urgency. In a sense, they are liable to be viewed as isolated, distinguishable categories that compete for moral ascendancy. Absent coherence of vision, there is reason to fear that the fundamental change and systemwide reform for which many are calling—reform that results in safe, high-quality health care delivery—will not be achieved.

Perhaps part of what is being asked for under the title “a theology of excellence” is the coherence of ethical vision about the “how” of health care delivery necessary to propel us across the quality chasm. To excel is to go beyond. What will take us beyond the minimal, essential though it is, to establish the bond of trust necessary if we are to be signs of hope?

## COVENANT

To be honest, I am somewhat at a loss as to what that “excellence,” that coherence might look like. As I write, I am reminded of a similar struggle Cardinal Bernardin had when preparing his 1995 address to the American Medical Association House of Delegates. What image could serve as a foundation for a renewal of physician practice?

His answer was to propose “renewing the covenant with patients and society.”<sup>8</sup> He chose the image of the covenant because it speaks of “moral obligations—as opposed to legal and contractual obligations—because they are based on fundamental human concepts of right and wrong.”<sup>9</sup> (See also Sr. Juliana M. Casey, IHM, and Richard F. Afable, MD, “Contract or Covenant?,” p. 25.) Without reviewing the specifics of how Cardinal Bernardin developed this insight, I would suggest that he was seeking to provide a much-needed depth to the understanding of the relationship of the physician with patients and society. It is this same type of depth,

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of beyond-ness, of excellence, that it seems all of health care delivery is in need of today.

I am not certain the image of covenant is the sole answer. But it might be helpful. Where Webster defines covenant as “a formal, solemn, and binding agreement,” the Old Testament provides a much richer understanding. Though in the Hebrew Scriptures “covenant” (*berit*) does signify a legal agreement between two persons or parties, it also has a theological meaning, signifying the relationship of the people of Israel to God. One definition of this aspect of covenant, speaking of the relationship of Yahweh and Israel at Mount Sinai, calls it a “divine constitution given to Israel with promises on conditions of obedience and penalties for disobedience.”<sup>10</sup> While “covenant” appears hundreds of times in the Old Testament, perhaps three examples from the Pentateuch will advance our reflection.

- Genesis 9:11: “I will establish my covenant with you, that never again shall all bodily creatures be destroyed by the waters of the flood.” In essence, Yahweh is making to Noah here a “first-do-no-harm” covenant.

- Genesis 17:7: “I will maintain my covenant with you and your descendants after you throughout the ages as an everlasting pact, to be your God and the God of your descendants after you.” The Abrahamic covenant defines relationship: You (Israel) will be my people, and I (Yahweh) will be your God.

- Deuteronomy 7:11: “You shall therefore carefully observe the commandments, the statutes and the decrees which I enjoin on you today.” The Sinai covenant seals the earlier definition of roles by delineating particular duties and responsibilities for maintaining the relationship.

So the overall covenantal aspects are, first, do no harm; second, define our relationship/roles; and, third, outline each other’s specific duties and responsibilities. Viewed in context, these examples provide a definition greater than the sum of their parts. Ultimately, the Old Testament covenant establishes an irrevocable bond of trust between unequal parties. Yahweh, the source of all being and meaning, extends to the previously sinful, unfaithful, and often weak people of Israel that which they cannot claim or earn: the promise of unwavering fidelity. Though as God Yahweh can do anything, because of the Sinai covenant God is no longer able to harm or abandon the unequal partner, Israel. The infinite One is bound forever in a special relationship that will

last until the end of time.

In the New Testament, "covenant" finds deeper meaning. Through the mystery of the Incarnation, God freely enters time in order that humanity might realize its God-given potential. And how is that possible? Salvation is achieved by another act of generosity, the ultimate generosity of sacrificial love. In Jesus, human life is given away in order that we might be saved.

What does all this say to Catholic health care? I would suggest that it turns the focus from *what the patient is due* to *what we are obliged to provide*. One must, without accusing the health care provider of self-idolatry, agree that he or she is clearly in a "power position" vis-à-vis the patient, most especially when the patient is ill or dying. Patients come to us in need of that which they cannot provide themselves. They expose themselves to us in their vulnerability.

And what response is most appropriate? Clearly, the legal elements of a contractual relationship are a first step: You will not be intentionally harmed, you will receive care, and your share of the common good will be made available to you. Is this response fully commensurate with the vulnerability and risk taken by the patient? Cardinal Bernardin felt it was not. He proposed that a far deeper response was required. By analogy, he suggested that our response ought to be to establish a covenant with those we serve. In a way, we limit our freedom by binding ourselves to the well-being of those we serve—a bond whose fullest understanding is achieved through the lens of sacrificial love.

In light of this description of covenant, does it seem unreasonable to propose that a covenantal attitude of fidelity and sacrificial love would nurture a bond of trust adequate for us to be a sign of hope? I leave that question to others to answer, but it does seem that a shift to a covenantal attitude would be a necessary first step toward creating a theology of excellence. Rather than ask what our contract requires of us, we ask: How must we act in order that the well-being of the other might be realized? What does "fidelity" mean in the provision of health care? And, when it becomes necessary: What must I sacrifice in order that a patient might be cared for properly?

If this tentative theological musing meets the test of further analysis, then we would not begin with a discussion of safety and quality, but rather with the requirement of fidelity that is marked by the radical beyond-ness of sacrificial love.

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### THE "WHY"—TRANSFORMATION

In discussing what would serve as the elements of a theology of excellence for the how of our ministry, we have suggested moving from a contractual to a covenantal perspective. Although the content of that particular discussion was guided by the Hebrew and Christian faith experience, a covenantal perspective also could be developed by utilizing more secular categories. In fact, one could argue inductively that, for most of human history, the ethics of healing or health care have been more than contractual. Perhaps that is why the AMA House of Delegates responded to Cardinal Bernardin's remarks with such affirmation. The cardinal named something that was in danger of being lost when health care becomes a commodity managed by a contract, rather than a service, a gift, which is in the context of a unique relationship. Unlike others of good will, who might resonate with such a "secular" covenant perspective, we are a people of faith who are called and gifted to be about the healing mission of Jesus Christ. We are the sacramental presence of the healing touch of Jesus in today's world.

And what is that healing touch? We know that, with rare exception, it is not the miraculous touch of Jesus experienced by those he healed during his ministry. It is a much deeper and more profound healing to which we witness—the world of sin has been conquered and God's reign is in our midst. Rather than seeing what is not, we see what has already transpired and what, in God's "time," will be realized. Our Easter/Pentecost faith requires us, in a sense, to read the Scriptures backward. It is in the almost unintelligible Book of Revelation, the Apocalypse, that we gain perspective on all that has and will transpire. Pope John Paul II spoke of this in his September 15, 2004, audience. He said, "The Lord has established his reign, intervening in history with supreme authority. Though God has entrusted mankind to be free to generate good and evil, history has as its ultimate seal the choice of divine providence. No matter what storms, wounds and devastation are wrought by evil, the book of the Apocalypse celebrates the end toward which history is guided through the efficacious work of God."<sup>11</sup>

Our sacramental witness in Catholic health care is, in fact, to transformation; it is to witness to the "efficacious work of God." Without succumbing completely to the rhetorical flourish of

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# A theology of excellence would have the urgency of making real the Reign of God.

homiletics, one can well question whether the way we provide health care, which includes the well-documented quality chasm, truly witnesses to the "efficacious work of God." This thought might lead us to ask what—if we were to view Catholic health care from the perspective of witnessing to God's reign—would we do differently? Obviously, answering this question would be another *Health Progress* article (if not several). I would suggest, however, that the manner in which we would engage in such reflection could provide much-needed content and depth to a theology of excellence vis-à-vis the transformational, the "why" dimension of Catholic health care.

### FILLING THE QUALITY CHASM

In summary, it is possible to construct a foundational theology of excellence for Catholic health care. As regards the "how" of Catholic health care, our pursuit of excellence would emerge from a change of perspective from the what-is-due-the-patient? position to one that causes us to ask, What does our covenantal relationship require us to provide to the patient? Covenantal fidelity and sacrificial love would compel us to fill up the quality chasm. As for the "why" of Catholic health care, because we are a sacramental witness to God's efficaciousness, our delivery of health care should mirror that efficaciousness. Again, we would be motivated always to be about more rather than less. And even when the more we desire cannot be achieved, we always will experience an unsettledness, a sense of urgency, that will motivate us to continue searching for the desired goal. A theology of excellence would have the coherence of a covenantal perspective and the urgency of making real the Reign of God. In the end, we

would pursue quality and safety in a distinctive manner because we would stand in a different place: a place "beyond" the minimum expectations of justice. We would look back into the delivery of health care with an eye of the Reign of God. Could there be anything more excellent? □

### NOTES

1. Institute of Medicine, *Insuring America's Health*, National Academies Press, Washington, DC, 2004; Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, National Academies Press, Washington, DC, 2001.
2. Joseph Bernardin, *A Sign of Hope: A Pastoral Letter on Healthcare*, Office of Communications, Archdiocese of Chicago, and the Catholic Health Association, St. Louis, 1995, p. 5.
3. Michael D. Place, "Ministry Leadership Development: A New Pilgrimage," *Health Progress*, September-October 2004, pp. 69, 57.
4. Peter A. Clark, "Medication Errors in Family Practice, in Hospitals and After Discharge from the Hospital: An Ethical Analysis," *Journal of Law, Medicine & Ethics*, vol. 32, 2004, p. 355.
5. Clarke.
6. Institute of Medicine, *Crossing the Quality Chasm*, p. 4.
7. Institute of Medicine, *Crossing the Quality Chasm*, p. 5.
8. Bernardin, "Renewing the Covenant with Patients and Society," in *Selected Works of Joseph Cardinal Bernardin*, vol. 2, Alphonse P. Spilly, ed., Liturgical Press, Collegeville, MN, 2000.
9. Bernardin, "Renewing the Covenant," p. 246.
10. F. Brown, S. Driver, and C. Briggs, *A Hebrew and English Lexicon of the Old Testament*, Clarendon Press, Oxford, England, 1951, p. 136.
11. Carol Glatz, "Despite Evil, God's Plan Leads toward People's Redemption, Says Pope," Catholic News Service, September 15, 2004, available at [www.catholicnews.com/data/stories.cns/0405052.htm](http://www.catholicnews.com/data/stories.cns/0405052.htm).

## MAINE CARE CENTER REDUCES USE OF BEDRAILS

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Since June 2004, staff have monitored the number of falls and injuries involving the side rails, reporting that data monthly. The report also contains information on residents' medication use, behaviors, and other quality indicators, such as infection rate. These reports are used at weekly team meetings so that caregivers can better analyze which practices help reduce side rail incidents. The number of falls and injuries dipped in July, but Murphy cautioned against drawing conclusions. "It is too soon to correlate practices with interventions," Murphy says.

Fournier and Murphy agree that their quality-improvement initiative is not unique in long-term care, but, they believe, the passion the staff has put into their effort may set it apart. "Our work in this area has nothing to do with regulatory requirements," Fournier notes. "When trends change, we listen and take action. One of our core values is compassion. It is our standard and heart value. We are striving for excellence so that we can enhance the dignity and well-being of residents in this community." □

For more information on St. Marguerite d'Youville Pavilion's side-rail initiative, contact Rose Levasseur, staff educator and patient safety officer, at 207-777-4200 or [rlevasseur@sochs.com](mailto:rlevasseur@sochs.com).

### NOTE

1. U.S. Food and Drug Administration, *Guidance for Industry and FDA Staff: Hospital Bed System Dimensional Guidance to Reduce Entrapment*, Washington, DC, August 30, 2004, available at [www.fda.gov/cdrh/occr/guidance/1537.html](http://www.fda.gov/cdrh/occr/guidance/1537.html).