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From the Director...

In this column I want to provide information about two exciting education opportunities that our Center has developed. First, we have established a partnership with DIA Learning in St. Louis to develop an interactive series of web based ethics education programs for health professionals, such as for ethics committee personnel. We have developed a special focus in the programs for Catholic health care. There will be 13 programs in the series, each running for 15 hours, including video narrative and commentary with interactive electronic readings and quizzes, and providing continuing education units. The first program is already available, "Persistent Vegetative State: To Live or Let Die": it features the well know case of Terri Schiavo to discuss treatment and care for patients in a persistent vegetative state, especially in light of JCAHO's standards. This program will be especially helpful for ethics education around the neuralgic ethical problem of withholding or withdrawing medical treatment in end-of-life care of patients. The second program is also available, "A National Emergency: Patient Safety": it features the renowned Institute of Medicine report on the large number of patients who die annually in US hospitals because of medical error and also JCAHO's standards on patient safety. This program will be especially helpful for ethics education on reducing medical error and enhancing patient safety in our health care settings. For further information about these exciting, interactive ethics education programs, please contact this website: www.dialearning.com.

Second, we have opened a new 9-credit Graduate Certificate Program in Clinical Health Care Ethics, beginning in August 2005, sponsored by the Center for Health Care Ethics at Saint Louis University. The Certificate Program serves hospital personnel and others engaged in health care. Its primary objective is to foster clinical ethics skills and knowledge (especially via case studies) needed by ethics committee-members, physicians, nurses, administrators, attorneys, social workers, chaplains, and others in healthcare. Participants can pursue an optional concentration in the Catholic tradition. To accommodate health professionals working full-time, the Program combines an extensive distance-learning component over a one year period, with two 2-3 day on-site seminars. Continuing education credits/units are available.

The courses and learning objectives in the Graduate Certificate Program include:

- A study of the principal ethical and legal norms that inform clinical ethics discussions (HCE.G501, Foundations of Clinical Ethics).
- A study of the main models for conducting clinical ethics consultations, presenting a framework for case studies (HCE.G502, Models of Clinical Consultation and Case Analysis).
- A study of informed consent and decision-making on behalf of incompetent patients (HCE.G510, Informed Consent and Surrogate Decision Making).
- A survey of the ethical issues and norms that pertain to healthcare for patients who are near the end of life (HCE.G511, Death and Dying).
- A study of medical error and patient safety, especially from the perspective of quality improvement (HCE.G513, Patient Safety and Medical Error).
- A study of the ethical and legal issues that arise in facilitating organ donation in the context of brain death, cardiac death, and living organ donation (HCE.G514, Organ Donation: Ethical Issues in Clinical Practice).
A study of the ethical and legal issues that arise in the care of children and adolescents (HCE.G515, Perinatal and Pediatric Ethics).
A mentored project for those completing the Graduate Certificate in Clinical Health Care Ethics (HCE.G589, Capstone Project: Ethics Case Analysis).

For further information and application materials for the Graduate Certificate Program in Clinical Health Care Ethics, please contact the Program Coordinator at chcercert@slu.edu, or the website at, http://chce.slu.edu/clinical_certificate.html or, tel. (314) 977-6661.

As usual, this issue of Health Care Ethics USA has three essays. The first essay is by Jan C. Heller, PhD, who is the System Director of Ethics and Theology at Providence Health System. His essay on “Demystifying Ministry Leadership Formation” discusses how ministry leadership formation for Catholic health care is a concept whose time has come. The second essay is by Scott Kashman MHA, FACHE, who is the Director of the Ambulatory & Emergency Care Center at Saint Mary’s Medical Center, Saginaw, Michigan. His essay on “Leadership Communication” discusses how to build a stronger culture of trust and results through business ethics, referring to an IRB-approved research study. The final essay is by Ann Suziedelis, PhD, a recent graduate of our PhD program, who is the Director of Mission Services at St. Joseph Mercy Oakland Hospital, Pontiac, Michigan. Her essay offers a refreshing look at the old chestnut of informed consent, presenting a cautionary tale. I hope you enjoy the essays and I look forward to receiving suggestions for topics that we might address in future issues.

Professor Gerard Magill, PhD
Executive Director & Department Chair
Center for Health Care Ethics
Demystifying Ministry Leadership Formation

Ministry leadership formation (MLF) for Catholic health care is a concept whose time has come. Motivated by the declining numbers of vowed religious working in Catholic health care, many Catholic health systems in the United States are either beginning MLF programs or are adapting their existing leadership development programs to reflect this emphasis. Five systems in the west, including Providence Health System, have joined together to create the Ministry Leadership Center, believing that no less than the future of Catholic health care as Catholic ministry is at stake. If the future of Catholic health care truly is at stake, it would be hard to find a more important issue to take up with the executives who are expected to participate in these MLF programs. Nevertheless, these executives have little understanding of formation as such. Moreover, when formation is explained to them, they sometimes become defensive. As they begin to understand that formation programs are intended not only to prepare them to lead Catholic health care ministries, but also actually to “form” or shape their personal and professional selves, they express both skepticism that such programs can succeed and not too subtle anger that someone thinks they need such “forming.”

In this article I explore the interesting challenge presented by the choice to cast these programs as leadership formation programs (rather than as development programs), and I try to demystify the programs themselves by examining formation through the more secular lens of organizational ethics. My goals are to help us begin to understand the term and the reason for its choice, and to suggest that, when seen in light of organizational ethics, executives need be neither skeptical nor defensive; indeed, they might find they have grounds to enter the formation process with a sense of expectation or even excitement.

Some Principles of Organizational Ethics

Organizational ethics is a field in health care ethics that is still maturing. With the impetus supplied by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), it was initially focused rather narrowly on business issues, but more recently it has broadened to include those factors that contribute to an ethical organizational culture or what some are calling the moral ecology of the organization. Broadly (and very briefly) construed, organizational ethics is concerned with what elsewhere I have called the three domains of ethics: conduct, character, and conditions—and these form the perspectives of two types of moral agents: the individual and the organization. That is, organizational ethics is concerned with the moral conduct of individuals as they are affected by conditions established or affected by the organization; with the moral character that inclines these same individuals to choose habitually in certain ways; and, with the organizational conditions that influence the conduct and characters of these individuals. Further, organizational ethics is concerned with the moral agency of the organization itself, for individuals in organizations may act jointly as a collective moral agent, and as a bounded whole the organization can be held morally (and legally) accountable for their actions individually and collectively.

Discussion

The above characterization of organizational ethics may be illustrated with a matrix, with examples given for individual and organizational agents. Note how the organization provides the conditions that both enable and constrain the individuals working within it, and also how the organization itself is enabled and constrained by the conditions within which it exists and functions.

<table>
<thead>
<tr>
<th>Conduct</th>
<th>Individual</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat a patient respectfully before surgery by not rushing through the</td>
<td>Seeking funds to expand the number of surgical suites to treat additional patients, with</td>
<td></td>
</tr>
</tbody>
</table>
Organizational ethics is concerned with each of these boxes, and especially with how they interact with one another. Leaders play a critical role in establishing and sustaining the organizational conditions (the culture and policies) that support the moral conduct and characters of individuals within organizations. Focusing on the selection and development of leaders is thus an efficient and effective strategy for affecting the moral agency and ecology of the organization as a whole. Said differently, all leaders affect the culture and policies of their organizations; leadership development programs are aimed at helping them to become self-conscious of their effects and to help them learn to guide their effects toward sustaining and promoting the organization’s mission.

How does leadership formation fit into this understanding of organizational ethics? Traditionally, formation is a term used to describe a life-long process of intellectual development and experientially based learning in which vowed religious and ordained clergy participate in order to enable them both to embody (in their characters) and to exemplify (in their conduct) the virtues church leaders believe appropriate to their vocations or callings. In terms of organizational ethics, formation programs may be viewed as a subset of leadership development programs. They aim to help leaders understand and establish the organizational conditions that shape the characters of individuals within the organization such that these individuals will habitually conduct themselves in ways that are consistent with the mission and values of the organization. In turn, some of these individuals will themselves become the leaders who will later establish or sustain the conditions that shape the characters and conduct of younger members of their communities, thus ideally ensuring that the mission and values (which are reason for the existence of the organization) will be perpetuated through time and space.

It is understandable why executives might resist formation. They may be Catholic but not vowed religious or ordained; they may be Christian but not Catholic; they may be practicing adherents to some recognized religious faith, but not Christian; or, they may be committed deeply to the mission and values of Catholic health care, but not a part of any faith community. But these formation programs are not intended to make them Catholic or even Christian—that is what makes them interesting from an organizational ethics perspective. Rather, they are aimed at helping executives understand and commit deeply (for their own reasons) to the Catholic health care ministry—its mission and values—and to pass that understanding and commitment on to the leaders who will succeed them. Yes, MLF programs are intended to affect the conduct and characters of participating executives, but any organization does this—MLF programs are designed to help us do this more intentionally or self-consciously.

Conclusion

Ministry leadership formation is an interesting challenge for Catholic health care, and much is at stake. But understood in terms of organizational ethics, ministry leadership formation may be seen as but one or many strategies designed to help leaders sustain Catholic health care as a Catholic health care ministry in the future, given the changing conditions under which that ministry is lived out organizationally.
Jan C. Heller, Ph.D.
System Director, Ethics and Theology
Providence Health System


**Suggested Readings**


**Questions For Discussion**

1. Are there other ways not discussed in this article that organizational ethics might help us understand ministry leadership formation?
2. What do you think about the fact that MLF programs will expect executives to explore and deepen their own spirituality? How might this be done without making them feel like they must convert or be part of an organized faith community (if they're not)?
3. Are you persuaded that leadership formation programs should be differentiated from leadership development programs? Why or why not?
Leadership Communication: Building a Stronger Culture of Trust and Results through Business Ethics Based on an IRB-Approved Research Study

Everyday, healthcare leaders are faced with difficult decisions that impact the delivery of care in their organizations. They provide the leadership to foster their institutions’ missions and manage the institutions’ resources. Resolving ethical issues increasingly occupies more of their time. Changes in reimbursement, capacity issues, resource allocation, staffing shortages, unions, regulatory changes and competition, further compound such issues. Employees, patients and physicians want to see fair and consistent decision-making in line with the organization’s mission and goals, to assure a level of confidence and trust. Once key stakeholders lose trust in key leaders, the organization may not be seen as credible.

This article describes and discusses a qualitative, IRB-approved research study designed to gain insight into how healthcare executives resolve ethical issues in their organizations. In particular, the goals of the study were threefold. The first goal was to understand how participants would address hypothetical ethics cases involving allocation of limited clinical resources, staffing shortages, fundraising, budget cuts, and clinician/patient conflict. The second goal was to gain a better understanding of the factors executives considered to resolve these issues. The third goal was to understand the impact that executive decisions have on an organization’s trust level and how the factors they considered influenced their decision-making processes.

Principles

Business ethics can be defined as a company’s attitude and conduct toward its employees, customers, community and stakeholders. It is often a matter of dealing with dilemmas or competing values that have no clear indication of what is right or wrong. Attention to business ethics helps ensure that when managers and leaders are struggling in times of crisis and confusion, they retain a strong moral compass. To this end, several principles of business ethics may be helpful to leaders faced with perplexing questions.

As with the physician-patient relationship, trust is a key element of the healthcare executive’s relationship with key stakeholders, including employees, patients, physicians and the public in general. If healthcare leaders are not trusted by their key stakeholders, their decisions will likely be undermined by their own lack of integrity. Integrity is a key virtue of the healthcare leader necessary for establishing trust with key stakeholders. Likewise, subsidiarity and the principle of participation also play key roles. Subsidiarity requires decisions to be made at the most appropriate level in the organization, while the principle of participation ensures that those most affected by the decision have some significant role in determining the decision. The practice of healthcare, both clinically and administratively, is inherently multidisciplinary. Healthcare leaders, therefore, should not make decisions in a vacuum. Clinical collaboration will often be necessary to resolve many ethical issues. Finally, stewardship is a key principle that healthcare leaders need to utilize when making decisions. Healthcare executives are charged with the responsibility of being wise stewards of the organization’s finances, human talents and the community’s healthcare resources so that they are used to the benefit of its stakeholders. Above all, healthcare executives are stewards of the organization’s mission and legacy, charged with ensuring that it continues strong and vibrant into the future.

Discussion

For this study, 145 executives representing a purposive sampling were mailed a questionnaire. There was a 41% positive response rate. According to the responses provided by the participants, 60% of the healthcare executives surveyed preferred to make ethical decisions on their own, 17% pulled together an ad hoc group, 14% utilized an ethics committee and 10% preferred to seek out advice from a colleague. Approximately 50% of the executives stated ‘legal’ factors as a consideration for resolving issues; 30% stated ‘financial’ factors were considered; and 20% stated ‘political or public
relation' factors were considered. According to the study, most healthcare executives do not use ethics committees. They view ethics committees as venues for resolving clinical issues versus business or corporate ethical issues. The study also suggests that a lack of decision making processes or systems for healthcare leaders within the same organization can lead to arbitrary and inconsistent resolutions. Study participants were mixed with regard to the influence that religion has on their decision-making. Some felt religion influenced all their decisions; some felt religion played no role; while others used their religious beliefs as one basis of reference. Several participants were unaware of whether there were any forums available to their employees for resolving ethical issues.

These considerations can considerably influence a healthcare leader’s ability to balance all factors when making a decision. For example, accepting a donation from a controversial pharmaceutical company may lead to short term financial gains for an organization. Financially, the decision may seem to make sense, but, if the community finds acceptance of a donation from this organization to be objectionable, it could lead to unfavorable publicity and in turn negatively affect donations to that institution. Ultimately, the long-term impact could also lead to reduction in referrals of patients, and thus decreased utilization and loss in revenue. In this example, financial, political/public relations and legal considerations all converge to influence the healthcare leader’s decision.

Ideally, a defined system or process of decision-making could help ensure that all of the relevant considerations are taken into account. In the absence of any such defined system or process of decision-making, consultation with an ethics committee could be helpful for ensuring that all of the relevant considerations and perspectives are being taken into account. Meetings, both spontaneous and scheduled, should occur on a regular basis between clinicians and healthcare executives. While the majority of the surveyed executives indicated that they resolved ethical issues on their own, many of the ethical issues they faced require clinician collaboration for effective resolution. No matter what process of decision-making healthcare leaders use, they should not make the decisions in isolation from those who are going to be most affected by those decisions. If certain groups are not included in the decision-making processes, a division can occur between executives and others. Many organizations are still faced with the ‘us versus them’ mentality involving clinicians versus healthcare executives. This may be created, not by a lack of commitment to take care of patients, but by unresolved differences over the allocation and prioritization of the institution’s limited resources. Decision-making should be transparent (known to everyone affected by the decision). When physicians, healthcare executives and other key employees work closely together, decision-making surrounding potential ethical issues becomes collaborative and transparent. These efforts lead to a stronger foundation of trust and sustainable results in an organization.

Conclusion

The results of this study suggest several areas of focus for executives, which will help foster ethical decision-making within their healthcare organizations:

- Fostering a culture of trust and collaboration is key, and may ultimately lead to improved clinical services, patient safety, patient & physician satisfaction, staff morale and financial performance for an organization;
- Developing systems to ensure leaders resolve issues consistently by aligning leadership goals, actions and performance evaluations with the organization’s values; and
- Ensuring that resources and processes are available for everyone within the organization to resolve ethical issues without fear of retribution.

Resolving ethical issues is a critical component of healthcare leaders’ responsibilities. With this responsibility, comes accountability of stewardship for the organization’s employees, physicians, patients and families. Attention must be paid to the ethical decision-making processes and the need for ethics resources for executives and staff. These processes are instrumental for ensuring the success of the organizations that are entrusted to healthcare leaders. They will help the healthcare leaders stay focused on their core business: taking care of the patients who rely on their organizations, each and every day.
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Saint Mary’s Medical Center, Saginaw, Michigan


Suggested Readings


The Ethics Resource Center website, www.ethics.org, which provides a useful tool and model for assessing organization’s ethical effectiveness (see Ethics Effectiveness Quick Test).

The Kashman Study, the Institutional Review Board (IRB)-approved research study which served as the basis to this article. For copies, write to Scott Kashman at skashman@saintmarys-saginaw.org.

Questions For Discussion

1. As a healthcare worker, do you use a formal ethics committee to assist in making organizational decisions? Why or why not?
2. Do your religious and/or spiritual beliefs impact your decision making process at work? How is or would this be looked upon by your organization?
3. In order for you to meet your budget for the next fiscal year, you are being asked to cut staffing levels to a level you believe would seriously jeopardize patient care in your area of responsibility. How do you respond? What ethical principles would you consider in making your decision? What decision making processes would you utilize?
Informed Consent: A Cautionary Tale

One can be forgiven for believing that the basic elements of the principles of bioethics have been more than sufficiently addressed since the 1970s. Surely this is so of the principle of informed consent—the right to control access to one’s body. After all, conversation has long since moved on to such fine points as advance consent, proxy consent, consent for minors, and the determination of a person’s ability to consent in some but not all circumstances. Undoubtedly there can be only a few old misfits remaining who fail to grasp the essentials of this most basic tenet of bioethics. Unfortunately, it seems that this is not the case, and that too many remain who still just don’t get it. This is a challenge to all in health care, because if there are cracks in the basic appreciation of one principle, we must be vigilant in watching for cracks elsewhere as well.

A serious concern about informed consent arose in the spring of 2003, when stories appeared in the U.S. press about medical students being trained to give pelvic exams by practicing on anesthetized women. The problem was not the participation in routine pre-surgery exams by students who were members of the patient’s care team. The problem was those students who were there for no reason but the enhancement of their own skills, examining women who had not agreed to be part of the noble cause of educating future physicians. Though this reality has been addressed, and changes have been made at many U.S. medical schools in the last two years, the fact that this practice existed into the twenty-first century should at the very least provoke us to examine our own health care institutions to see if we are assuming more understanding, acceptance, and application of ethical principles than actually exists.

Principles

Discussion of the principle of informed consent over the last few decades has worked its way through an assessment of the physician’s obligation to disclose, to focus now on the quality of patient consent. What we are considering here, unfortunately, is a far more basic ethical and legal dictate than either of those concerns. U.S. Supreme Court Justice Cardoza stated it clearly in 1914, in noting that, “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.” Essentially, that means that in most circumstances a person’s body cannot be touched without his or her consent. Certainly, it is necessary for the common good that medical students develop expertise in the skills of their profession, and much of this learning requires the good will and cooperation of patients. Problems arise, however, when these virtues of human kindness are assumed by the physician, rather than clearly offered by the patient. It is then that matters of consent become deeply problematic.

Discussion

Much of the response to allegations that groups of three or four medical students were present in operating rooms to perform pelvic exams on anesthetized woman skirted the issue by pointing out that medical students are often members of a patient care team, or that surgeons routinely perform pelvic exams on anesthetized patients before gynecological surgeries. These facts are true, but are not at issue here. The real issue was brought to the fore by three physicians in an article in the American Journal of Obstetrics and Gynecology in March 2003. One of them, pediatrician Ari Silver-Isenstadt, had himself been offended by gynecological practice sessions while a medical student at the University of Pennsylvania, and had refused to take part in them. “My problem was that if [the women] found out about it, they might be really upset, and it was really only being done for my benefit. I felt like I would be violating their trust.” An article in Student Life, a newspaper at Washington University in St. Louis, MO, echoes this in stating that the controversy concerns students practicing their examination skills, noting that the practice was not for the benefit of the patient, “but intended only to enhance the clinical skills of the medical student.”
What is troublesome in reading through the many articles that addressed this issue in the spring and summer of 2003 is that a number of students and medical professors continued not to see a problem. One unnamed female physician in Charlotte, North Carolina, is quoted as saying that she never thought of these exams as harmful, even if consent was not given. She opined paternalistically that patients “have much more important things to worry about in medical care.” Some point out that patients entering a facility where medical students are trained sign a form explaining that students will be involved in their care, and that that is sufficient notice. But others ask how that information can be understood to cover the practice of allowing groups of students not on the care team to examine anesthetized patients for training purposes alone. One of the more disturbing elements is the finding by the journal study mentioned above that medical students who have not completed OB/GYN rotations have a higher general regard for the need to obtain informed consent from patients than do those who have, by a margin of 70% to 51%. “The OB/GYN clerkship seems to be the defining event in this erosion, as opposed to gradual erosion throughout students’ many clerkships or rotations,” concludes Dr. Peter Ubel, one of the study’s authors. This suggests the need to search out and address practices in our hospitals that might have a detrimental effect on the fundamental and practical value placed on any ethical principle by health care professionals.

Conclusion

It is sad that some have learned so little over the years. We blanche, for example, at the details of a 1932 case in which a woman in labor asked to see a physician instead of a medical student, only to have the student call in a dozen of his peers, each of whom examined her as she screamed for them to stop. While the issue we discuss here is not similarly malicious, it does nevertheless involve the same fundamental disregard for the human dignity of patients, by disregarding or circumventing the need to inform them and seek their consent. It is sad that the practice places so little value on the need for trust between physician and patient, and so little faith in the goodness of patients and their willingness to participate in physician education if asked. Dr. Daniel Federman, senior dean for clinical teaching at Harvard University Medical School, is quoted as saying that after the complaints of 2003 led to a new policy requiring that women be asked to consent to exams for training proposes, “Very few patients decline.” Silver-Isenstadt notes that, “... the simple solution is to ask people’s permission. They’ll say yes. And it teaches the lesson to medical students that it’s really all about the patient. Not all about the medical student.”

All of this serves to remind us that medicine constantly involves new players and new issues, and that even the most fundamental ethical principles must not only be taught theoretically, but that their application must be reconsidered and revisited on a consistent basis when real patients are involved.

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Suggested Readings


Questions For Discussion

1. How can we develop a proactive plan to identify weaknesses in the application of ethical principles in this hospital before lapses are brought to our attention?
2. What educational opportunities can we provide for our staff to keep their ethical sensibilities sharp?
3. Do our hospital policies need to be edited to better address both the training needs of medical students and the rights of patients?