THE "NEXT GENERATION" MODEL

Ethics Committee Members Are Beginning to Hold Themselves Responsible for Measurable Results

BY NANCY PARENT BANCROFT, PhD

Recently, while attempting to look up something on the Catholic Health Association's website, I happened to reread the statements there concerning strategic directions, mission plan, and ethics strategy.* It struck me that making progress on the mission plan ("Strengthen our ability to understand, articulate, and act on Catholic identity") is necessary in order to effect the ethics strategy ("Exercise leadership in ethics for health care and broader societal issues"). A deeper understanding of the foundations and evolving traditions of Roman Catholicism can provide the guidance needed for the continuing development of our moral life as a health care community.

As a system, we at Trinity Health, Novi, MI, are in the process of adopting, adapting, and implementing "Next Generation Model of Clinical Ethics" (NGMCE) Committees, which is patterned on one developed at St. Joseph Health System, Orange, CA. Johnny Cox, PhD, St. Joseph's vice president, theology and ethics, presented the model at Trinity's systemwide Ethics Forum in the spring of 2002. Listening to him, many of us were persuaded that the model would be an effective means of advancing the work of ethics in health care.

In brief, the Next Generation Model challenges ethics committees to recommit themselves as instruments of ethical change within their institutions. In the spirit of responsible stewardship, the model invites committee members to hold themselves accountable for measurable outcomes. When those committee members ask themselves, at the end of each year's work, "Has this institution changed for the better because of our efforts?" they should be able to answer in the affirmative in very specific ways. Lest this daunting charge seem overwhelming, the NGMCE recognizes that health care has within it many centers of ethical responsibility. Consequently, it guides ethics committees to collaborate with other departments and disciplines, both in setting the agenda for ethical concerns and in increasing conscious attention to the moral perspectives in the planning, managing, and delivery of health care.

How the Model Works

Four foundational elements distinguish NGMCE.

They Are Proactive The primary function of the model is no longer case consultation but, rather, addressing, enhancing, and at times changing processes and structures that affect the ethical delivery of patient care services. Although ethics cases will continue to surface and need resolution with the help of clinical ethics committees and/or case consultation teams, the clinical cases brought to the NGMCE Committee serve as learning labs that help committee members identify opportunities to improve processes and procedures so as to reduce the occurrence of similar ethical dilemmas in the future. Following the case review, the committee looks "upstream" and asks, "Would any change in structure or process prevent this painful situation from happening again?"

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*FY2003-05 Strategic Plan for the Ministry Engaged, which can be found at www.chausa.org/TRANSFORM/03-05STRATPLN.ASP.

They Are Outcomes Focused Once the committee has identified the organizational structures that contribute to ethical tensions, it takes on the responsibility for helping to bring about specific changes that can improve the health and well-being of both those who receive care and those who provide it. The NGMCE Committee develops annual goals with measurable outcomes, holding itself accountable for facilitating changes that improve the ethical delivery of health care services. Committee members tap the organization's expertise in continuous quality improvement to identify indicators and plan a process that will move the organization toward the highest level of ethical health care delivery.

They Are Integrated Since ethics in the organization are not the responsibility of ethics committee members alone, the NGMCE Committee collaborates closely with management, clinical services, and others to identify and work toward agreed-upon outcomes. Clinical ethics committees will be more effective to the degree that they integrate their efforts with all of their organization's centers of ethical decision making.

Ideally, opportunities for improvement will be found in various departments as staffs recognize gaps between the organization's stated mission and values and the ways in which services are actually provided. The model can then serve as a resource for the development of ethically significant changes.

They Are Oriented to Mission and Values Many traditional ethics committees rely on a secular understanding of clinical ethics principles, such as autonomy and beneficence, overlooking a richer resource for making high-quality ethical decisions. Catholic identity and Trinity Health's mission, values, vision, and preferred cultural characteristics—these are significant lenses through which our NGMCE Committee members are asked to analyze processes and structures affecting the ethical delivery of patient care services.

Ethical Integration Is Vital

Although it is a promising approach, the new model will do little to promote Catholic ethics in health care unless it faithfully mirrors the mission and values of the Catholic Church. If those of us identified as "leaders in ethics for health care"—system ethicists, facility ethicists, local ethics committee members, professors, theologians, bishops, and others—are to be more effective agents of ethical growth, we must have a clear vision of what ethical excellence might look like.

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If Catholic health care is defined primarily as the continuation of Jesus' healing ministry, then ethical excellence might be recognized by the extent to which Gospel values are integrated into all aspects of health care. The vision, mission, and purpose statements of our respective organizations reflect what our founders and sponsors have identified as aspects of Catholic identity that hold particular meaning for health care ministry. These documents describe how to continue the healing ministry of Jesus in today's health care context. Unfortunately, it appears that we, in our day-to-day decisions, usually limit our attention to the tasks related to a narrow area of responsibility, and in doing so lose sight of the mission as a whole.

Take, for example, our system's mission statement:

> We serve together in Trinity Health,
> in the spirit of the Gospel,
> to heal body, mind and spirit,
> to improve the health of our communities
> and to steward the resources entrusted to us.

My understanding is that the central part of this mission—what we are about—is stated in the phrases, "to heal body, mind and spirit" and "to improve the health of our communities." All that we do should positively affect the holistic care of persons and the health of our communities. Trinity Health is in this ministry to ensure that this central goal is achieved by working together, mirroring Gospel values. Yet all too often that central piece is seen as the responsibility of clinical services; the last line ("to steward the resources entrusted to us") is seen as the responsibility of the finance department; and only the first part ("we serve . . . in the spirit of the Gospel") is seen as the responsibility of the mission staff. Ethical excellence will come about to the degree that all of us in the organization take ownership of the entire mission statement. Mission leaders and ethicists need to ask themselves, "Is what I'm doing having a positive impact on patient care? If not, why am I doing it?" Planners and finance and clinical staff members need to assess their decisions in light of the organization's values. We will know that our organizations are truly committed to achieving ethical excellence once we see clear, "hard-wired" expectations that employees in all departments embrace the whole mission statement in their operations. Examples of this will include policies,

department and personal goals, employee evaluations, and compensation.

In today's difficult financial health care market, finance departments have begun to persuade the rest of us that, if we are to survive as a ministry, we all have to take responsibility for fiscal attentiveness. Although our complex organizations continue to need professionals with specific expertise, they will not approach ethical excellence in health care until they replicate what finance has tried to teach us all, regardless of our roles—that is, to take responsibility for the entire mission statement.

Essential Elements

I have identified some elements in Trinity Health's mission statement that could, if we were to articulate them more clearly and consciously apply them to health care, move us closer to ethical excellence. Although I believe that these elements are essential to advancing the agenda of ethics in health care, I do not presume to suggest that my list of them is comprehensive. My hope is that what follows will stimulate reflection and discussion among those of us who consider this goal worthwhile.

"We serve . . ." In a 1989 article, the late Fr. Richard A. McCormick, SJ, wrote, "A Christian theological ethic is founded on the fact that something has been done to and for us. . . . There is a prior action of God at once revelatory and response-engendering that provides the entire grounding and meaning of the Christian ethic."[1] Excellence in Catholic health care ethics will result from personal and communal awareness of God's having initiated a relationship with us. Although health care is a human necessity, and thus an obligation of a civilized society, ethical excellence in Catholic health care transcends duty and becomes an eager desire to lovingly serve. When care of the poor is viewed simply as charity, and diversity among the leadership is identified as only a duty of social justice, it is a sign that Catholic spirituality is only marginally influencing the ethics agenda.

I am not suggesting that there is anything wrong with secular humanism as motivation for doing good things. When Jesus gave his Sermon on the Mount, he did not identify any particular motive as necessary when feeding the hungry or sheltering the homeless. But would our efforts in health care be different if they were the result of a predisposition to respond in loving service, stemming from gratitude for relational experience with God? I fear that unless we rekindle our spiritual grounding as motivation for our services in health care, our decisions will result in increased duplication of service and our actions will fall far short of the desires of our founders.

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At one time I was taught and believed that those who work in a Catholic health care facility need only commit to the values of the organization. On further reflection, I wonder if the quality of service required can be given if the facility's leaders, at least, fail to demonstrate the lived spirituality that literally inspires such service. Is this a core competency that should be required of board members and senior leadership? If so, do we begin to require behavioral interviews and recommendations that demonstrate a life of service that is a response to Grace?

". . . together . . ." Ethical excellence cannot be limited to choosing the right action. It needs to be concerned about developing and modeling relationships, structures, and processes that truly honor the dignity and diversity of human persons and reverence in meaningful ways all of creation. This includes such things as attention to a respectful and supportive workplace environment, and to the ways decisions are made throughout the organization and the ways materials are acquired, used, and discarded.

Excellence in relational ethics means not only that we are called into solidarity with the marginalized and the suffering but also that solidarity is possible only when honoring subsidiarity. Put another way, human beings' ability to truly empathize is quite limited. It is by listening to persons making decisions for themselves that we come to appreciate the meaning of their experiences and value the concerns within their context of being. In faithful adherence to Catholic identity, ethical decision making in health care, both in institutions and when establishing norms for the field, should follow a process that genuinely, meaningfully honors the principles of solidarity and subsidiarity.

". . . in the spirit of the Gospel . . ." Meditating solely on Scripture would provide an ample agenda for ethical growth. The two points that follow are, I believe, important themes that should be reflected in the development of health care ethics. First, the teachings of Jesus are countercultural. In an attempt to survive in the difficult contemporary health care environment, Catholic health care has borrowed much from business, sometimes at the cost of seriously blurring the vision, weakening the goals, and diluting the values of the founders spon-

soring the facilities. Strategic planning that gives more time and attention to capturing market share than to identifying the unmet needs of the most vulnerable may, for example, be missing the mark.

A second and most important lesson that we in ethics need to keep learning is that our moral agenda needs to result from our focus on God and our continued attempt to mirror God's acceptance and loving care. Rather than being overly preoccupied with norms, a Catholic organization should primarily be concerned with mirroring the Gospel values of inclusion, sensitivity, and responsiveness—especially responsiveness to suffering. Jesus quotes Isaiah when he sternly rebukes the Pharisees: "This people honors me only with lip service, while their hearts are far from me. The worship they offer me is worthless, the doctrines they teach are only human regulations" (Mk 7:6-7).

This tendency is most evident in the area of ethics and reproductive health. Consider, for example, the many recent discussions regarding emergency contraception for women who have been raped, in which the focus on regulation has overshadowed compassion. Most newspaper and magazine articles about this show a near absence of concern for how to minister to the woman who has been abused. Ethics excellence requires that we keep sustained focus on both the requirements and cautions of the Gospel.

". . . to heal body, mind and spirit . . ." Ethical excellence in health care would make attention to the whole person a reality. Poor medical insurance coverage for people who are mentally ill does not negate our responsibility to care for them. Large numbers of single-family and single-parent households, combined with shorter hospital stays, provide a moral context that cannot be ignored when trying to do ethical discharge planning.

Throughout Roman Catholic history, there has been a need to fight off a tendency toward a dualistic understanding of human persons. A determination to meet the needs of the whole person in health care and to develop ethical standards that honor the person as intrinsically relational would be powerful correctives to this problem.

". . . to improve the health of our communities . . ." Of course, clinical ethics committees can give their attention to only a limited number of topics, given the fact that most committee members are already stretched to the limits of their time and energy from the demands of their jobs in the organization.

Nevertheless, the CHA ethics strategy includes the exercise of ethics leadership in broader societal issues. The realities of poverty, joblessness, poor housing, as well as the prevalence of domestic violence and addiction across all socioeconomic lines, cannot be ignored by those charged with making sure that all in need of health care are recognized and responded to in a meaningfully beneficial manner. One of the useful features of the Next Generation Model is that it provides ways for members from the clinical ethics committee to connect with concerned persons outside the committee in order to give attention to societal ethics issues.

". . . and to steward the resources entrusted to us." Stewardship, particularly stewardship of financial resources, is receiving a lot of attention in these difficult financial times. In ethical decisions related to funding, Catholic health care needs to make sure it does not contribute to expanding the ever-widening gap existing between the haves and have-nots. Doing so will include (but not be limited to) decisions concerning, for example, cutting direct care or low-income positions without altering variable compensation or executive salaries, or purchasing advanced technology that can result in higher health care costs.

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Needed: Constant Conversion

My motivation for beginning a conversation about what comprises ethical excellence in Catholic health care is the knowledge that, under stress, we all regress. As Catholics, we are still affected by the sexual scandals in the church. As Americans, we bear the consequences of the recent war, as well as serious economic pressures on our institutions. Under these stressors, it is easy for all of us involved with ethics to become legalistic and controlling. We run the risk of sinking back into the manualist tradition that motivated the Second Vatican Council to identify the development of moral theology as needing special attention.

Fr. McCormick shared his wisdom concerning this problem when he wrote:

> Legalism is a point of view and a corresponding emotional response that gives priority to a human structure over the Gospel purposes it serves. Practically . . . it is a gimmick whereby we get all wrapped in lesser laws and get frightfully serious about them. We convince ourselves that we are good because of their observance. This is a con-

Continued on page 55

COMMUNICATION STRATEGIES

Continued from page 12

telephone numbers—information on how to:

- Become a volunteer
- Apply for a job
- Give a donation
- Contact the patient's nurse
- Summon a taxicab (or use public transportation)
- Secure a facility map that describes which services are located on each floor (this information should also be in elevators)
- Find the gift shop
- Request an escort back to the lobby and/or to the visitor's car

These guides can also include marketing information on the organization's history, mission, and services, with perhaps mention of some of the superlatives it has earned along the way.

Hotels advertise their other services (restaurants, fitness centers, and salons, for example) in and around elevators. Health care organizations can follow suit by placing promotional materials; favorable media articles; and announcements of new and current programs, services, and other activities in the same locations.

Reception/waiting areas, information desks, emergency departments, pharmacies, and other similar locations should have a display offering visitors a brochure describing the organization's services, educational offerings, and events. These are also good places to station volunteer nurses and others to conduct health screenings. Parking lot attendants and mobile cart drivers can offer visitors promotional materials and community education schedules.

These activities should not be limited to patients' family members and friends of patients; they should also be extended to vendors, participants in classes or events, and everyone else who walks through our doors. Just think: If we were to effectively develop and implement low-cost strategies like these to reach our hundreds of thousands of visitors, we might greatly reduce the number of dollars we spend in the much more expensive areas of marketing and communications. □

THE "NEXT GENERATION" MODEL

Continued from page 30

> stant temptation of people of faith—to derive their religious security from a structure, to lean upon it. St. Paul attacked it vigorously in his letter to the Galatians. Faith, however, is *something we must recover and* deepen daily.[2]

If we are to be successful as leaders in ethics we need to keep focus on the source of all moral life. How many of our ethics meetings focus on spiritual nurturing? How often do we reflect communally on the Gospel to help set the ethical agenda for health care? The work of Sr. Carol Taylor, CSFN, PhD, *on organizational* integrity is very applicable when considering leadership that will aim at ethical excellence. Sr. Carol writes, "It doesn't 'just happen' as a function of good people doing good things in health care. It requires an intentional, persistent focus."[3]

This is an old and oft-repeated message. It is oft-repeated because most of us need the repetition: We are called to constant conversion. If leaders in Catholic health care ethics are to effectively promote ethical excellence, we need to be committed to a life of constant conversion. Focusing more on God than on ourselves and, with the help of the Spirit, courageously reflecting on our Catholic identity for guidance as to what deserves our greatest attention, we will be better prepared to serve as the leaders needed to advance the ethical agenda in today's health care environment. □

NOTES

1. Richard A. McCormick, "Theology and Ethics," *Hastings Center Report,* May-June 1989, p. 6.
2. Richard A. McCormick, *The Critical Calling,* Georgetown University Press, Washington, DC, 1989, pp. 9-10.
3. Carol Taylor, "The Buck Stops Here," *Health Progress,* September-October 2001, p. 5.