INTEGRATEDETHICS: AN INNOVATIVE PROGRAM TO IMPROVE ETHICS QUALITY IN HEALTH CARE

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The IntegratedEthics model represents a fundamental departure from the traditional approach to ethics in health care organizations. IntegratedEthics was developed by the National Center for Ethics in Health Care within the United States Government's Department of Veterans Affairs (VA). The Veterans Health Administration (VHA) is the largest integrated health care system in the United States, delivering health services to nearly 6,000,000 patients each year through more than 1,500 sites of care.

The IntegratedEthics model was developed and refined over more than five years by a design team comprising individuals from diverse fields including bioethics, medicine, public administration, business, education, communications, nursing, and social sciences. The design team used a rigorous consensus development process that included in-depth literature reviews across multiple fields of study and extensive input from internal and external stakeholders representing numerous organizations. IntegratedEthics structures, methods, and tools have been systematically evaluated through validity testing, field testing, and a 12-month demonstration project in 25 separate health care facilities. Since early 2008, IntegratedEthics has been implemented throughout all of VA's 153 medical centers and 21 regional networks. The model is being continuously expanded and improved as new resource materials are added over time.

IntegratedEthics is receiving national and international attention. We have received positive press, requests for informational presentations and suggestions for how to implement the program from a diverse group of organizations in the public sector (e.g., United States Navy, Centers for Disease Control and Prevention), professional organizations (e.g., American Medical Association, American Society for Bioethics and Humanities), universities (e.g., Georgetown University, University of Chicago, Duquesne University), hospital systems (e.g., Harvard Hospitals, Kaiser Permanente, Ascension Health, Catholic Hospital Association), and health ministries in Japan and Canada (e.g., Province of Alberta, Province of British Columbia). While the model was designed to meet the needs of health care organizations, most of its concepts are equally applicable to other types of organizations.

This article describes the conceptual underpinnings of the IntegratedEthics model and the rationale for its development. It describes the shortcomings of the traditional ethics committee model, which has changed little in the past 20 years. Next, it presents an overview of the IntegratedEthics model and how the model draws on 21st century thinking across fields ranging from organizational studies to quality management. Finally, the article describes in detail the three major functions of IntegratedEthics and their corresponding organizational structures. A subsequent paper in this journal will describe the various strategies and tools used to implement the model and how these were expanded and improved over time.

Defining Ethics

Dictionaries variously define ethics as a set of principles of right conduct, the study of the general nature of morals and of the specific moral choices to be made by a person, the body of moral principles or values governing or distinctive of a particular culture or group, and the rules or standards governing the conduct of a person or the members of a profession. (dictionary.com, "Ethics," 2010) However, the word "ethics" takes on somewhat different meanings in various social contexts.

In the government sector, for example, the word "ethics" is often used to refer to specific legal rules of conduct for government employees that emphasize conflicts of interest. In 1978, in the aftermath of the Watergate scandal, Congress passed the "Ethics in Government Act," which established the Office of Government Ethics and other mechanisms to prevent and resolve conflicts of interest on the part of federal employees. Many states have since established analogous laws on ethics in state government.

Similarly, in the corporate world, "ethics" is often understood to mean adherence to legal and regulatory requirements, and is often used interchangeably with the term "compliance." Under United States Sentencing Commission guidelines, corporations are expected to maintain "Effective Compliance and Ethics Programs" to demonstrate that they are exercising "due diligence to prevent and detect criminal conduct." (U.S. Sentencing Commission, 2004, § 3E1.1)

In contrast, in the academic arena, "ethics" has a very different meaning. In philosophy departments, ethics is considered a branch of philosophy. Graduate schools often have programs or centers for applied ethics, which apply ethical theory to a range of topics relevant to a particular field of study (e.g., clinical ethics, business ethics, public administration ethics). Some areas of applied ethics have split off from the field of philosophy to become multidisciplinary fields in their own right, complete with professional societies, scholarly journals, and in some cases, independent academic departments.

Ethics in Health Care Organizations

Health care organizations are complex and multifaceted institutions that do not fit neatly into any of the social contexts described above. For example, hospitals must deal with clinical ethics issues, like those pertaining to life-sustaining treatment and conflicts between families and health care teams. Both public and private hospitals must address matters of business and managerial ethics, such as supervisor-subordinate relationships, stakeholder involvement, and responsibilities to the community. At the same time, hospitals must comply with a very extensive and complicated set of legal and regulatory standards. Depending on their ownership and mission, some hospitals may also need to be concerned with government ethics, public administration ethics, faith-based ethics, research ethics, and the like.

Historically, in health care institutions, the primary mechanism for addressing ethical issues has been the institutional ethics committee. Institutional ethics committees (also known by other names such as hospital ethics committees, bioethics committees, ethics advisory committees, clinical ethics committees, and organizational ethics committees) date back to the 1970s; the

number of hospital ethics committees has grown dramatically over the past 30 years. In 1981, only 1% of U.S. hospitals reported having an ethics committee, (Younger, 1983, p. 902) whereas by 1990, the proportion had risen to 60%. (American Hospital Association, 1985, p. 60) In 1987, Maryland became the first state to enact legislation requiring hospitals to establish institutional ethics committees. In 1992, the Joint Commission for Accreditation of Healthcare Organizations began requiring that health care organizations "have in place a mechanism for the consideration of ethical issues arising in the care of patients." (Joint Commission, 1992, p. 104) By 1998, over 90% of U.S. hospitals had established ethics committees. (McGee, AJOB, 2002, p. 76)

Most ethics committees are multidisciplinary and include health care professionals from various disciplines (e.g., doctors, nurses, and social workers). Such committees also frequently include staff from other clinical disciplines, hospital administrators, attorneys, clergy, community members, and ethicists.

Shortcomings of the Traditional Ethics Committee Model

1. Ethics committees are not well integrated with other parts of the health care organization.

Traditionally, ethics committees have focused the vast majority of their time and attention on clinical ethics issues, especially those that pertain to end-of-life care. (McGee, Cambridge Quarterly, 2002, p. 89) However, end-of-life issues represent only a small fraction of the ethical issues that arise in health care organizations. We conducted focus groups to identify the greatest ethical challenges faced by various stakeholder groups involved in health care. Interestingly, of the groups we studied, only ethics committee chairpersons identified end-of-life care as the greatest ethical challenge. In fact, each of the different groups identified different challenges. (Foglia, 2009, pp. 28-36)

The broad range of ethical challenges that arise in health care organizations tend to be handled through a patchwork of discrete programs: for example, clinical ethics concerns are within the purview of ethics committees, research ethics concerns are handled by the institutional review board, and business and management ethics concerns go to compliance officers and human resources staff. Moreover, these parties tend to operate in relative isolation and tend not to communicate with each other to identify and address overlapping or related concerns.

Recently, some ethics committees have made efforts to expand beyond clinical ethics to a broader conception of organizational ethics, which also encompasses business ethics. (Pentz, 1999, p. 38) To the extent they exist, organizational ethics committees are often subcommittees of institutional ethics committees, and often mirror traditional ethics committees in their structure and functions. (American Academy of Pediatrics, 2001, p. 206) Concerns have been raised, however, about whether the traditional ethics committee model provides the necessary structure, functions, and member qualifications to take on this expanded role. (American Academy of Pediatrics, 2001, p. 206)

2. Traditional ethics committees lack a clearly defined purpose.

Three activities have become the *sine qua non* of the traditional ethics committee – education, consultation, and policy work. Educational activities typically include self-education as well as education of other employees (especially clinicians), patients and families, and in some cases, the broader community. Ethics consultation typically consists of helping employees, patients and families resolve clinical ethics conflicts. Policy activities encompass the formulation and/or interpretation of institutional policies, typically on end-of-life and patients rights issues. In a national survey of ethics committees in the U.S., ethics committee chairs considered their committees to be most successful at education (34%), consultation (31%), and policy work (22%). (McGee, AJOB, 2002, p. 77)

At least informally, traditional ethics committees often describe their purpose by referencing these three activities. However, it should be noted that describing the committee's activities is not the same as describing the committee's purpose. The activities of the committee should derive from its purpose, and not the other way around.

When traditional ethics committees describe their purpose more formally, in policies or other official statements, they often use phrases such as "to provide forum for discussion," "to promote ethical reflection," "to facilitate dialogue," "to create a moral space for deliberation," or "to cultivate an exchange of ideas." A problem with such descriptions is that they do not explain the ethics committee's instrumental value to the organization or its mission. Further, they are too vague to lend themselves to measurement or improvement efforts. Some ethics committees actually defend this vagueness as a virtue and categorically object to efforts at assessing an ethics committee's effectiveness. (Hoffman, 1993, pp. 677-680)

3. Traditional ethics committees lack quality standards and accountability.

Remarkably little has changed since 1994 when John Fletcher and Diane Hoffman declared, "The time for a laissez faire approach to ethics committees is long past." (Fletcher, 1994, p. 337) From what we have observed on internet discussion groups and at national bioethics meetings, the *ad hoc* approach they described back then is still common today:

> With some important exceptions, most members of ethics committees engage in little or no serious study of clinical ethics or related topics… In many places, committee members begin to serve without even a modest orientation to the committee's tasks… Standards of due process are not followed and may even be unknown to the committee.

While much has been written about the need for ethics committees to establish clear standards and metrics, there has not been a great deal of progress in this regard. In general, traditional ethics committees are not evaluated in terms of specific structure, process, and outcome measures of quality; evaluation tends to consist exclusively of formative self-evaluation. (Wilson, 1993, p. 31)

4. Traditional ethics committees have not evolved in response to advances of the last 25 years.

Health care organizations have changed a lot in the last 25 years as new knowledge has been generated across multiple fields of study. Yet ethics committees, for the most part, have changed very little. In particular, they have generally failed to take into account significant developments in areas such as:

- Organizational studies
- Leadership and management theory
- Quality management and improvement
- Complex systems theory
- Social, cognitive, and cultural psychology
- Human factors engineering

Traditional ethics committees seem similarly unaffected by modern developments in the related worlds of corporate ethics, public administration ethics, Catholic health care ethics, and the like.

Ethics committees' failure to adapt to changing times is worrisome. Since ethics committees literally deal with matters of life and death, an ethics committee that lacks clear standards and mechanisms for quality control can do a great deal of harm. Dealing with ethical issues in health care organizations is no simple matter and requires a modern-day understanding of how complex organizations work and how they affect human experience and behavior.

Recent developments call into question many entrenched notions that traditional ethics committees take for granted. For example, in the field of quality improvement, it is now recognized that certain actions designed to influence behaviors among health care providers are considered "weak actions" because without stronger, systems-level interventions, they are unlikely to be effective. Both education and policy (two mainstays of the traditional ethics committee model) are considered weak actions. (Interview with Dr. Gosbee, 2010)

The IntegratedEthics Model

VA has recognized the need to establish a national, standardized, comprehensive, systematic, integrated approach to ethics in health care—and IntegratedEthics was designed to meet that need. This innovative model is based on established methods for achieving performance excellence, principles of continuous quality improvement, and proven strategies for organizational change. While the model was designed to meet the needs of health care organizations, most of its concepts are equally applicable to other types of organizations.

The Concept of Ethics Quality

The tagline of IntegratedEthics – "improving ethics quality in health care" – captures the essential purpose of IntegratedEthics. While quality has become a buzzword for health care organizations in recent years, these same organizations have placed relatively little emphasis on quality as it relates to ethics. IntegratedEthics helps organizations to fill this gap by systematically prioritizing, promoting, measuring, and improving performance relating to ethics, just as they do with other organizational imperatives.

A central tenet of the IntegratedEthics model is that ethics is integral to quality. A health care provider who fails to meet established ethical standards is not delivering high quality health care. Conversely, a failure to meet minimum quality standards raises ethical concerns. Thus, health care ethics and health care quality cannot be separated.

When most people in health care think of quality, they think of technical quality (e.g., clinical indicators) and service quality (e.g., patient satisfaction). But ethics quality is equally important. (Wynia, 1999, p. 296) Ethics quality means that practices throughout an organization are consistent with widely accepted ethical standards, norms, or expectations for the organization and its staff. These practices are set forth in organizational mission and value statements, codes of ethics, professional guidelines, consensus statements and position papers, public and institutional policies. Ethics quality may be evaluated through structure, process, and outcome measures.

For example, let's say a patient undergoes a surgical procedure. From a technical quality perspective, the operation was perfectly executed, and from a service quality perspective, the patient was perfectly satisfied with the care he received. So the care was of high quality, right? Well, not necessarily. Imagine that the patient was never really informed—or was even misinformed—about the procedure he received. This would indicate a problem with ethics quality.

The idea of ethics quality in health care is not entirely new. Donabedian, who is widely regarded as the father of quality measurement in health care, defined quality to include both technical and interpersonal components, with the latter defined as "conformity to legitimate patient expectations and to social and professional norms." (Donebian, 1979, p. 280) Others have proposed "ethicality" – the degree to which clinical practices conform to established ethical standards – as an important element of health care quality. (Fox, 1996, p. 132) Still others have argued that performance measures for ethics should be routinely included in health care quality assessments. (Wynia, 1999, p. 298)

Levels of Ethics Quality

Ethics quality is the product of the interplay of factors at three levels: (1) decisions and actions, (2) systems and processes, and (3) environment and culture. Together, these three levels define the ethics quality of an organization.

The levels of ethics quality are well illustrated by the image of an iceberg, as shown in Figure 1.

FIGURE 1

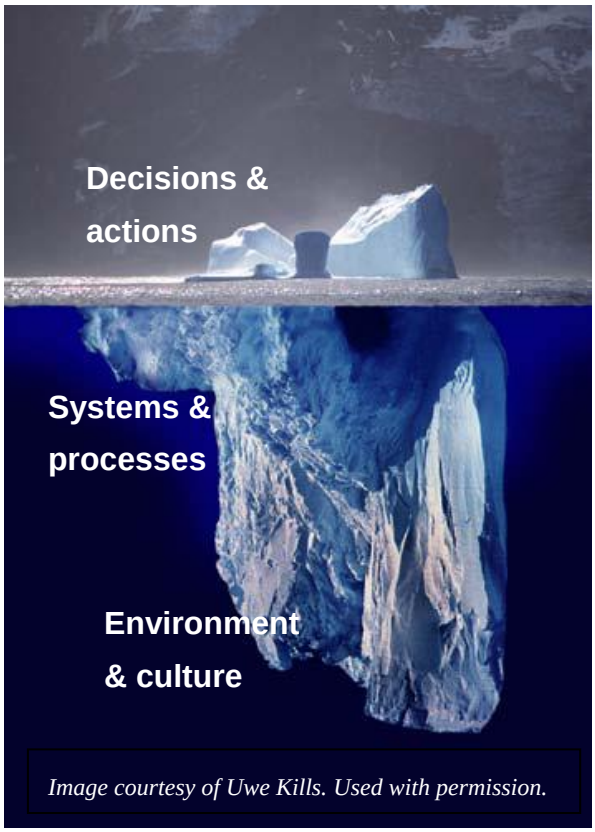


Image courtesy of Uwe Kills. Used with permission.

At the surface of the ethics iceberg lie easily observable *decisions and actions*, and the events that flow from them, in the everyday practices of an organization and its staff.

Beneath that, however, organizational *systems and processes* drive decision making. These organizational factors are not readily visible in themselves, but they become apparent when one looks for them, for example, by examining patterns and trends in requests for ethics consultations.

Deeper still lie the organization's ethical *environment and culture*, which powerfully, but almost imperceptibly, shape its overall ethics practices. This deepest level consists of values, understandings, assumptions, habits, and unspoken messages – what people in the organization know but rarely make explicit. This level is critically important because it is the foundation for everything else. Yet because this level can only be revealed through deliberate and careful exploration, it is often overlooked.

Traditional ethics committees often make the mistake of spending too much time in a reactive mode, focusing only on the most visible ethics concerns (i.e., the "tip of the iceberg"). However, to have a lasting impact on ethics quality, ethics programs must do more. They must continually probe beneath the operational surface, to identify and address the deeper organizational factors that influence observable practices. Only then will they be successful at improving ethics quality organization-wide.

Instead of focusing narrowly on one level, the IntegratedEthics model embraces a more comprehensive approach. The model is structured around three "core functions," each of which targets a different level of ethics quality:

1. Ethics consultation – targets ethics quality at the level of decisions and actions;
2. Preventive ethics – targets the level of systems and processes; and
3. Ethical leadership – targets the level of environment and culture.

Thus, in contrast to the traditional ethics committee model, the core functions of IntegratedEthics follow directly from its purpose. The core functions are described in detail later in the paper.

Domains of Health Care Ethics

While traditional ethics committees generally focus on clinical ethics issues, particularly those relating to end-of-life care, the IntegratedEthics model deals with the full range of ethical concerns in health care. In the model, these concerns are categorized into *ethics content domains,* which were developed and tested through a systematic process. First we derived a comprehensive set of ethical concerns from multiple sources including literature review, identification of "red flag" items that could be considered strong indicators of problems with an organization's ethics culture, review of requests for ethics consultation received by the National Center for Ethics in Health Care, and suggestions from a panel of external experts. The comprehensive list of topics was organized by major themes and revised to limit overlap between domains and topics. The domains and topics were then revised based on input from an external panel and field based staff for clarity, usability, and applicability to the Veterans Health Administration as well as in other health care organizations.

The IntegratedEthics model defines the ethics content domains for health care as follows:

- Shared decision making with patients (how well the organization promotes collaborative decision making between clinicians and patients)
- Ethical practices in end-of-life care (how well the organization addresses ethical aspects of caring for patients near the end of life)
- Ethical practices at the beginning of life (how well the organization promotes ethical practices with respect to conception, pregnancy, and the peri-natal period)
- Patient privacy and confidentiality (how well the organization protects patient privacy and confidentiality)
- Professionalism in patient care (how well the organization fosters behavior appropriate for health care professionals)
- Ethical practices in resource allocation (how well the organization demonstrates fairness in allocating resources across programs, services, and patients)
- Ethical practices in business and management (how well the organization promotes high ethical standards in its business and management practices)
- Ethical practices in research (how well the organization ensures that its employees follow ethical standards that apply to research practices)
- Ethical practices in the everyday workplace (how well the organization supports ethical behavior in everyday interactions in the workplace)

These content domains were designed to cover the ethical issues faced all types of health care organizations, including acute care hospitals, rehabilitation hospitals, outpatient facilities, nursing homes, home care organizations, and health care systems. While the Veterans Health Administration focuses on serving veterans of the U.S. military, the content domains are applicable to diverse patient populations (e.g., pediatric, obstetric, active duty military).

While the IntegratedEthics content domains encompass the full range of ethical issues faced by most health care organizations, some organizations may need for additional domains depending on specific mission-specific responsibilities. For example, VHA has special responsibilities by virtue of its role as a government organization, and for that reason has added the following domain:

- Ethical practices in government service (how well the organization fosters behavior appropriate for government employees)

Additional domains derived from special mission-specific responsibilities might include, for example:

- Ethical practices in mission integration (how well the organization manages the relationship between individual values and the values of Catholic health care)
- Ethical practices in military medicine (how well the organization ensures that its employees follow ethical standards that apply to military medicine)
- Ethical practices in occupational medicine (how well the organization manages conflicting ethical responsibilities to workers, employers, and the public)

Rules-Based and Values-Based Approaches to Ethics

Ethics programs are sometimes characterized as "rules-oriented" or "values-oriented." Rules-based ethics programs are designed to prevent, detect, and punish violations of law. (Paine, 1997, p. 107; Oak, undated, p. 63; Treviño, 1999, p. 135) Such programs tend to emphasize legal compliance by:

- communicating minimal legal standards that employees must comply with
- monitoring employee behavior to assess compliance with these standards
- instituting procedures to report employees who fail to comply
- disciplining offending employees (Jeurrisen, 2003)

On the other hand, values-based approaches recognize that ethics means much more than mere compliance with legal duties. As one commentator put it:

> You can't write enough laws to tell us what to do at all times every day of the week…. We've got to develop the critical thinking and critical reasoning skills of our people because most of the ethical issues that we deal with are in the ethical gray areas. (Gebler, 2006, p. 345)

For values-based ethics programs, it is not enough for employees to meet minimal legal standards; instead, they are expected to make well-considered judgments that translate organizational values into action—especially in the "ethical gray areas." (Paine, 1997, p. 109; Oak, undated, p. 64) To achieve this, values-based approaches seek to create an ethical environment and culture. They work to ensure that key values permeate all levels of an organization, are discussed openly and frequently, and become a part of everyday decision making.

Whereas traditional ethics committees tend to distance themselves from rules-based approaches, and consider compliance issues the responsibility of others in the organization, IntegratedEthics recognizes that rules-based approaches and values-based approaches to ethics *both* play vital roles in the ethical life of organizations. Organizations with a health ethical environment and culture consider not only what they *must* do, but also what they *should* do – finding ethically optimal ways to interpret and act on the rules, in service of the organization's mission and values. And while compliance with laws, regulations, and institutional policies is important, overemphasizing rules can lead to "moral mediocrity," (Paine, 1997, p. 108) or worse, to unethical practices, if employees equate "no rule" with "no problem." (Oak, undated, p. 63) The key, then, is to strike an appropriate balance – which is best achieved through an integrated approach.

The IntegratedEthics Core Functions

As described above, IntegratedEthics improves ethics quality by targeting three levels – decisions and actions, systems and processes, and environment and culture – through three core functions – ethics consultation, preventive ethics, and ethical leadership.

The following section is excerpted from the internal VA publication entitled **Ethics Consultation: Responding to Ethics Questions in Health Care** by Ellen Fox, Kenneth A. Berkowitz, Barbara L. Chanko, and Tia Powell. (Available at: www.ethics.va.gov/integratedethics/ECC.asp)

ETHICS CONSULTATION: Responding to Ethics Question in Health Care

When people make a decision or take an action, ethical concerns often arise. An ethics program must have an effective mechanism for responding to these concerns to help specific staff members, patients, and families. An *ethics consultation service* is designed to perform this function. Today, virtually every hospital is the U.S. has an ethics consultation service, but there is great variability in terms of the knowledge, skills, and processes brought to bear in performing ethics consultation. Ethics consultation may be the only area in health care in which we allow staff who are not required to meet clear professional standards, and whose qualifications and expertise can vary greatly, to be so deeply involved in critical, often life-and-death decisions.

What is ethics consultation?

For the purposes of this document, we define ***ethics consultation in health care*** as *a service provided by an individual ethics consultant, ethics consultation team, or ethics committee to help patients, staff, and others resolve ethical concerns in a health care setting.*

The goals of ethics consultation

The overall goal of ethics consultation is to *improve health care quality by facilitating the resolution of ethical concerns*. By providing a forum for discussion and methods for careful analysis, effective ethics consultation:

- promotes practices consistent with high ethical standards
- helps to foster consensus and resolve conflict in an atmosphere of respect
- honors participants' authority and values in the decision-making process
- educates participants to handle current and future ethical concerns

A brief history of ethics consultation

Ethics consultation in health care settings dates back nearly 35 years. In the 1970s the first consultation services were established. In the 1980s a professional society devoted to ethics consultation was formed, and the first books on ethics consultation were published. (Cranford, 1984; Fletcher, 1989) In the mid-1990s a national consensus conference described goals of ethics consultation and methods for evaluating its quality and effectiveness. (*Journal of Clinical Ethics*, special section, 1996)

Today, ethics consultation is widely recognized as an essential part of health care delivery. The vast majority of U.S. hospitals have active ethics consultation services. (Fox, 2007, p. 15) The Joint Commission, which accredits health care organizations, requires that hospitals develop and implement such a process to handle ethical concerns when they arise. (Joint Commission, 2006, Standard RI 1.10) Moreover, ethics consultation has been endorsed by numerous governmental and professional bodies and is legally mandated under specific circumstances in several states. (Tulsky, 1996, p. 112)

The need for an ethics consultation function

Effective ethics consultation has been shown to improve ethical decision making and practice, enhance patient and provider satisfaction, facilitate the resolution of disputes, and increase knowledge of health care ethics. (Dubler, 2004) Moreover, ethics consultation has been shown to save health care institutions money by reducing the provision of nonbeneficial treatments, as well as lengths of stay. (Schneiderman, 2002, p. 1170; Schneiderman, 2000, p. 3922; Dowdy, 1998, p. 256; Heilicser, 2000, p. 35)

It is therefore essential for every health care facility to have an effective local mechanism for responding to ethical concerns—that is, an ethics consultation service. Ethics consultation services handle ethics case consultations as well as other types of consultations, including requests for general information, policy clarification, document review, discussion of hypothetical or historical cases, or ethical analysis of an organizational ethics question.

Organizing ethics consultation

Health care ethics consultation may be performed by an individual ethics consultant, an ethics committee, or an ethics consultation team. The team model is most commonly used: two-thirds

of hospitals in the United States indicate that they use this model more commonly than they do either the individual or the committee model. (Fox, 2007, p. 18) However, each model has advantages and disadvantages. Although some ethics consultation services might rely exclusively on one of these three models, we recommend against this, since all three models have their place. Instead, *for **each** consultation, the ethics consultation service should determine which model is most appropriate given the particular request*. For example, some consultations can be best addressed by an individual consultant and some by the ethics committee or ethics consultation team model. Ethics consultation services should have consistent processes for determining how different types of consultations will be handled.

Proficiencies required for ethics consultation

In 1998, the American Society for Bioethics and Humanities (ASBH) published a report entitled *Core Competencies for Health Care Ethics Consultation.* (American Society of Bioethics, 1998) That report discusses the knowledge, skills, and character traits required for ethics consultation. The *Core Competencies* report notes that when an individual consultant performs ethics consultation, the consultant must have advanced knowledge and skills across multiple areas. In contrast, when the team or committee model is used, requisite knowledge and skills can be distributed across the various members of the group. We agree with that assessment but note that the greater the collective expertise in an ethics consultation service, the more useful and effective that service will be.

Recently, the ASBH formed a Task Force to produce an updated version of the *Core Competencies* report. The original report was significantly revised, and relies heavily on the IntegratedEthics model. As noted in the revised draft, "Resources from the VA's National Center for Ethics in Health Care are prominently featured in this version of the *Core Competencies*." We endorse the recommendations of the updated *Core Competencies* report, which will soon be available on the ASBH Web site at www.asbh.org.

Critical success factors for ethics consultation

In complex organizations certain factors are generally predictive of the likelihood that a specialized service will achieve its goals. To provide an effective mechanism for addressing ethical concerns in health care, a consultation service must have *integration, leadership support, expertise, staff time*, and *resources. Access, accountability, organizational learning*, and *evaluation* are additional factors that should be ensured. Because all these factors are critical for the success of ethics consultation services, each should be addressed in *policy.*

The CASES Approach

We at the National Center for Ethics in Health Care designed the CASES approach as a practical, systematic, step-by-step approach to ethics consultation. The CASES steps were designed to guide ethics consultants through the complex process needed to effectively respond to ethical questions and concerns.

The steps of the CASES approach are detailed in Figure 2. They are intended to be used in much the same way that clinicians use a standard format for taking a patient's history, performing a physical exam, or writing up a clinical case. For a detailed explanation of the CASES approach, refer to: www.ethics.va.gov/docs/integratedethics/Ethics_Consultation_Responding_to_Ethics_Questions_in_Health_Care_20070808.pdf.

FIGURE 2

ETHICS CONSULTATION:
Responding to Ethics Questions in Health Care

The CASES Approach

CLARIFY the Consultation Request
- Characterize the type of consultation request
- Obtain preliminary information from the requester
- Establish realistic expectations about the consultation process
- Formulate the ethics question

ASSEMBLE the Relevant Information
- Consider the types of information needed
- Identify the appropriate sources of information
- Gather information systematically from each source
- Summarize the case and the ethics question

SYNTHESIZE the Information
- Determine whether a formal meeting is needed
- Engage in ethical analysis
- Identify the ethically appropriate decision maker
- Facilitate moral deliberation about ethically justifiable options

EXPLAIN the Synthesis
- Communicate the synthesis to key participants
- Provide additional resources
- Document the consultation in the health record
- Document the consultation in consultation service records

SUPPORT the Consultation Process
- Follow up with participants
- Evaluate the consultation
- Adjust the consultation process
- Identify underlying systems issues

IntegratedEthics includes tools to assist practitioners in using the CASES approach. These include a trifold pocket card for easy reference; the card outlines the details of each step in

CASES and is available at www.ethics.va.gov/IntegratedEthics. ECWeb, a secure internet hosted database, reinforces the CASES approach, helps ethics consultants manage consultation records, and supports quality improvement efforts. IntegratedEthics also provides assessment tools and educational materials to help consultants enhance their proficiency and to improve the overall effectiveness of the consultation team. The IntegratedEthics tools will be described in more detail in a subsequent paper.

The following section is excerpted from the internal VA publication entitled **Preventive Ethics: Addressing Ethics Quality Gaps on a Systems Level** by Ellen Fox, Melissa Bottrell, Mary Beth Foglia, and Rebecca Stoeckle. Available at: www.ethics.va.gov/integratedethics/PEC.asp

PREVENTIVE ETHICS: Addressing Ethics Quality Gaps on a Systems Level

In addition to responding to individual ethics questions as they arise, it is essential that organizations address the underlying systems and processes that influence ethical behavior. Every ethics program needs a systematic approach for proactively identifying, prioritizing, and addressing concerns about ethics quality at the organizational level. That is the role of the IntegratedEthics preventive ethics function.

What is preventive ethics?

In the IntegratedEthics model, we define ***preventive ethics*** as *activities performed by an individual or group on behalf of a health care organization to identify, prioritize, and address systemic ethics issues.*

We define an ***ethics issue*** as an ongoing situation involving organizational systems and processes that gives rise to ethical concerns, i.e., that gives rise to uncertainty or conflicts about values. We use the term "ethics issues" to distinguish systemic ethical problems from the more familiar concept of "ethics cases." Ethics issues differ from ethics cases in that issues describe ongoing situations, while cases describe events that occur at a particular time; in addition, issues involve organizational systems and processes, while cases involve specific decisions and actions by individuals.

To help illustrate the difference, imagine a conflict about withdrawing a ventilator from a post-operative patient: the family wants the ventilator removed, but the neurosurgeon thinks removal would be premature. The parties might request an ethics consultation to help them decide what to do about the individual patient case. But what if this were not the first time this sort of situation had come to the attention of the ethics consultation service? What if it were typical of many consultations involving neurosurgery patients? In such circumstances, responding specifically to questions about the particular situation (i.e., through ethics consultation) is not enough. What is needed is a systematic approach to addressing the underlying systems and

processes that repeatedly give rise to similar ethical concerns. That is the role of preventive ethics.

Preventive ethics is not restricted to ethics issues in clinical care but is relevant to a whole host of issues. For example, it might be used to address ethics quality gaps in personnel practices, fiscal management, or protection of research subjects.

The goal of preventive ethics

The overall goal of preventive ethics is to *improve quality by identifying, prioritizing, and addressing ethics quality gaps on a systems level.* The more specific aim is to produce measurable improvements in the organization's ethics practices by implementing systems-level changes that reduce disparities between current practices and best practices in the relevant area. Preventive ethics applies quality improvement techniques to improve ethics quality.

Specific quality improvement interventions in preventive ethics may include:

- redesigning work processes to better support ethical practice
- implementing checklists, reminders, and decision support
- evaluating organizational performance with respect to ethical practices
- developing specific protocols to promote ethical practices
- designing strategies for patients and/or staff to address systemwide knowledge deficits
- offering incentives and rewards to motivate and acknowledge ethical practices among staff

A brief history of preventive ethics

Historically, efforts to improve ethics practices in health care have focused on the three traditional functions of an ethics committee: education, policy development, and consultation on individual patient cases. In recent years, however, there has been growing recognition of how organizational factors influence ethics practices and of the importance of systems thinking.

Organizational factors, such as socialization, environmental pressures, and hierarchical relationships, can "stack the deck" against employees being able to act in accordance with ethical standards. (Smith, 1995, p. 10) Whether an individual can overcome "macro-level obstacles" to ethical behavior created by the structure of a health care institution depends on the interplay of numerous factors, including the likely consequences for the individual, fear of embarrassment, and the actions of others in similar positions in the institution. (Kelman, 1989) Psychological studies suggest that it can be very difficult for an individual to act in accordance with ethical norms and standards if he or she encounters serious organizational barriers. (Worthley, 1997) And while medical ethics has traditionally emphasized individual, patient-level decision making, "the course of care may well be shaped largely by how the care system is organized." (Lynn, 2000, p. p. S215) Of course, how the care system is organized depends not only on clinicians but also on business and office staff, information systems personnel, human resources staff, and others.

The term "preventive ethics," first introduced to the ethics literature in 1993, (Forrow, 1993, p. 289) captures this growing awareness of the organizational dimension of ethics in health care. Preventive ethics calls for "explicit, critical reflection on the institutional factors that influence patient care," and in some instances, "the reform of institutions so that they promote rather than undermine the ethical values important for quality patient care. . . . By drawing attention to factors that lead to dilemmas (such as the institutional structure, unrealistic patient expectations, or different cultural views), preventive ethics can help staff develop mechanisms to avert serious conflicts and to reach ethically defensible plans more readily." (Forrow, 1993, p. 291)

In recent years, efforts to apply systems thinking to ethics in health care have become commonplace. One proposed model, for example, urges ethics committees to "address and 'attack' ethical issues and concerns before conflicts arise and beyond the context of individual cases and their management" and to "move 'upstream' in their orientation and thinking about ethical issues." (Blake, 2000, p. 25) Health care facilities are reporting on their experience with implementing a "performance-improvement organizational ethics role." (Rueping, 2000, p. 51) Today, many agree that "the most exciting prospects for ethics committees and consultants involve integrating them into the quality improvement culture of health care organizations." (Singer, 2001)

With increasing recognition of the importance of systems approaches to ethics in health care, reactive ethics programs that focus primarily on specific ethics cases are no longer adequate. Instead, every health care organization must have an effective preventive ethics function to identify, prioritize, and address ethics quality gaps proactively on a systems level.

The need for a preventive ethics function

Ideally, all health care providers in an organization should be involved in identifying, prioritizing, and addressing ethical issues on a systems level. As a practical matter, however, the preventive ethics function needs to be associated with specific organizational structures and processes. To be effective, every preventive ethics function must have:

- someone to coordinate the function (a preventive ethics coordinator)
- staff to carry out preventive ethics activities
- an organizing structure (a preventive ethics team or teams)
- a specific, systematic approach

Why? Clear leadership for the function is important because preventive ethics doesn't just happen spontaneously; it demands active management. Measuring ethics quality often requires special resourcefulness and effort, since ethical practices are often difficult to objectify or quantify. (Fox in Hanson, 1999; Fox, 1996, p. 132) Unless someone is specifically charged with responsibility for seeking out and addressing systemic ethics issues, such issues tend be neglected. (Walshe, 2004, p. 105; McCarthy, 2006, p. 168) Moreover, because the concept of preventive ethics is relatively new in health care, it may be unfamiliar to staff. Thus, preventive ethics must have champions to explain it and promote it in the organization, as well as workers to carry it out. We know from other contexts that effective health care improvement teams need

strong team leadership and high levels of teamwork (Mills, 2004, p. 159) that individuals or specially convened groups alone cannot provide. Finally, preventive ethics calls for adapting quality improvement methods specifically for ethics in health care. Doing this well requires specialized skills and knowledge and a specific method or process, as well as group learning over time.

Organizing preventive ethics

Preventive ethics encompasses two types of activities to address systemic ethics issues: (1) general maintenance activities and (2) quality improvement cycles.
General maintenance activities typically include:

- periodically updating policies on various ethical practices
- providing regular ethics education for staff
- maintaining continuous readiness relating to ethics for surveys by Joint Commission and other accreditation organizations

In contrast, quality improvement cycles are time-limited interventions targeted toward specific ethics quality gaps.

These two types of activities require different skills and methods and thus are often best carried out by different individuals. Maintenance activities are best carried out by standing committees—for example, many ethics committees have subcommittees devoted to policy, education, and accreditation readiness—whose members develop specialized knowledge and skills over time.

Improvement cycles, however, are best carried out by small, dynamic workgroups that include one or more "core" team members as well as one or more *ad hoc* members who have subject matter expertise in the particular ethics issue being addressed. The core team members should be carefully selected to ensure they have the proficiencies needed for quality improvement cycles (see discussion of proficiencies below).

Bringing ethics maintenance activities and ethics quality improvement cycles together under a preventive ethics umbrella helps to ensure that they are effectively coordinated and that systems thinking is applied to all the components of preventive ethics. Ethics maintenance activities can benefit from a quality improvement approach. For example, instead of carrying out an educational program for education's own sake, a preventive ethics approach targets educational activities to address identified quality gaps (e.g., clinical staff have significant misconceptions about the appropriate use of life-sustaining treatment), sets specific goals (e.g., 80% of clinical staff will complete the training and score at least 70 on the post-test), and then evaluates the effectiveness of the activities in meeting those goals. A quality improvement mindset is similarly useful when developing or updating policy or ensuring that the health care organization maintains accreditation readiness with respect to ethics standards.

At the same time, the broad institutional perspective and special skills of those who carry out ethics maintenance activities can inform and enhance the work of those who carry out ethics

quality improvement cycles. For example, in the course of addressing an ethics quality gap in employee privacy, the preventive ethics team might identify the need for a new policy in this area and request assistance from the group responsible for maintaining ethics policy.

Proficiencies required for preventive ethics

To be able to address ethics quality gaps at a systems level, every preventive ethics team should include individuals with:

- knowledge of quality improvement principles, methods, and practices
- knowledge of relevant organizational environment(s)
- knowledge of organizational change strategies
- knowledge of ethics topics and concepts
- skill in moral reasoning
- skill in systems thinking

Critical success factors for preventive ethics

To be effective, the preventive ethics function requires adequate *integration, leadership support, expertise, staff time,* and *resources.* Critical success factors also include *access, accountability, organizational learning,* and *evaluation.* Because all these factors are critical to the success of preventive ethics, they should be set out in *policy.*

The ISSUES Approach

We at the National Center for Ethics in Health Care designed the ISSUES approach as a step-by-step method to help preventive ethics teams improve the systems and processes that influence ethics practices in a health care organization. While the organization's quality management staff may use standard QI methods, such as "Plan-Do-Study-Act" (PDSA), to address clinical or managerial quality issues, ISSUES is designed specifically to address ethics quality issues. The steps of the ISSUES approach are summarized in Figure 3. For a more detailed description see: www.ethics.va.gov/docs/integratedethics/Preventive_Ethics_Addressing_Ethics_Quality_Gaps_on_a_Systems_Level_20070808.pdf.

FIGURE 3

Preventive Ethics:
Addressing Ethics Quality Gaps on a Systems Level

The ISSUES Approach

IDENTIFY an Issue
- Identify ethics issues proactively
- Characterize the type of issue
- Clarify each issue by listing the improvement goal

STUDY the Issue
- Diagram the process behind the relevant practice
- Gather specific data about best practices
- Gather specific data about current practices
- Refine the improvement goal to reflect the ethics quality gap

SELECT a Strategy
- Identify the major cause(s) of the ethics quality gap—do a root cause analysis
- Brainstorm about possible strategies to narrow the gap
- Choose one or more strategies to try

UNDERTAKE a Plan
- Plan how to carry out the strategy
- Plan how to evaluate the strategy
- Execute the plan

EVALUATE and Adjust
- Check the execution and the results
- Adjust as necessary
- Evaluate your ISSUES process

SUSTAIN and Spread
- Sustain the improvement
- Disseminate the improvement
- Continue monitoring

As with the other core functions, IntegratedEthics includes practical tools to support the implementation of preventive ethics. These include a pocket card for instant reference, a video course which includes training exercises, both of which are available at www.va.ethics.gov/IntegratedEthics. Also included are standardized ISSUES logs, storyboards, and outlines.

The following section is excerpted from the internal VA publication entitled: **Ethical Leadership: Fostering an Ethical Environment and Culture** by Ellen Fox, Bette-Jane Crigger, Melissa Bottrell, and Paul Bauck. Available at: www.ethics.va.gov/integratedethics/ELC.asp

ETHICAL LEADERSHIP: Fostering an Ethical Environment and Culture

The third core function of IntegratedEthics is ethical leadership, which addresses ethics quality at the level of organizational environment and culture. Leaders in any health care system have obligations as health care providers and as managers. As health care providers, they have an obligation to meet the health care needs of individual patients. In addition, as managers of both health care professionals and other staff, leaders are responsible for creating a workplace culture based on integrity, accountability, fairness, and respect. (Joint Commission, 2006, Standard RI 1.10)

To fulfill these roles, leaders must meet their own ethical obligations and ensure that employees throughout the organization are supported in adhering to high ethical standards. Because the behavior of individual employees is influenced by the culture in which they work, the goal of ethical leadership is to foster an ethical environment and culture.

Although much has been written about ethics and leadership, there is little practical, how-to advice for leaders who wish to improve ethics quality in their organizations. IntegratedEthics seeks to fill that void by drawing on and complementing scholarly discussions of ethical leadership in ways that can inform health care leaders' day-to-day practices. We combine insights from ethicists and managers to provide a practical model. Our aim is offer helpful guidance, not to engage in a thorough conceptual exploration of ethics in health care or leadership. By leaders, we primarily mean staff at the executive leadership to mid-manager levels, although leaders at all levels of health care organizations may find this approach useful.

What is ethical leadership?

The phrase 'ethical leadership' is redundant. Leadership can't exist without ethics . . . and ethics can't exist without leadership.

– Sonny Perdue

While virtually everyone agrees that ethics is at the heart of leadership, there is no single, widely accepted understanding of just what ethical leadership is. "Ethical leadership" (also "moral leadership" or "values-based leadership") is a key concept in the literature of many different fields, including management, (Safty, 2003, p. 85; Herman, 2004) public administration, (Cooper, 2006; Bowman, 1991; Garofalo, 1999) health care management, (Sears, 1998, p. 91;

Dolan, 2004, p. 7; Annison, 1998) business ethics, (Costa, 1998; Gini, 1997, p. 325; Kouzes, 2002) bioethics, (Aroskar, 1994, p. 270; Jonsen, 1987, p. 96; Storch, 2004) and others.

Some writers suggest that the key to ethical leadership is the development of certain moral virtues or character traits. Others associate ethical leadership with specific management styles. Still others take ethical leadership to hinge on how leaders make decisions and thus offer specific philosophical principles and/or models for ethical decision making.

Systematic analysis or scholarly writing on the topic is limited. As one commentator put it:

> For the most part, the discussion of ethics in the leadership literature is fragmented, there is little reference to other works on the subject, and one gets the sense that most authors write as if they were starting from scratch. (Ciulla, 1998)

In the IntegratedEthics model we define ethical leadership as *activities on the part of leaders to foster an ethical environment and culture*. Rarely is it the case that ethical lapses in organizations are due to "rogue employees" or "bad apples" who willfully misbehave. Instead, research shows that the ethical behavior of individuals is profoundly influenced by the environment and culture in which they work. In organizations with a strong ethical culture, the frequency of observed ethical misconduct is dramatically reduced. (Ethics Resource Center, 2000) For this reason, we believe that fostering an organizational environment and culture that makes it easy for employees to "do the right thing" is the key to ethical leadership.

What is an ethical environment and culture?

Research has shown that certain features of an organization's environment and culture predictably affect ethical practices in a positive way. (Treviño, 1999, pp. 132-150) The IntegratedEthics model identifies specific features that characterize an organization with an ethical environment and culture.

In an organization with a healthy ethical environment and culture, virtually everyone:

- appreciates that ethics is important
- recognizes and discusses ethical concerns
- seeks consultation on ethics cases when needed
- works to resolve ethics issues on a systems level
- sees ethics as part of quality
- understands what is expected of him or her
- feels empowered to behave ethically
- views organizational decisions as ethical

How do leaders affect their organization's ethical environment and culture?

> *The task of ethics management is to define and give life to an organization's guiding values, to create an environment that supports ethically sound behavior, and to instill a sense of shared accountability among employees.*
>
> – Lynn S. Paine

Leaders' behavior—including everything a leader says and does—can affect the environment and culture of their organization in obvious or subtle ways. The "primary embedding mechanisms" through which leaders' words and actions shape organizational culture are: (Schein, 2004)

- what leaders pay attention to, measure, and control on a regular basis
- how leaders react to critical incidents and organizational crises
- observed criteria by which leaders allocate scarce resources
- deliberate role modeling, teaching, and coaching
- observed criteria by which leaders allocate rewards and status
- observed criteria by which leaders recruit, select, promote, retire, and ostracize organizational members

The messages leaders send through these primary mechanisms are reinforced through such additional means as organization design and structure, systems and procedures, the design of physical space, and the organization's rituals, stories, legends, and myths about people and events. (Schein, 2004).

The influence of leadership behavior on the ethical environment and culture of organizations is well documented. Whether that influence is deliberate or unintentional, it is powerful. Employees tend to adjust their own ethical orientations to the behavior they observe among leaders in their organization. Research has shown, in fact, that—astonishingly!—"most leaders are significantly more likely to lower their subordinates' ethical standards than to elevate them." (Jukiewicz, 2006, p. 247) To counteract this tendency, leaders must take proactive steps to foster an ethical environment and culture.

Fostering an ethical environment and culture

Research has shown that leaders play a critical role in creating, sustaining, or changing all aspects of organizational culture, including ethical culture. For example, one survey found that:

> Where employees perceived that supervisors and executives regularly pay attention to ethics, take ethics seriously, and care about ethics and values as much as the bottom line, all of the outcomes were significantly more positive. (Treviño, 1999, p. 148)

Other research on the relationship between ethical culture and ethical practice has shown that specific ethics-related actions by leaders (such as talking about the importance of ethical behavior or setting a good example for ethical practice) are strongly associated with desired outcomes (such as lower rates of observed ethical misconduct, fewer situations inviting ethical misconduct, and higher levels of overall employee satisfaction with the organization). (Treviño, 2003, pp. 25-35) How leaders behave displays for employees what is acceptable (or accepted) conduct in the workplace. Leaders are role models as much by virtue of their status and role within the organization and their power to affect others as they are by virtue of their personal character or leadership style. To be an effective ethical leader, an individual:

> must be viewed as an attractive, credible, and legitimate role model who engages in normatively appropriate behavior and makes the ethics message salient. . . . Explicit ethics-related communication and reinforcement contribute to the salience of the leader's ethics message. (Brown, 2005, p. 130)

Being personally morally upright is surely essential, but leaders must recognize that their own virtuous character, even coupled with self-conscious role modeling, isn't enough to guarantee an ethical environment and culture. In fact, a morally deficient organizational culture can prevail despite the best intentions of morally upright managers. (Giganti, 2004, p. 10) As one major corporate leader put it:

> I thought we were in control. In reality, the organization was decaying at its core, and many of my managers and employees knew this. But no one told me. (Kaptein, 2005, p. 302)

It isn't unusual for leaders to assume everything is fine from an ethical perspective when in fact it is not. Research has shown that perceptions of organizational ethics are "lovely at the top" – that is, the higher the level of leadership, the "rosier" the perceptions of organizational ethics. (Treviño, 1999, p. 140) One of the most important things leaders must understand about their influence on the organization's ethical environment and culture is that they can inadvertently encourage or endorse unethical behavior despite their best intentions and even without being aware they are doing so. This can happen in any of several ways, such as:

> **Failing to link performance incentives to ethical practice**. When leaders create strong incentives to perform in certain areas without creating equally strong incentives to adhere to ethical practice in achieving the desired goals, they set the stage for ethical lapses. Lopsided incentives can leave employees feeling pressured to do whatever it takes to "make the measure" even when doing so raises ethical concerns. Leaders need to incentivize ethical practice just as they incentivize other behaviors. (Wynia, 1999, p. 297)
>
> **Overemphasizing compliance with legal standards**. Paradoxically, when leaders put too much emphasis on legal compliance, they can actually encourage unethical practice. Employees must know, understand, and adhere to law, regulation, and policy, of course. However, studies have shown that an organizational culture that emphasizes obedience to authority and following the rules is associated with more unethical behavior than a

culture that emphasizes individual employee responsibility and acting on the basis of organizational values. (Treviño, 1999, p. 148)

The way a supervisor uses incentives can encourage ethical or unethical behavior. When a supervisor tells employees to reach the goal as quickly as possible and that he/she doesn't want to know how they do it—that just encourages unethical behavior.

– Focus group, VA leaders

Setting unrealistic expectations for performance. When leaders set unrealistic or unattainable goals they invite employees to game the system or misrepresent results. When leaders fail to take into account organizational barriers to achieving performance expectations, they may inadvertently set up situations in which the only way to "succeed" is by engaging in behavior that employees know is wrong. In such cases, employees are likely to become cynical, especially when they believe that those who are lauded for their performance have compromised their integrity in order to get there. (Ethics Resource Center, 2000)

Inappropriately blaming individuals. Leaders have a responsibility to hold employees accountable for their actions in the organization. But when leaders blame individuals for outcomes those employees can't control or that result from flawed organizational processes and systems, this too sends a message that ethics doesn't matter much. When a particular individual is singled out for behavior that is known to be common and widely tolerated in the organization, this gives the impression that leaders care more about protecting themselves than being fair. Further, when employees are penalized for doing things that are intended to promote the organization's mission and values, the problem is compounded; employees perceive that political expedience can trump ethical practice. (Arthur Anderson Co., 1999).

The real problem is that ethics takes a back seat to political or operational practicalities when people get punished in some way for doing what they think is the right thing from the perspective of organizational mission and values.

– Focus group, VA leaders

When leaders care more about good performance numbers than accurate performance numbers, focus on accreditation requirements as simply a compliance burden, issue orders that are impossible to fulfill, or look for scapegoats to blame for a crisis, they send messages that have powerful effects in shaping the organization's environment and how staff members perceive the organization, their place in it, and the behaviors that are valued.

Ethical leadership, then, requires a great deal more than high ideals and good intentions; it requires commitment and proactive effort. An ethical environment and culture don't just happen spontaneously; they must be developed and nurtured. Leaders need to treat ethics the same way

they treat other organizational priorities. That is, they need to utilize all the tools at a leader's disposal to influence organizational performance—such as defining clear lines of accountability, establishing and using formal program structures and processes, communicating formally and informally with staff, aligning incentive systems with desired results, and allocating staff, resources, and personal time.

If leaders are to meet the challenge of fostering an ethical environment and culture, it is essential that they cultivate specific knowledge, skills, and habits required to demonstrate true ethical leadership.

The ethical leadership function of IntegratedEthics calls on leaders to observe four "compass points," as illustrated in Figure 4. The ethical leadership compass applies insights and principles from organizational and business ethics to leadership in the context of health care ethics. It is specifically designed to help leaders orient themselves to their unique responsibilities in the terrain of ethics in health care, and to provide practical guidance to help them address the challenges of fostering an environment and culture that support ethical practices across their organizations. A more detailed description of the Four Compass Points is available at: www.ethics.va.gov/docs/integratedethics/Ethical_Leadership_Fostering_an_Ethical_Environment_and_Culture_20070808.pdf

FIGURE 4

ETHICAL LEADERSHIP:
Fostering an Ethical Environment and Culture

The Four Compass Points

Demonstrate that ethics is a priority
- Talk about ethics
- Prove that ethics matters to you
- Encourage discussion of ethical concerns

Communicate clear expectations for ethical practice
- Recognize when expectations need to be clarified
- Be explicit, give examples, explain the underlying values
- Anticipate barriers to meeting your expectations

Practice ethical decision making
- Identify decisions that raise ethical concerns
- Address ethical decisions systematically
- Explain your decisions

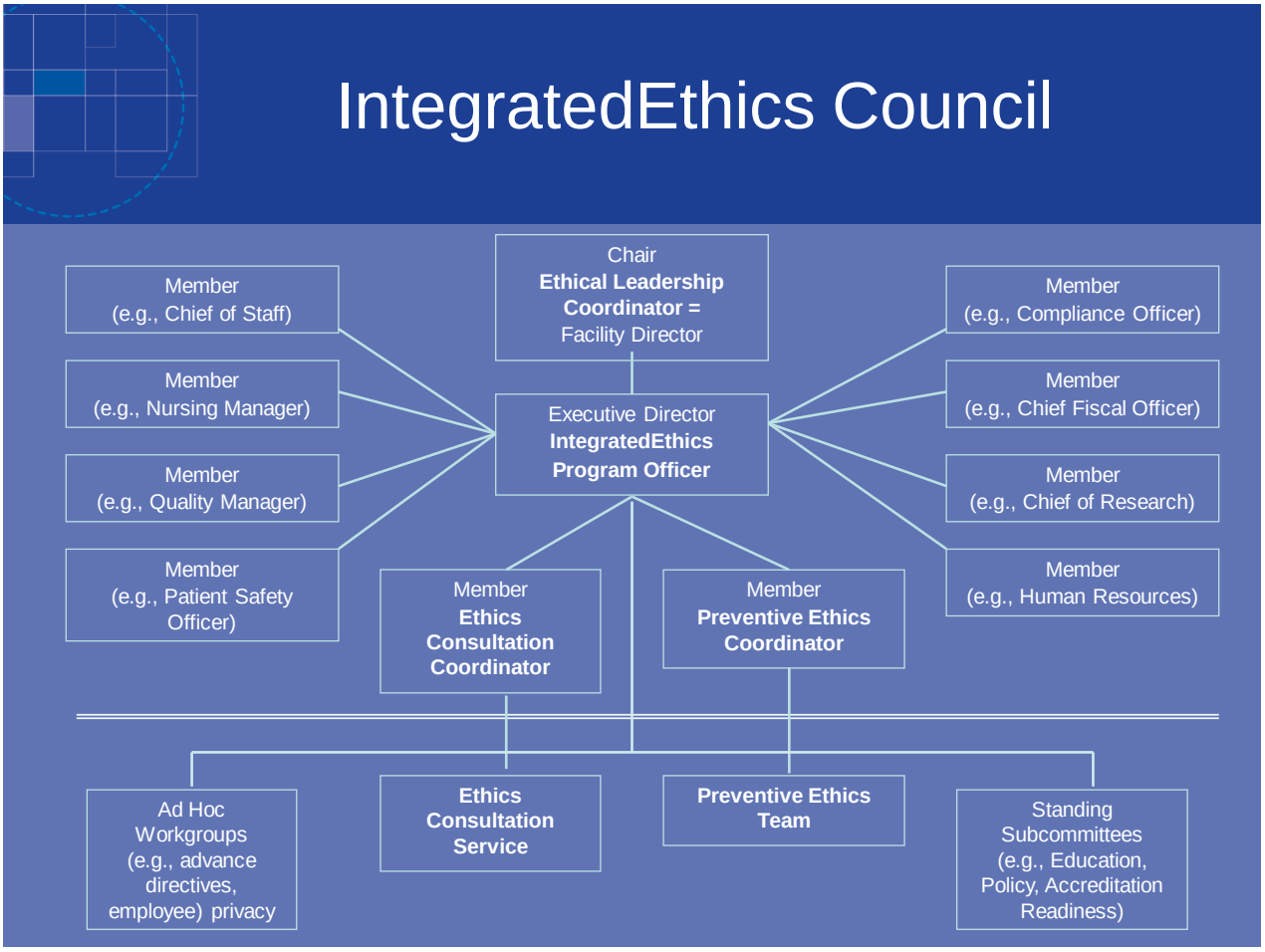
Support your local ethics program
- Know what your ethics program is and what it does
- Champion the program
- Support participation by others

As with the other components of IntegratedEthics, the ethical leadership function is supported by tools and educational materials. These include a compass point bookmark for quick reference, a video course, and a self-assessment tool, all of which are available at www.ethics.va.gov/IntegratedEthics.

IntegratedEthics Program Structure

An IntegratedEthics program has two essential tasks. First, the program must move ethics into the organizational mainstream; second, it must coordinate ethics-related activities throughout the organization. This requires more than simply implementing the three core functions. It also requires strong leadership support, involvement of multiple programs, and clear lines of accountability. These requirements are reflected in the structure of the IntegratedEthics Council as shown in Figure 5.

FIGURE 5



The **IntegratedEthics Council** provides the formal structure for the program at the facility level. The council oversees the implementation of IntegratedEthics, the development of policy and

education relating to IntegratedEthics, and the operation of IntegratedEthics functions. The Council also ensures the coordination of ethics-related activities throughout the facility.

The **Ethical Leadership Coordinator** is the medical center director. The Coordinator ensures the overall success of the program by chairing the IntegratedEthics Council, championing the program, and directing the ethical leadership function.

The **IntegratedEthics Program Officer** is responsible for the day-to-day management of the program and reports directly to the Ethical Leadership Coordinator. The Program Officer works closely with the chair of the Council, functioning as an executive director, administrative officer, or co-chair. The Program Officer should be a skilled manager and a well-respected member of the staff.

The membership of the Council also includes the **Ethics Consultation Coordinator** and the **Preventive Ethics Coordinator**, who lead the ethics consultation service and preventive ethics team, respectively. Each role requires specific knowledge and skills.

Finally, the Council includes **leaders and senior staff** from programs and offices that encounter ethical concerns. For example, Council membership may include the chief of staff, associate chiefs of staff, chief fiscal officer, patient safety officer, human resources director, information security or privacy officer, compliance officers, nursing representatives, and the like.

In addition to overseeing the ethics consultation service and preventive ethics team, the Council may also oversee standing subcommittees addressing, for example, policy, education, or accreditation readiness. The Council may also establish *ad hoc* workgroups to address specific topics identified by the Council or other facility personnel.

Another important responsibility of the Council is to ensure the IntegratedEthics program achieves annual implementation goals and performance measures, as well as timely completion of two measurement tools designed to provide an overall assessment of ethics quality: the IntegratedEthics Facility Workbook and the IntegratedEthics Staff Survey. The Facility Workbook is a self-assessment completed annually by facility teams, and the IntegratedEthics Staff Survey is an all-employee survey administered every other year. Both tools help facilities evaluate current ethics quality, identify strengths as well as opportunities for improvement, set goals, and develop quality improvement plans.

Because VA's health care system is so large, it requires extra layers of IntegratedEthics management. The VHA health care delivery system is organized into regional networks of institutions; at this level, IntegratedEthics is coordinated by the **IntegratedEthics Point of Contact**, who reports directly to the network director or a regional leadership council. In addition, an **IntegratedEthics Board** helps to address ethical issues on a network level, especially those issues common to multiple facilities.

New Paradigm for Ethics in Health Care

In summary, the IntegratedEthics Model represents a fundamental departure from the traditional ethics committee model, remedying many of its shortcomings:

Traditional Ethics Committee Model	IntegratedEthics Model
Isolated Committee	Integrated Program
Narrowly focused	Comprehensive
Purpose vague	Purpose clear
Functions based on tradition	Functions derived from purpose
One-size-fits-all structure	Structures tailored to functions
Ad hoc approach	Clear standards
Reactive	Proactive
Case-based	Systems-oriented
No performance metrics	Clear performance metrics

IntegratedEthics refocuses an organization's approach to ethics in health care from a reactive, case-based endeavor in which various aspects of ethics (e.g., clinical, organizational, professional, research, business, government) are handled in a disjointed fashion, into a proactive, systems-oriented, comprehensive approach. It moves ethics out of institutional silos into collaborative relationships that cut across the organization. Its comprehensive approach to ethics encompasses all three levels of the "iceberg," the full range of ethics content domains, and both rules- and values-based approaches to ethics. This practical, structured, systems-oriented, results-driven approach is designed to translate theory into practice – and make ethics an integral part of what goes on in health care organizations every day.

IntegratedEthics represents a paradigm shift: a new way of thinking about ethics. By envisioning new ways of looking at ethical concerns in health care, new approaches for addressing them in all their complexity, and new channels for achieving integration across the system, IntegratedEthics empowers organizations and their employees to "do the right thing" *because* it is the right thing to do.

Disclaimer

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The **corresponding author** and **contributing authors** held significant roles in the original conceptualization and development of the core intellectual content of IntegratedEthics and original tools. A subsequent paper will describe the various strategies and tools used to implement the model and how these were expanded and improved over time.

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References

American Academy of Pediatrics, Committee on Bioethics. 2001. "Institutional Ethics Committees". *Pediatrics,* 107(1): 205-209.

American Hospital Association. 1985. "Ethics committees double since '83: Survey". *Hospitals.* 59(Nov. 1):60-61.

American Society for Bioethics and Humanities. 1998. *Task Force on Standards for Bioethics and Consultation, Core Competencies for Health Care Ethics Consultation: The Report of the American Society for Bioethics and Humanities.* Glenview, IL: American Society for Bioethics and Humanities.

Annison M.H. and D. Willfond. 1998. *Trust Matters: New Directions in Health Care Leadership.* San Francisco, CA: Jossey-Bass.

Aroskar M.A. 1994. "The challenge of ethical leadership in nursing". *Journal of Professional Nursing,* 10(5):270.

Arthur Anderson Co. 1999. *Ethical Concerns and Reputation Risk Management: A Study of Leading U.K. Companies.* London, U.K.: London Business School.

Blake D.C. 2000. "Reinventing the healthcare ethics committee". *HEC Forum,* 12(1):8-32.

Bowman J.S. (ed.). 1991. *Ethical Frontiers in Public Management: Seeking New Strategies for Resolving Ethical Dilemmas.* San Francisco, CA: Jossey-Bass.

Brown M.E., L. Treviño, D. Harrison. 2005. "Ethical leadership: A social learning perspective for construct development and testing". *Organizational Behavior and Human Decision Processes,* 97:117-134.

Ciulla J.B. 1998. *Ethics, The Heart of Leadership.* Westport, CT: Praeger Publishers.

Cooper T.L. 2006. *The Responsible Administrator: An Approach to Ethics for the Administrative Suite* (5th ed.). San Francisco, CA: Jossey-Bass.

Costa J.D. 1998. *The Ethical Imperative: Why Moral Leadership Is Good for Business.* Reading, MA: Perseus Books.

Cranford R.E. and A. Doudera (eds.). 1984. *Institutional Ethics Committees and Health Care Decision Making.* Ann Arbor, MI: Health Administration Press.

Dictionary.com, "ethics," in *Dictionary.com Unabridged*. Available at http://dictionary.reference.com (accessed 18 August 2010).

Dolan T.C. 2004. "A time for ethical leadership: ACHE affiliates can provide the moral leadership our nation's healthcare system needs". *Healthcare Executive,* 19(1):6-8.

Donabedian A. 1979. "The quality of medical care: A concept in search of a definition". *Journal of Family Practice,* 9(2):277–84.

Dowdy M.D., C. Robertson, J. Bander. 1998. "A study of proactive ethics consultation for critically and terminally ill patients with extended lengths of stay". *Critical Care Medicine,* 26(11):252-259.

Dubler N. and C. Liebman. 2004. *Bioethics Mediation: A Guide to Shaping Shared Solutions.* New York, NY: United Hospital Fund.

Ethics Resource Center. 2000. *2000 National Business Ethics Survey.* Available at http://www.ethics.org/resource/2000-national-business-ethics-survey-nbes (accessed 18 August 2010).

Fletcher, J.C. and D. Hoffmann. 1994. "Ethics Committees: Time to Experiment with Standards". *Annals of Internal Medicine,* 120(4):335-338.

Fletcher J.C., N. Quist, A. Jonsen (eds.). 1989. *Ethics Consultation in Health Care.* Ann Arbor, MI: Health Administration Press.

Foglia M.B., R. Pearlman, M. Bottrell, J. Altemose, E. Fox, 2009. "Ethical challenges within Veterans Administration healthcare facilities: perspectives of managers, clinicians, patients, and ethics committee chairpersons". *American Journal of Bioethics,* 9(4):28-36.

Forrow L., R. Arnold, L. Parker. 1993. "Preventive ethics: Expanding the horizons of clinical ethics". *Journal of Clinical Ethics,* 4(4):287-294.

Fox E. "Rethinking doctor think". In Hanson M.J. and D. Callahan (eds.). 1999. *The Goals of Medicine: The Forgotten Issue in Health Care Reform.* Washington, DC: Georgetown University Press.

Fox E. and R. Arnold. 1996. "Evaluating outcomes in ethics consultation research". *Journal of Clinical Ethics,* 7(2):127–38.

Fox E., S. Myers, R. Pearlman. 2007. "Ethics consultation in U.S. hospitals: A national survey". *American Journal of Bioethics,* 7(2):13-25.

Garofalo C. and D. Geuras. 1999. *Ethics in the Public Service: The Moral Mind at Work.* Washington, DC: Georgetown University Press.

Gebler D. 2006. "Is your culture a risk factor?" *Business & Society Review,* 111:337–362.

Giganti E. 2004. "Organizational ethics is 'systems thinking'". *Health Progress,* 85(3):10-11.

Gini A. 1997. "Moral leadership: An overview". *Journal of Business Ethics,* 16(3):323-330.

Heilicser B.J., D. Meltzer, M. Siegler. 2000. "The effect of clinical medical ethics consultation on healthcare costs". *Journal of Clinical Ethics,* 11(1):31-38.

Herman R.D. 2004. *The Jossey-Bass Handbook of Nonprofit Leadership and Management* (2d ed.). San Francisco, CA: Jossey-Bass.

Hoffmann D.E. 1993. "Evaluating Ethics Committees: A View from the Outside". *Milbank Quarterly,* 71:677-701.

Interview with John Gosbee, M.D., Human factors engineering and healthcare specialist, National Center for Patient Safety, Department of Veteran Affairs. Available at http://depts.washington.edu/labweb/Education/ContEdu/interview_JGosbee.pdf (accessed 8 August 2010).

Jeurrisen R. "Moral complexity in organizations". In Korthals M. and R. Bogers (eds.). 2003. *Proceedings of the Frontis Workshop on Ethics for Life Sciences.* Wageningen, The Netherlands; May 18–21, 2003. Available at www.library.wur.nl/frontis/ethics (accessed 6 August 2010).

Joint Commission on Accreditation of Healthcare Organizations. 2006. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Oakbrook Terrace, IL: Joint Commission on the Accreditation of Healthcare Organizations.

Joint Commission on Accreditation of Healthcare Organizations. 1992. *Comprehensive Accreditation Manual for Hospital*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations.

Jonsen A.R. 1987. "Leadership in meeting ethical challenges". *Journal of Medical Education,* 62(2):95-99.

Journal of Clinical Ethics special section. 1996. "Evaluation of case consultation in clinical ethics". *Journal of Clinical Ethics,* 7(2):109-149.

Jurkiewicz C.L. 2006. "Soul food: Morrison and the transformative power of ethical leadership in the public sector". *Public Integrity,* 8(3):245-256.

Kelman H.C. and V. Hamilton. 1989. *Crimes of Obedience.* New Haven, CT: Yale University Press.

Kouzes J.M. and B. Posner. 2002. *The Leadership Challenge* (3d ed.). San Francisco, CA: Jossey-Bass.

Lynn J., H. Arkes, M. Stevens et al. 2000. "Rethinking fundamental assumptions: SUPPORT's implications for future reform". *Journal of the American Geriatric Society*, 48(5 Suppl):S214-S221.

McCarthy D. and D. Blumenthal. 2006. "Stories from the sharp end: Case studies in safety improvement". *Milbank Quarterly*, 84(1):165-200.

McGee G., J. Spanogle, A. Caplan, D, Asch. 2002. "A national study of ethics committees". *American Journal of Bioethics*, 1(4):74–80.

McGee G., J. Spanogle, A. Caplan, D. Penny, D. Asch. 2002. "Successes and Failures of Hospital Ethics Committees: A National Survey of Ethics Committee Chairs". *Cambridge Quarterly of Healthcare Ethics*, 11:87–93.

Mills P.D., and W. Weeks. 2004. "Characteristics of successful quality improvement teams: Lessons from five collaborative projects in VHA". *Joint Commission Journal on Quality and Safety*, 30(3):152-161.

Oak J.C. "Integrating ethics with compliance". Reprinted in *The Compliance Case Study Library.* Alexandria VA: Council of Ethical Organizations 60–76.

Paine L.S. 1994. "Managing for organizational integrity". *Harvard Business Review*, Mar–Apr 106–17.

Pentz R.D. 1999. "Beyond case consultation: an expanded model for organizational ethics". *Journal of Clinical Ethics*, Spring;10(1):34-41.

Rueping J. and D. Dugan. 2000. "A next generation ethics program in progress: Lessons from experience". *HEC Forum*, 12(1):49-56.

Safty A. 2003. "Moral leadership: Beyond management and governance". *Harvard International Review*, 25(3):84-90.

Schneiderman L.J., T. Gilmer, H. Teetzel et al. 2003. "Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: A randomized controlled trial". *Journal of the American Medical Association*, 290(9):1166-1172.

Schneiderman L.J., T. Gilmer, H. Teetzel. 2000. "Impact of ethics consultations in the intensive care setting: A randomized, controlled trial". *Critical Care Medicine*, 28(12): 3920-3924.

Sears H.J. 1998. "Values-based leadership and organizational development during restructuring". *Seminars for Nurse Managers*, 6(2):89-95.

Singer P.A., E. Pellegrino, M. Siegler 2001. "Clinical ethics revisited". *BMC Medical Ethics*, 2(1). Available at http://www.biomedcentral.com/1472-6939/2/1 (accessed 6 August 2010).

Smith K.G., S. Carroll, S. Ashford. 1995. "Intra- and interorganizational cooperation: Toward a research agenda". *Academy of Management Journal*, 38(1):7-23.

Storch J.L., P. Rodney, R. Starzomski (eds.). 2004. *Toward a Moral Horizon: Nursing Ethics for Leadership and Practice.* Toronto, CN: Pearson/Prentice Hall.

Treviño L.K., M. Brown L. Hartman. 2003. "A qualitative investigation of perceived executive ethical leadership: Perceptions from inside and outside the executive suite". *Human Relations*, 55:5-37.

Treviño L.K., G. Weaver, D. Gibson, B. Toffler. 1999. "Managing ethics and legal compliance: What works and what hurts". *California Management Review*, 41(2):131–51.

Tulsky, J.A. and E. Fox. 1996. "Evaluating ethics consultation: Framing the question". *Journal of Clinical Ethics*, 7(2):109-115.

United States Sentencing Commission. 2004. *Guidelines Manual*. Available at www.ussc.gov/2004guid/gl2004.pdf (accessed 12 August 2010).

Walshe K. and S. Shortell. 2004. "When things go wrong: How health care organizations deal with major failures". *Health Affairs*, 23(3):103-111.

Wilson, R.F., M. Neff-Smith, D. Phillips, J. Fletcher. 1993. "Hospital ethics committees: Are they evaluating their performance?" *HEC Forum*, 5(1):1-34.

Worthley J.A. 1997. *The Ethics of the Ordinary in Health Care.* Chicago, IL: Health Administration Press.

Wynia M.K. 1999. "Performance measures for ethics quality". *Effective Clinical Practice*, 2(6):294–99.

Youngner S.J., D. Jackson, C. Coulton, B. Juknialis, E. Smith. 1983. "A national survey of hospital ethics committees". *Critical Care Medicine.* 1983 11(11):902-5.