GOVERNANCE ETHICS IN HEALTHCARE ORGANIZATIONS

Gerard Magill and Lawrence Prybil
Governance Ethics in Healthcare Organizations

Drawing on the findings of a series of empirical studies undertaken with boards of directors and CEOs in the United States, this groundbreaking book develops a new paradigm to provide a structured analysis of ethical healthcare governance.

*Governance Ethics in Healthcare Organizations* begins by presenting a clear framework for ethical analysis, designed around basic features of ethics—who we are, how we function, and what we do—before discussing the paradigm in relation to clinical, organizational, and professional ethics. It goes on to apply this framework in areas that are pivotal for effective governance in healthcare: oversight structures for trustees and executives, community benefit, community health, patient care, patient safety, and conflicted collaborative arrangements.

This book is an important read for all those interested in healthcare management, corporate governance, and healthcare ethics, including academics, students, and practitioners.

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Gerard Magill and Lawrence Prybil

We dedicate this book to our spouses, Marilyn Prybil and Mary Anne Campbell, whose love and support inspired us throughout this work.
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1 Ethics paradigm

Introduction

This book discusses governance ethics in healthcare organizations to provide ethical guidance about trustee oversight. In addition to boards of directors and executives in healthcare, scholars, students, and professionals interested in the governance oversight of organizations will find the book to be enlightening. The analysis combines a theory perspective and an application perspective to develop a structured analysis of governance ethics.

The analysis explains that governance ethics is similar to already established fields in health ethics (clinical, organizational, and professional ethics). The general approach adopted by these established fields combines theoretical and applied perspectives to provide practical guidance. They guide their constituencies on specific issues, such as end of life care in clinical ethics, or financial propriety in organizational ethics, or conflicts of interest in professional ethics. In contrast, governance ethics deals with very different topics that relate to trustee oversight of healthcare organizations, such as with regard to patient safety or community health. Hence, governance ethics can be described as an emerging field in healthcare.

There is a considerable amount of literature on corporate governance.1 This literature includes the relation among corporate governance, ethics (typically dealing with business ethics),2 and corporate social responsibility.3 However, very little has been published on the ethics of governance in healthcare organizations.4 This significant gap in the literature is addressed by this book. To understand the importance of this discussion, it is helpful to consider the need for governance ethics, nationally and internationally.

Need for governance ethics

Over recent decades, public confidence in healthcare organizations has declined significantly. This decline has led to vigorous efforts to improve trust in health care organizations, both public and private.5 At the same time, significant growth of large healthcare systems has occurred. The number of multi-unit health systems, both governmental and private, has increased noticeably. Also, the proportion

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of community hospitals becoming part of health systems continues to expand steadily. This growth has stressed the crucial role of finances in a changing health economy. Not surprisingly, there has emerged a greater awareness of the need for more effective governance. This means that boards of directors and executives need to be more accountable in a manner that is evident to the populations they serve. This constitutes a call for organizational transparency to the communities served by healthcare organizations. Also, the extent of corporate fraud and abuse across the United States is well recognized. Such abuse has led to stricter government regulations. For example, the renowned Sarbanes-Oxley Act was passed with strict compliance requirements. The act sought several goals: to diminish fraudulent financial activity; to enhance the independence of external auditing; and to emphasize the need for better oversight by boards of directors. This legislation applied only to for-profit corporations. Nonetheless, the legislation also reflected concerns about the effectiveness of nonprofit boards. Hence, the legislation prompted trustees to provide better governance leadership. The goal here is to nurture public trust in healthcare organizations.

Public trust is in large measure related to the well-known disparities in healthcare access and affordability. These are exacerbated by the accompanying connection between quality and safety. Historically, these issues have haunted the United States, and continue to do so today. The loss of public trust in these sectors has been widespread and extensively documented. This distrust was especially evident in nonprofit healthcare in relation to the tension between what is known as mission and margin. This tension refers to the organization’s polarized commitment to serve its communities (mission) and the organization’s financial success (margin). For example, this tension challenges healthcare leaders to ensure the success of an organization such as with regard to ethical procurement and resourcing. However, the tension between mission and margin also requires healthcare leaders to care for employees such as with regard to remuneration across professional differences. This tension emphasizes that success should not be reduced merely to management or fiscal efficiencies. In turn, concern about this moral tension raised significant issues related to justice, such as meeting the community’s health needs fairly and holding healthcare morally accountable.

This widespread distrust created challenges for boards of directors in both for-profit and nonprofit sectors. These challenges highlight the need for effective governance that overlaps with but goes beyond compliance requirements. This need was especially the case in healthcare. Moreover, this need for improvement was recognized in many different nations. This international awareness indicated the increasing focus on board function and trustee accountability in hospitals and healthcare systems globally.

Over recent decades, continuous quality improvement became a characteristic of healthcare delivery. The time for continuous improvement of governance accountability in healthcare organizations has arrived. This accountability goes beyond the board’s conventional responsibility for organizational oversight.
Boards of directors now need to scrutinize themselves more closely than ever. This scrutiny must seek to ensure that an organization’s mission, processes, and practices will enable the organization to perform at its peak. As a result, the caliber of governance in healthcare organizations is under intense examination. In particular, there is an acknowledgment of the need for research-based findings to support actionable knowledge that will enhance governance in hospitals and health systems. Similarly, there is a growing recognition that trustees should develop a sophisticated ethical compass to help navigate potential compromises in healthcare institutions.

Obviously, boards of directors with their institutional management teams have complex responsibilities. They are responsible for overseeing a complex array of structures, processes, outcomes, and external regulations. That oversight is necessary to continuously measure, monitor, and improve organizational performance. Board effectiveness lies at the core of governance in the fast-changing environment of healthcare. It is indispensable both to identify responsibilities and to design oversight mechanisms. Without these, trust of internal and external stakeholders will be eroded. This emphasis on a sustainable approach to accountability requires the utmost transparency. That is, healthcare must be resilient in the face of so many challenges. There needs to be greater oversight by trustees and executives to demonstrate organizational accountability in a manner that is evident to the populations served.

The multiple board responsibilities of trustees range from specific fiduciary duties to broader ethical obligations. All of these responsibilities require accountability to the communities served. For example, this means providing access to crucial information about the cost, price, and quality of services to achieve value. Undoubtedly, there are puzzling variations in these data. These variations contribute to widespread public concern. Such concern deals as much with the efficiency of healthcare organizations as with the effectiveness of their leadership, including governance. Hence, healthcare organizations must be increasingly accountable to their communities. Accountability of trustees means defining expectations and establishing measurement and improvement metrics of governance. This study of governance ethics in healthcare organizations seeks to engage these issues.

The ethics paradigm

The book aims to provide a structured analysis of governance ethics in healthcare organizations by presenting a new ethics paradigm that is applied to pivotal topics. The ethics paradigm provides an original framework for ethical analysis. Typically, books in the established fields of health ethics combine ethical theory with ethical principles to discuss practical topics. Discussions of ethical theory include approaches to ethics reasoning—such as deontology, utilitarianism, and communitarianism. Discussions of ethical principles include different ethical concepts—such as autonomy, beneficence, and justice. A very different approach is adopted in this book. Here, the ethics paradigm develops a more
Ethics paradigm

general approach that underlies ethical theories and principles, by providing a framework for an ethical analysis that does not require formal ethics training or expertise.

The framework of the paradigm guides ethical discourse by providing a structure that coalesces relevant data to interpret specific issues. The core structure of the ethics paradigm revolves around basic features of ethics: who we are, how we function, what we do. These features form a leitmotif throughout the study. The framework includes a focus on decision-making (concentrating on accountability vis-à-vis how we function). However, there is also a broader perspective that deals with stewardship (engaging identity vis-à-vis who we are) and quality (addressing best practices vis-à-vis what we do).

These basic features generate the three components of the ethics paradigm. Each component is related to specific governance contexts. The foundation component (who we are) operates within the context of engaging the healthcare environment. The process component (how we function) operates within the context of undertaking organizational oversight. The practice component (what we do) operates within the context of fostering organizational culture.

These basic features of ethics are indispensable for promoting leadership in governance: leadership regarding institutional identity (who we are); leadership regarding corporate accountability (how we function); and leadership regarding performance quality (what we do). In turn, these leadership features foster specific outcomes: the leadership focus on identity fosters outcomes regarding organizational stewardship of an institution’s mission; the leadership focus on accountability fosters outcomes regarding decision-making via participative deliberation; and the leadership focus on quality fosters outcomes regarding best practices for standards of conduct. Here is a diagram of the ethics paradigm (Table 1.1).

The ethics paradigm is applied throughout the book to discuss topics that are pivotal for governance ethics in healthcare organizations. It can be helpful at the outset to provide an overview of these applied topics.

Applied topics

The theory perspective of the book explains the ethics paradigm (Chapters 1–3). This is complemented by the applied perspective of the book (Chapters 4–9).

<table>
<thead>
<tr>
<th>Components</th>
<th>Foundation component</th>
<th>Process component</th>
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<td>Identity: who we are</td>
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<td><strong>Outcomes</strong></td>
<td>Organizational stewardship of mission</td>
<td>Decision-making via participative deliberation</td>
<td>Best practices for standards of conduct</td>
</tr>
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Table 1.1 Ethics paradigm
In these applied chapters, the ethics paradigm is applied to specific topics that are crucial for governance ethics. Typically, other studies around governance in healthcare organizations focus on finance issues. In contrast, this work focuses on issues related to the healthcare of patients and communities. Naturally, this focus recognizes that finance is an indispensable aspect of board stewardship.

The applied topics begin with a discussion of governance structure for trustees. The subsequent topics consider major issues regarding effective governance in healthcare organizations: community benefit, community health, patient care, and patient safety. These topics are pivotal for governance ethics because they have contributed in no small measure to undermining public confidence in healthcare organizations, both private and public. In turn, these topics lead to an over-arching ethical problem for healthcare governance that deals with conflicted collaborative arrangements: how to distinguish wrongful complicity from legitimate cooperation with activities in other organizations. The discussion ends with a brief concluding chapter on how this approach to governance ethics can foster virtuous organizations in healthcare. Discourse on virtue ethics explains that individuals can become virtuous by connecting moral character, practical wisdom, and laudable actions. Similarly, the ethics paradigm enables an organization to become virtuous by connecting moral character (via the concept of identity, who we are), practical wisdom (via the concept of accountability, how we function), and action (via the concept of quality, what we do).

In these applied chapters, the ethics paradigm is applied to identify hallmarks for governance ethics in healthcare organizations. These hallmarks are accompanied with specific ethical imperatives for boards of directors and executives. These hallmarks and accompanying ethical imperatives, along with the topics engaged in each chapter, are listed regularly, to identify them clearly in the analysis.

The topics that are discussed in the book arose from landmark research reports that have shaped the field. In particular, reports by one of the co-authors of this book (with many other accompanying publications) provide critical data for the ethical analysis. The reports were undertaken with boards of directors and CEOs. The focus was on assessing and improving governance performance. The process provided unprecedented access to many large health systems. This access refers to the information provided by the boards of directors and CEOs of these health systems. The research addressed their governance oversight. For example, one report engaged 14 of the 15 largest health systems in the United States. The information derived from these reports indicates the priority issues identified by these trustees and CEOs for governance of their organizations.

**Conclusion**

This book on governance ethics in healthcare organizations deals with an emerging field that contrasts yet is consistent with the established fields of clinical, organizational, and professional ethics. Specifically, the ethics paradigm is connected with these established fields to examine governance ethics.
The originality of this study is twofold. Its first contribution lies in the way it constructs the ethics paradigm to demonstrate a consistency of ethics discourse in the well-established fields of clinical, organizational, and professional ethics in healthcare. All too often, these fields are perceived to be sufficiently different as to forgo a foundational consistency between them. Its second contribution rests in the way it presents the relatively new field of governance ethics as being consistent with these already established ethics fields in healthcare. Hence, throughout the study, the alignment between these various fields is emphasized to apply the ethics paradigm to governance ethics, thereby unpacking the accompanying moral imperatives that emerge from the topics discussed.

The book is designed to enlighten trustees and executives as well as to provide guidance for scholars, students, and professionals in healthcare. The authors hope that the ethical analysis will be of special interest internationally to boards of directors and executives in healthcare to enhance governance oversight of their organizations.

Notes


Select readings


2 Clinical and organizational ethics

Introduction

The analysis of governance ethics in healthcare organizations in this book is both theoretical and applied. The goal is to foster greater board oversight, focusing on the need for continuous evaluation and evidence-based improvements. This chapter engages the theoretical perspective to explain how the ethics paradigm (that is later applied to governance ethics) is aligned with clinical ethics and organizational ethics. The discussion begins with clinical ethics, which is the more usual landscape for discourse in healthcare.

Clinical ethics

Society could not function well across the spectrum of its interests, conflicts, and dilemmas without a sense of common morality as a foundation for practical decisions, such as about conscientious objection.¹ Common morality might be described as a general awareness that binds ethically serious people across cultures,² with human rights providing an obvious example.³ But this awareness does not mean there is readily accessible agreement when discussing specific issues. Indeed, there is no uniformity about how to describe this basic sense of morality, especially when seeking shared solutions to build consensus.⁴ Hence, various accounts of morality are provided by different ethical theories, which, in turn, develop ethical principles to guide reasoning and decision-making. These theories and principles are manifest extensively in clinical ethics.

Ethical theories and principles

There are many theories that shape the debate about ethics in healthcare. Utilitarianism is the ethical theory that ascertains whether an action is right or wrong based upon its consequences. Consequentialism is a related theory. Utility and consequences are central concepts in these approaches. Deontology or deontological ethics is the theory that ascertains whether an action is right or wrong based upon universal maxims that apply to all cases of the same kind, independent of consequences. Duty is a central concept in this approach. Liberal Individualism

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Clinical and organizational ethics

is a theory that is based upon rights to justify claims that individuals or groups can make upon others. The concept of rights is central in this approach. Communitarianism is a theory based upon a view of the community that celebrates the general welfare or common purposes. The concept of solidarity is central in this approach. The Ethics of Care is another ethical theory that is based upon traits of personal relationships, such as compassion, fidelity, and love. Virtue ethics combines insights from other ethical theories to connect moral character, practical wisdom, and laudable actions. Many other ethical theories have been developed, such as on Casuistry, Feminist Ethics, Natural Law, Situational Ethics, or Teleological Ethics.5

A consensus has emerged from these ethical theories about ethical principles to guide moral reasoning and decision-making. In healthcare, a widely adopted explanation can be found in a clustering of four principles of biomedical ethics known as “principlism.” These principles are autonomy, non-maleficence, beneficence, and justice.6 This approach has extensively influenced clinical education.7 Hence, it is helpful to appreciate how these principles impact clinical ethics.

The ethical principle of respect for personal autonomy upholds the individual’s liberty and capacity for intentional action, upon which the crucial concepts of consent, competency, and surrogacy can be based. Also, the ethical principle of non-maleficence asserts the obligation not to inflict harm on others, upon which the central concepts of negligence, standard of care, and non-treatment can be based. Furthermore, the ethical principle of beneficence emphasizes the obligation to act for the benefit of others, upon which the key concepts of paternalism, the quality of life, and balancing burdens can be based. Finally, the ethical principle of justice fosters solidarity, upon which the social concepts of fair opportunity, access to healthcare, resource allocation, and rationing can be based. Integrated with these four ethical principles in healthcare is the clinician-patient relationship, upon which are based the accountability concepts of veracity, privacy, confidentiality, and fidelity in healthcare.8

This link between ethical theory and principle that guide moral reasoning and decision-making provides the landscape for connecting clinical and organizational ethics as well-established fields in healthcare. Each area has developed at a very different pace. Clinical ethics has received the most attention.9 The extensive practice of clinical ethics includes many different arenas, such as clinical research ethics,10 transplant ethics,11 and emerging debates over face and limb transplantation.12 In organizational ethics, though receiving less attention, there has been substantial discourse, including on corporate morality and social responsibility,13 as explained in the following analysis.14 In contrast, little attention has been given to governance ethics that deals with the responsibilities of boards of directors in healthcare organizations. However, there has been a noticeable increase in ethics literature on governance issues in healthcare.15 Furthermore, there has been growing attention to ethical issues around governance in general.16

The theoretical discussion in this section considers how the ethics paradigm (that is applied to governance ethics in subsequent chapters) is aligned with clinical ethics. To explain this alignment, a widely practiced aspect of clinical ethics is
examined: the role of ethics consultation services that facilitate the resolution of dilemmas or value conflicts in patient care.

**Ethics consultation services**

Three characteristics emerged in the development of clinical ethics consultations that are consistent with the ethics paradigm: stewardship, ethics decision-making, and best practices for quality outcomes. Clinical ethics consultations, often described as ethics consultation services, are typically connected with the role of ethics committee in hospitals.17

One characteristic of ethics consultation services deals with stewardship. Historically ethics committees and ethics consultation services required prudent hospital stewardship, reflecting a long tradition of medical stewardship.18 Ethics committees and ethics consultation services developed in the USA after several landmark court cases. In particular, the supreme court of New Jersey’s ruling on the case of Karen Ann Quinlan in 1976 encouraged the development and use of ethics committees as being the appropriate body, rather than legal courts, to resolve treatment dilemmas in complex end-of-life cases.19 Since 1992, The Joint Commission on Accreditation of Healthcare Organizations (known today as the Joint Commission), has had a voluntary process with which hospitals typically comply. This process mandates that accredited hospitals establish an organizational resource like an ethics committee to deal with clinical ethical concerns within the organization. In other words, the courts and the Joint Commission have encouraged healthcare to steward its organizational resources to improve ethics services. As a result, ethics consultation services for a long time have been routine in hospitals.20 These services work closely with the ethics committee,21 focusing increasingly upon quality,22 such as in developing preventive approaches that try to avoid dilemmas emerging.23

Another characteristic of ethics consultation services deals with ethics decision-making processes. These decision-making processes are at the heart of ethics consultation services, constituting what is referred to as an ethics facilitation approach. The work of the ethicist is to facilitate an ethics consultation with other healthcare professionals and the families involved in the treatment and care of patients. Ordinarily, the ethicist is connected with the ethics committee in a hospital. This ethics facilitation role emerged over many decades of experience in healthcare. It has long been recognized that the various roles of the hospital ethics committee and the ethics consultant can overlap.24 As these roles developed in the early decades of this specialty, there was considerable debate about these issues: what are the crucial issues in ethics consultation (e.g., its paradigms, goals, and effectiveness) and who should participate in these ethics consultations,25 such as doctors because of their clinical training or philosophers because of their ethical reasoning skills.26 As a result, expertise in ethics consultations was connected increasingly with giving court testimony, with clinical and social expertise, and with regulation.27
As experience accrued over several decades, different roles for ethics consultations were considered. For some, the ethics consultant might assume a role that is akin to being an analyst, adviser, or adversary; for others, the role might be akin to being an expert, or educator, or counsellor, or advocate; and for many the role might be akin to being a colleague, negotiator, case manager, or mediator to resolve conflict. These role options were assembled into two broad models. On the one hand, there was a hard model that considered the ethics consultant as undertaking an independent investigation, including an interview with the patient and the issuance of a recommendation. On the other hand, there was the soft model that construed the ethics consultant in a facilitation role, bringing together the relevant parties, helping to sort out the facts, clarifying the problem at hand, raising important issues, and noting useful distinctions in the process of the ethical engagement.

These roles of the ethics consultant were oriented toward an education process or toward an expert-oriented intervention leading to a practical outcome. The debate revolved around the following issues. On the one hand, regarding the hard model (emphasizing intervention and outcomes), the ethics consultant focuses upon knowledge and expertise to provide a practical solution. In this approach, the ethics consultant is more likely to accept responsibility for ethical decision-making. On the other hand, regarding the soft model (emphasizing an education process), the ethics consultant adopts the role of being a facilitator of ethical discourse, making no claim to superior ethical knowledge. In this approach, a good decision is reached through a process in which the relevant considerations of the stakeholders have been evaluated.

After years of debate and experience, the ethics facilitation role emerged as the preferred approach. Eventually, the American Society for Bioethics and Humanities (ASBH) settled the debate by recommending the ethics facilitation approach for ethics consultation, in contrast to a more authoritarian approach. In 2006, the ASBH published voluntary guidelines called, Core Competencies for Healthcare Ethics Consultation. The ASBH subsequently provided an education guide for training around these competencies for ethics consultation. The ASBH published a revised second edition of the Core Competencies in 2011. The revised edition continues to recommend the ethics facilitation approach and includes a major new section (13 pages in contrast to two pages in the original edition) on the quality and evaluation of ethics consultation services. The focus on quality in ethics consultations is of paramount importance, especially regarding empirical evaluations, ongoing assessment, quality improvement, and cost. The focus of the ASBH is upon patient-centered care. Also, the ASBH approach is similar to the system of Integrated Ethics in the Veterans Health Administration.

There have been many landmark studies using objective criteria that provide substantive support for the effectiveness of this approach to clinical ethics consultation. These studies include randomized controlled trials, as well as pilot and longitudinal studies. Also, there have been multiple surveys and many reviews have been undertaken. Akin to experience in the USA, in other countries
there has been a similar scrutiny of ethics consultation services.\textsuperscript{50} This scrutiny has examined progress in different countries,\textsuperscript{51} focusing on the variety of ethical issues involved.\textsuperscript{52}

Because ethics consultations can occur across an extensive range of clinical environments and concerns, the ASBH provides a straightforward explanation of what is involved:

Health care ethics consultation (HCEC or “ethics consultation”) is a set of services provided by an individual or group in response to questions from patients, families, surrogates, health care professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care.\textsuperscript{53}

As mentioned earlier, from the varying approaches to ethics consultation, the ethics facilitation approach was recommended by the ASBH, described in this way:

The ethics facilitation approach is informed by the context in which HCEC is done and involves two core features: (1) identifying and analyzing the nature of the value uncertainty, and (2) facilitating the building of a principled ethics resolution.\textsuperscript{54}

The ethics facilitation approach requires specific competencies. Both editions of the ASBH Core Competencies explain the need for these competencies. The ASBH identifies core skills, core knowledge, and personal attributes for proficiency in ethics consultations. Different people can perform the ethics consultation service, though debate continues over the relative advantages of an individual or a team-based approach.\textsuperscript{55} An ethics consultation service may vary the approach adopted.\textsuperscript{56} Hence, the different roles and responsibilities of those performing the service will require varying levels of competency, with an individual working alone (i.e., not with a team) requiring the highest level of competency.\textsuperscript{57} The core skills for ethics consultations are assembled in three related categories.

To begin, ethical assessment and analysis skills can be basic (to deal with straightforward situations) or advanced (to deal with complex cases). The assessment competency is to identify the nature of a conflict or value uncertainty that generates the need for an ethics consultation. The analytical competency is to critically evaluate the case and identify justifiable options using relevant ethics knowledge and concepts. Next, process skills pertain to the following: overseeing an ethics consultation service; conducting a specific ethics consultation, including the facilitation of any formal meetings required; and evaluating consultations retrospectively to support ongoing improvement (this point is new in the second edition of the ASBH Core Competencies).\textsuperscript{58} Finally, interpersonal skills are required to perform across the spectrum of ethics consultations, such as to listen and communicate effectively,\textsuperscript{59} or to discern appropriate timing for an ethics consultation.\textsuperscript{60}

In turn, the core knowledge areas can be divided into basic (an introductory sense of the topic) and advanced (a detailed understanding of the topic). These
core knowledge areas, which can overlap, include the following: knowledge of moral reasoning and ethical theory; an understanding of common bioethical issues and concepts; a sense of the clinical landscape; comprehension of relevant health law and professional codes; and an awareness of the beliefs of the local patient and staff population. Knowledge of these key concepts constitutes a foundation for the ASBH professional certification for ethics consultants that was initiated in 2017. The discussion on professionalization has occurred for a long time, including the following considerations: about requiring a code of ethics; about professional qualifications needed; about competencies and empirically driven standards, such as charting and documentation; about credentialing requirements including the quality of ethics consultants, including prior training; about certification processes including examinations; and about formal accreditation of ethics consultants.

In addition to core skills and core knowledge areas, there are basic attributes, attitudes, and behaviors that are required for ethics consultants. These terms are used to replace the language of character that appeared in the first edition of the ASBH Core Competencies. However, these traits cannot be divided into basic and advanced. An example is that personal integrity should infuse the work of an ethics consultant.

The discussion here has considered two characteristics of ethics consultation services, stewardship and decision-making processes. The third characteristic of ethics consultation services deals with best practices. The focus on best practices highlights quality outcomes. Here, a connection is drawn between standards and quality. The basic point is that best practices can lead to improved quality. Here, best practices are based on data from comprehensive research with clearly documented outcomes, adopting an evidence-based approach. When best practices result from data, they can be used to measure and increase quality by improving performance related to the identified standards. When this occurs, measures for best practices relate to quality improvement. That is, benchmarking enables an organization to measure or compare its performance against recognized best practices.

In other words, best practices can be adopted as benchmarks in the sense of identifying standards of quality. Hence, the accomplishments of continuous quality improvement in healthcare generally, and more specifically in ethics consultation, are based upon objective and comprehensive research about evidence-based practice. That focus is emphasized by the ASBH, explaining that its “ultimate commitment . . . is to improve and maintain the quality of HCEC” (referring to healthcare ethics consultation).

To summarize, there are three characteristics of ethics consultation services: the need for stewardship of organizational resources, the focus on decision-making processes that adopts the ethics facilitation approach, and the emphasis on best practices for quality outcomes. It is important to emphasize that these distinguishing characteristics of clinical ethics in ethics consultation services are aligned with the ethics paradigm (presented in Chapter 1), as follows.

First, in ethics consultations the need for stewardship of organizational resources lies behind the legal exhortation to create ethics committee services. The legal
Clinical and organizational ethics
determination in the landmark case of Karen Ann Quinlan urged hospitals to steward their resources, rather than relying on the courts, to resolve end-of-life treatment dilemmas. As a result, the Joint Commission mandated that hospitals should establish an organizational resource (such as an ethics committee) to undertake this role of ethics consultation as a basic standard of accreditation. This need for organizational stewardship reflects the foundation component of the ethics paradigm. Second, in ethics consultations the focus on decision-making processes led the ASBH to adopt an ethics facilitation approach. This focus on decision-making reflects the process component of the ethics paradigm. Third, in ethics consultations the emphasis on best practices reflects the commitment of the ASBH to improve quality outcomes. This emphasis reflects the practice component of the ethics paradigm. Finally, these characteristics of ethics consultation services that align with the ethics paradigm help clinical ethics to address the deficit of public trust in healthcare organizations, both public and private. The design of the ethics paradigm in Chapter 1 was presented in the context of addressing the loss of public trust. The widespread use of ethics consultation services nurtures the public’s confidence in clinical ethics. This typically occurs at the end of life when patients and families encounter traumatic dilemmas. Another impressive testimony to public trust in ethics consultation services is the continuing requirement of them by the Joint Commission as a crucial standard of hospital accreditation. As the ethics paradigm is adopted throughout this book, each applied topic sheds light on renewing and nurturing public trust in healthcare organizations.

Organizational ethics

These three characteristics of clinical ethics (stewardship, decision-making, best practices) that are aligned with the ethics paradigm also pertain to organizational ethics in healthcare. Because the delivery of healthcare today involves a connection between clinical and organizational issues, these distinct realms are increasingly perceived as being closely related. Recognizing these overlapping fields, the ASBH combined clinical ethics and organizational ethics in its revised edition of the Core Competencies for Healthcare Ethics Consultation. Reflecting this close affinity, ethics committees often support both fields in a variety of models, such as the following: expanding the role of the clinical ethics committee to include organizational ethics issues; creating a distinct organizational ethics committee to address business, financial and other corporate ethics issues; or having a single ethics committee with an expanded mission to include both clinical ethics and organizational ethics subgroups. This combination bolsters the rationale in this study for recognizing the affinity between organizational ethics and the more established field of clinical ethics.

Despite this connection between these fields, it remains useful to discuss organizational ethics as a distinctive area of expertise. Retaining an organizational perspective enables ethics discourse to address specific challenges that occur in the institutional environment of healthcare delivery. In other words, organizational ethics addresses value related issues linked with the institution in the broadest
sense, including its business, management, corporate, and compliance interests. This broad view of organizational ethics in healthcare includes the institution’s values and policies, the allocation of resources, the behavior of its personnel, and the services to its communities and constituencies.

This distinctive approach to organizational ethics recognizes these overlapping issues while acknowledging the wisdom accrued in clinical ethics. Typically, discussions of organizational ethics in the realm of business emphasize the role of stakeholders, referred to as stakeholder theory. Developed originally by R. Edward Freeman, stakeholder theory recognizes a variety of roles and values of individuals with a moral stake in an organization to present a way for resolving business and corporate conflicts.79 However, the approach to organizational ethics in healthcare that is adopted in this analysis includes but is broader than stakeholder theory.

To understand this broader approach to organizational ethics, it is helpful to refer again to the ethics paradigm. The authors of this study developed the ethics paradigm as an organizational ethics project, while recognizing and adopting the characteristics of clinical ethics (stewardship, decision-making, best practices). A brief word on the development of the ethics paradigm can enlighten the significance of organizational ethics here.

The development of the ethics paradigm involved extensive consultation by the authors.80 The project involved major sectors in healthcare across the USA. A wide range of leaders were consulted (representing a diversity of geographical locations and market profiles) to measure interest in organizational ethics and to clarify common themes that should shape an ethics paradigm. There were several phases in the consultation project via telephone conference calls and face-to-face interviews: undertaking telephone interviews with a number of nationally respected leaders in healthcare to inquire about their understanding of the need for an ethics paradigm in healthcare;81 preparing an early draft of the paradigm that was sent to another group of leaders in healthcare subsequently interviewed by telephone;82 and sending a revised draft of the paradigm to another group who then met with the authors for a roundtable discussion to finalize its format.83

This historical background sheds light on how the terms in the ethics paradigm adopt predominantly organizational language. The three basic features of ethics in the paradigm (who we are, how we function, what we do) generate its three guiding components. The foundation component (reflecting the leitmotif who we are) operates within the context of engaging the healthcare environment. The process component (reflecting the leitmotif how we function) operates within the context of undertaking organizational oversight. The practice component (reflecting the leitmotif what we do) operates within the context of fostering organizational culture. The three components engage three related contexts that appear regularly in the literature on organizations and governance:84 the contexts of the healthcare environment, of organizational oversight, and of organizational culture.

In turn, these components promote leadership that fosters specific outcomes. That is, the leadership focus on institutional identity (reflecting the leitmotif who we are) fosters outcomes regarding organizational stewardship of an institution’s
mission; the leadership focus on corporate accountability (reflecting the leitmotif *how we function*) fosters outcomes regarding decision-making via participative deliberation; and the leadership focus on performance quality (reflecting the leitmotif *what we do*) fosters outcomes regarding best practices for standards of conduct. A closer look at the components of the ethics paradigm (Table 1.1) clarify the alignment of organizational ethics.

**Foundation component**

In the foundation component of the ethics paradigm, the healthcare environment is the context for promoting leadership regarding organizational identity (reflecting the leitmotif *who we are*) to discuss outcomes related to stewardship of an organization’s mission. Here stewardship extends beyond dealing with limited resources to enhance the integration of personal and institutional integrity across the organization. This integrity is manifest in its responsibility to nurture what is received from others for future generations, thereby contributing to sustainability.85 The institution must nurture what the community has given it to honor the past and to prepare for the future.86 Stewardship enhances a sense of the healthcare organization’s commitment to the community and thereby increases public trust in healthcare organizations, including prudent use of resources. When there are influences upon an organization that compromise its integrity, those influences can be construed as a form of institutional compromise; and when that occurs, public trust is undermined.87 Of course, it is important to recognize that a commitment to integrity is both personal and organizational to avoid compromise for short-term gain and to nurture trust in the community.88

Perhaps the most basic challenge of stewardship in healthcare is to continue the organization’s mission of healing patients and communities. One of the greatest dangers in healthcare today, as mentioned previously, is to focus so much upon fiscal demands that an organization’s basic mission of care can be compromised. An unbalanced focus on these fiscal demands can force the organization’s margin against its mission. Of course, resource management and fiscal responsibility are crucial for every organization, but they should serve the organization’s core purpose. Unfortunately, organizations can mistakenly pursue a reductive understanding of corporate responsibility. That mistake can occur by focusing only on finances and resources (margin) in a manner that can ultimately undermine the

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**Table 1.1 Ethics paradigm**

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<tr>
<th>Components</th>
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main goal of healthcare, healing patients and communities (mission). In contrast, the foundation component of the ethics paradigm encourages corporate morality to focus upon social responsibility from the perspective of stewardship that supports the mission of the institution.\textsuperscript{89}

**Process component**

In the process component of the ethics paradigm, organizational oversight in healthcare is the context for promoting leadership regarding accountability (reflecting the leitmotif \textit{how we function}) to discuss outcomes related to decision-making via participative deliberation. The importance of participative decision-making is widely recognized as indispensable in ethics. Standard steps in the decision-making process in clinical ethics can be readily adopted in organizational ethics, as follows.\textsuperscript{90} The decision-making process emphasizes two related parts: the identification of a specific problem and the resolution of the problem.\textsuperscript{91} Of course, the various steps of this process can vary depending on circumstances, so flexibility is necessary.

The identification of the problem starts with three steps. To begin, there is a recognition of the problem that includes the following: involve all the appropriate stakeholders; compile and record the appropriate data; specify the relevant aspects of the ethical dilemma regarding related values. Also, there is the description of the problem: indicate what characterizes the problem; clarify the goals that are involved; identify the basic ethical conflict. Furthermore, indicate the cause and effect relations in the problem: explain why the problem exists; distinguish the root cause from the symptoms of the problem; summarize the basic ethical issue.

Next, the process of ethical resolution involves another three steps. To begin, there is the clarification of realistic options, which includes the following: create a positive milieu for an ethical resolution to emerge; explore options that are available; investigate the ethical legitimacy of the main options. Also, there is the determination of the best ethical solution to the problem: eliminate the least likely options; weigh the viable options regarding the goals being pursued; make a rational and objective ethical decision. Furthermore, there is the implementation of the decision, including a subsequent evaluation: communicate the decision as the best ethical option in terms of risks, benefits, costs, and workability; take action to implement the decision (considering who, what, when, and how); have a quality improvement assessment of the decision-making process.

In other words, the participative decision-making process seeks to identify the relevant problem and to resolve it. This process of moral decision-making can be related to a role for the moral imagination. That is, the moral imagination can facilitate a broad awareness of complex circumstances (especially the values and narratives involved), an appreciation of the relevant ethical conflicts, and a sense of how to devise ethically acceptable solutions or alternatives.\textsuperscript{92} When faced with complicated situations, the moral imagination can provide a capacity to intellectually grasp and ethically reason in a comprehensive manner, often involving religious perspectives or beliefs.\textsuperscript{93} The process component of the ethics paradigm entails sophisticated decision making steps.
**Practice component**

In the practice component of the ethics paradigm, organizational culture is the context for promoting leadership regarding quality (reflecting the leitmotif *what we do*) to discuss outcomes related to best practices for standards of conduct. This component deals with behavior across the organization to improve the quality of healthcare, such as indicated in reports from the Institute of Medicine. This practice component focuses upon behavior in a manner that develops organizational performance with objective measures of progress. The practice component of the ethics paradigm functions in an integrative manner with its foundation and process components. The practice component implements the organization’s deliberative processes (such as occurs with strategic planning) and its stewardship of the organization’s mission (such as occurs with building the public’s trust).

Together, the three components of the ethics paradigm provide a moral compass for the institutional integrity of healthcare organizations. This occurs by connecting *who we are* (the foundation component), *how we function* (the process component), and *what we do* (the practice component). Furthermore, the cohesive rapport between these components helps to establish a fine balance between margin and mission, thereby contributing to the renewal of public confidence in healthcare.

**Conclusion**

The need for and importance of organizational ethics in healthcare is supported robustly in other landmark studies on corporate morality. For example, a report by The Institute of Business Ethics in the United Kingdom, titled *Does Business Ethics Pay*, adopted several measures of performance over a five-year period. The study concluded that when large corporations demonstrate a practical commitment to ethical conduct they improved financial performance in the long term. Also, an influential study using five measures of performance (innovation, customer retention, turnover, quality, and profitability) provided evidence of a positive correlation between companies that try to be ethical and the organization’s performance. That study explained that companies perceived as trustworthy with institutional integrity perform better with higher profits than companies perceived to be less ethical. The importance of virtuous organizations is well recognized for moving institutions from crisis to exemplary leadership, and is discussed in the final chapter of this book.

This chapter has presented a theoretical discussion of how the established fields of clinical ethics and organizational ethics can be aligned with the ethics paradigm as a framework for an applied ethical analysis. The consistency pertains to the focus of the framework on stewardship, ethics decision-making, and best practices. The consistency of ethics discourse in this alignment also can be shown to pertain to professional ethics, as discussed in the next chapter. Throughout this study, the alignment between these various fields is emphasized to later apply the ethics paradigm to governance ethics in healthcare organizations.
Notes

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17 The analysis in this section of the chapter is a development of one of the co-authors previously published research, G. Magill, “Quality in Ethics Consultation,” Medicine, Health Care and Philosophy 16 (4) (2013): 761–774.


34 For an account of the emergence of healthcare ethics committees in general and healthcare ethics consultation services in particular, see: R. E. Cranford, et al., *Institutional Ethics Committees and Health Care Decision-making* (Ann Arbor, MI: Health Administration Press, 1984).

35 American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation* (Glenview, IL: ASBH, 2006). For an explanation of
the ethics facilitation approach versus the authoritarian approach to ethics consulta-
tion, see pp. 5–6.
36 See: American Society for Bioethics and Humanities (ASBH), *Improving Compe-
tencies in Clinical Ethics Consultation. An Education Guide*, 2nd ed. (Glenview, IL: ASBH, 2015); American Society for Bioethics and Humanities, *Clinical Eth-
ics Consultation Affairs Committee, Addressing Patient-Centered Ethical Issues in Health Care: A Case-Based Study Guide* (Glenview, IL: ASBH, 2017); American Society for Bioethics and Humanities, Clinical Ethics Consultation Affairs Com-
mittee, *Resources for Developing Advanced Skills in Ethics Consultation* (Glenview, IL: ASBH, 2017). A similar approach has been developed for Catholic healthcare, Catho-
37 American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, IL: ASBH, 2011).
38 For a comparison of the two editions and an explanation of the need for greater
40 See: L. D. Wocial, E. Molnar, M. A. Ott, “Values, Quality, and Evaluation in Ethics
44 American Society for Bioethics and Humanities (ASBH), *Addressing Patient Cen-
45 On the approach of Integrated Ethics, see: E. Fox, “Integrated Ethics: An Innova-
46 See: A. Rudnick, et al., “Informal Ethics Consultations in Academic Health Care Set-
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61 American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, IL: ASBH, 2011), 26–31, section II.2.3.


70 American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, IL: ASBH, 2011), Appendix II, item 11.

71 American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, IL: ASBH, 2011), 32–33, section II.2.4.

72 American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, IL: ASBH, 2011), 34–42.
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73 American Society for Bioethics and Humanities (ASBH), *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, IL: ASBH, 2011), 44, section II.3.3.


77 American Society for Bioethics and Humanities, *Core Competencies for Healthcare Ethics Consultation*, 2nd ed. (Glenview, IL, 2011), 54.


81 The leaders we consulted in Phase I (with the roles and titles at the time of the interviews) were: J. Berg, Director, Academic Affairs, Institute for Ethics, American Medical Association; William Cox, President and CEO, Alliance of Catholic Healthcare Systems, Sacramento, CA; R. Davidson, President and CEO, American Hospital Association, Washington, DC; B. Halm, President and CEO, Benedictine Health System, Duluth, MN; J. King, former President and CEO, Legacy Health System, Portland, OR; W. Mason, Chair, Board of Directors, Baptist-St. Vincent Health System, Jacksonville, FL; J. Morris, III, CEO, Kootenai Medical Center, Coeur D’Alene, ID; Sr. M. R. Rocklage, RSM, Chair, Board of Directors, Sisters of Mercy Health System, St. Louis, MO; D. Russell, President and CEO, Catholic Health East, Newtown Square, PA; G. Sprenger, President and CEO, Allina Health System, Minneapolis, MN; S. Ummel, Principal and National Advisor on IDNs, Ernst & Young, Chicago, IL.

82 The leaders we consulted in Phase II (with the roles and titles at the time of the interviews) were: D. Brennan, President and CEO, Daughters of Charity National Health
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System, St. Louis, MO; G. Christiansen, President and CEO, Carondelet Health System, St. Louis, MO; J. Dorsey, President and CEO, Columbia HealthOne, Denver, CO; Sr. P. Eck, CBS, Chair, Board of Directors, Bon Secours Health System, Inc., Marriottsville, MD; Rev. M. Place, President and CEO, Catholic Health Association, St. Louis, MO; C. T. Smith, President and CEO, Voluntary Hospitals of America, Inc., Irving, Texas; R. Statuto, President and CEO, St. Joseph Health System, Orange, CA; A. Yuspeh, Senior Vice President/Ethics Compliance and Corporate Responsibility, Columbia/HCA, Nashville, TN.

The leaders we consulted in Phase III (with the roles and titles at the time of the interviews) were: D. Brodeur, Ph.D., Senior VP, Stewardship, SSM Healthcare, St. Louis, MO; F. Brown, Vice-Chair, BJC Health System, St. Louis, MO; M. Connelly, President and CEO, Catholic Healthcare Partners, Cincinnati, OH; W. Cox, President and CEO, Alliance of Catholic Healthcare Systems, Sacramento, CA; J. S. Lore, President and CEO, Sisters of St. Joseph Health System, Ann Arbor, MI; Sr. M. R. Rocklage, RSM, President and CEO, Sisters of Mercy Health System, St. Louis, MO. The leaders we consulted after the roundtable (with affiliations listed as in Spring 1999) were: D. Berwick, M.D., President and CEO, Institute for Healthcare Improvement, Boston, MA; J. Dalton, President and CEO, Quorum Health Group, Inc., Brentwood, TN; A. Herman, Consultant to the President, Texas Health Resources, Dallas, TX. Subsequently, an early draft executive summary was published as follows: G. Magill, L. Prybil, “Guidelines for Organizational Ethics,” Health Progress (July–August, 2001): 12–14.


The decision making steps listed here were initially developed by one of the authors in, B. Devlin, G. Magill, “The Process of Ethical Decision-making,” in W. E. Scott, ed., Current Ethical Thinking in Anaesthesia and Intensive Care, special issue of the journal, Best Practice & Research Clinical Anaesthesiology 20 (4) (2006): 493–506. The discussion in this chapter develops the earlier analysis presented in this journal article.


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100 K. S. Cameron, D. Bright, A. Caza, “Exploring the Relationships between Organizational Virtuousness and Performance,” American Behavioral Scientist (February 2004); the entire issue discusses contributions to positive organizational scholarship, with theoretical and empirical studies.


Select readings


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3 Professional ethics

Introduction

The previous two chapters explained how the ethics paradigm provides a framework for applied analysis to foster consistency of ethics discourse across the established fields of clinical ethics and organizational ethics in healthcare. This chapter continues the theoretical discussion to apply the ethics paradigm to professional ethics. The purpose of engaging the ethics paradigm with these established fields is to later apply it to governance ethics as an emerging field in healthcare.

At the outset of this discussion it is helpful to describe professional ethics. The previous chapter offered extensive explanations of clinical ethics and organizational ethics. Briefly these fields can be described in this manner. Clinical ethics deals with values, reasoning, and responsibilities regarding treatment issues related to patients and medical providers. Organizational ethics deals with values, reasoning, and responsibilities regarding corporate issues related to institutions. Professional ethics deals with values, reasoning and responsibilities regarding professionals (e.g., nurses, physicians, social workers) with specialized practices and typically with accompanying codes of conduct.

There is a need for consistency of discourse in professional ethics because of the extensive array of topics and approaches in this large field. In general, professional ethics explores the implications of professional relations in society. Typically, discussions deal with this topic either directly or implicitly by considering the role of ethics in various fields. These discussions engage on a broad perspective across the professions, or within a specific profession, including behavior analysts, biotechnology, business, computing and information technology, education and teaching, engineering and technology, forensic science, law and criminal justice, media and journalism, pastors, police, public relations, public service, social work, and sports. Moreover, there is an abundance of literature on professional ethics regarding the health professions generally, and more narrowly addressing addiction care, anesthesiology, dentistry, family therapy, health information management, mental health and counseling, midwifery, nursing, pharmaceuticals, pharmacy, physical therapy, and more.
physicians, physicians’ assistants, and public health. Not surprisingly, a concern for professional ethics has generated an abundance of codes of ethics in the various helping professions, including bioethicists, family counselors, physicians, psychologists, nurses, social workers. Furthermore, there is extensive literature on health management that is discussed later in this chapter.

From the long list of references in the previous paragraph, it is apparent that there is an extraordinary range of issues in professional ethics. When faced with such a vast array of topics and approaches, it is daunting to traverse such an expansive terrain. Here, the ethics paradigm can be helpful to seek consistency across the myriad topics discussed in professional ethics.

The ethics paradigm revolves around the leitmotif of who we are, how we function, and what we do. These basic features of ethics are indispensable for encouraging leadership regarding identity, accountability, and quality, each promoting the following outcomes. The focus on identity (who we are) promotes the outcome of organizational stewardship of an institution’s mission. The focus on accountability (how we function) promotes the outcome of decision-making via participative deliberation. The focus on quality (what we do) promotes the outcome of best practices for standards of conduct.

The previous chapter emphasized stewardship, decision-making, and best practices as aspects of clinical ethics and organizational ethics to explain their alignment with the ethics paradigm. This chapter’s discussion of professional ethics focuses on the leadership concepts of identity, accountability, and quality as they promote the outcomes of stewardship, decision-making, best practices. These three concepts of identity, accountability, and quality in the ethics paradigm provide a framework for applied analysis to foster consistency of ethics discourse in professional ethics. This quest for consistency occurs by using the three concepts to organize the varied topics that arise in the materials discussed. The following discussion engages many well-known approaches as representative of the diverse issues in professional ethics. The ethics paradigm (Table 1.1) guides the discussion.

Naturally, governance ethics relates to the professional work of health executives and health management. Hence, it can be helpful to explain how the ethics paradigm is consistent with discourse in these areas.

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</table>
Code of Ethics of the American College of Healthcare Executives

To begin the conversation on professional ethics in healthcare, it can be enlightening to consider the Code of Ethics of the American College of Healthcare Executives (ACHE). The code of ethics delineates the responsibilities of healthcare executives to its constituencies: to the profession of healthcare management (Section I); to patients or others served (Section II); to the organization (Section III); to employees (Section IV); to community and society (Section V). In addition to these sections there is an introductory Preamble. In each of these sections, the various items that are delineated lead to a considerable list of requirements. Moreover, these items recur in various ways in the ACHE’s policies, including the following: the ACHE’s policy statements such as on responsibility to the community or ensuring quality and patient safety; the ACHE’s ethical policy statements such as on protecting confidentiality or creating an ethical culture; and the ACHE commitment to social responsibility, such as on public protection or advocating for diversity.

The concepts of identity, accountability, and quality in the ethics paradigm can provide a framework for applied analysis to organize the recurring themes in the ACHE code as being characteristic of professional ethics. These concepts are discussed briefly in the next section, with references to the various sections of the ACHE’s code of ethics. First, the concept of identity in the ethics paradigm highlights the leitmotif of who we are, promoting the outcome of stewardship of an organization’s mission. This concept of identity is evident in the focus of the code of ethics upon the mission of the ACHE as an organization (Section I). This focus emphasizes the importance of allocating limited resources as a function of organizational stewardship while respecting patient customs and practices consistent with the organization’s philosophy (Section III). However, stewardship extends beyond financial constraints to include the organization’s mission. Hence, respecting organizational identity requires the following: being truthful regarding information and communication; fostering a healthcare environment as free from harassment or coercion; and addressing mistakes effectively to minimize their recurrence (Sections III and IV).

Second, the concept of accountability in the ethics paradigm highlights the leitmotif of how we function, promoting the outcome of decision-making via participative deliberation. This concept of accountability is evident in the focus of the code of ethics upon cooperative activities that establish procedures to uphold patient autonomy, rights, confidentiality, and privacy (Sections II and III). These cooperative activities should support mechanisms for enlightened decisions about services, for sound management decisions that engage employee expertise, for addressing issues in clinical and organizational ethics, and for participative deliberation in public policy (Sections III, IV, and V). This concept of accountability highlights the scope and function of the ACHE ethics committee (appointed by the board of directors) to review and evaluate the code of ethics, recommend
action by the board including suspension or expulsion, and develop policy statements and guidelines for ethical conduct.\textsuperscript{44} Emphasizing organizational oversight nurtures a context where there is accountability through regulatory compliance with processes to resolve conflicts of interest and avoid abuse of power (Sections I and II).

Third, the concept of \textit{quality} in the ethics paradigm highlights the leitmotif of \textit{what we do}, promoting the outcome of best practices for standards of conduct. This concept of \textit{quality} is evident in the focus of the code of ethics upon standards of conduct of ethical behavior in professional relationships (Preamble). These standards advance professional activities with honesty, respect, and fairness. These activities should support the quality of care or service rendered through evidence-based clinical practices and sound management standards and business practices that avoid fraud and abuse and report negative activities promptly (Sections II and III). Highlighting quality across the organization develops an organizational culture that combines the following: protecting the reputation of management as a profession through ethical conduct; celebrating inclusivity to avoid discrimination; and respecting the needs of the community in healthcare services for all (Sections I, IV, and V).

In sum, the concepts of \textit{identity}, \textit{accountability}, and \textit{quality} in the ethics paradigm provides a framework for applied analysis to organize multiple requirements in the ACHE code of ethics as being characteristic of professional ethics. The ethics paradigm is designed to have an impact on public trust and confidence in healthcare organizations. Similarly, the ACHE’s code of ethics is designed to build trust and confidence regarding healthcare professionals with the public (Preamble). This impact reflects the organization’s mission that healthcare executives are dedicated to improving the health of communities served and to fostering excellence in the organization’s vision for healthcare management.\textsuperscript{45} Insofar as this commitment is reflected in the ACHE’s strategic plan to respond to the rapidly changing healthcare environment,\textsuperscript{46} the ACHE’s concern with public trust and confidence in healthcare organizations is robust. That is, the ethics paradigm highlights the ACHE’s commitment to public trust and confidence.

\textbf{Identity, accountability, and quality in healthcare management ethics}

A way of illustrating the significance of the ethics paradigm for professional ethics in healthcare management is to focus individually on each of the three concepts of \textit{identity}, \textit{accountability}, and \textit{quality}. This consideration of each concept individually occurs in relation to several influential books on ethics in healthcare management, as follows: \textit{Ethics and Professionalism for Healthcare Managers};\textsuperscript{47} \textit{Ethics and Management Dilemmas in Healthcare};\textsuperscript{48} \textit{Managerial Ethics in Healthcare};\textsuperscript{49} \textit{Ethics in Health Administration: A Practical Approach for Decision Makers};\textsuperscript{50} and \textit{Ethics in Health Services Management}.\textsuperscript{51}

First, the concept of \textit{identity} that highlights \textit{who we are} in the ethics paradigm is evident in the book \textit{Ethics and Professionalism for Healthcare Managers}. The
concept of identity can help to clarify the discussion of the profession of healthcare management, professionalism, and stewardship of fiduciary duties regarding the mission of an organization. This concept of identity is evident in the other books, as follows: in Ethics and Management Dilemmas in Healthcare, in the discussion of the importance of the stewardship and mission of the healthcare organization; in Managerial Ethics in Healthcare, in the discussion of organizations as moral agents (related to stakeholder theory and the tension between mission and margin in organizations); in Ethics in Health Administration: A Practical Approach for Decision Makers, in the emphasis upon stewardship and mission in the section on organizational influences on ethics; and in Ethics in Health Services Management, in the focus upon the organization’s mission as crucial for establishing integrity.

Second, the concept of accountability that highlights how we function in the ethics paradigm is evident in Ethics and Professionalism for Healthcare Managers where the book discusses ethical decision-making and interactions in healthcare organizations. This concept of accountability is evident in the other books, as follows: in Ethics and Management Dilemmas in Healthcare, in the need for ethical decision-making processes to have a consistent approach to the many challenges faced by healthcare managers; in Managerial Ethics in Healthcare, in the general discussion of moral decision-making throughout the book, and more specifically in encouraging organizations to foster deliberative processes in public policy; in Ethics in Health Administration: A Practical Approach for Decision Makers, in the discussion of ethical decision-making not only in consent but also by decision makers across the organization; and in Ethics in Health Services Management, in placing corporate decision-making at the center of the book’s discussion of topics.

Third, the concept of quality that highlights what we do in the ethics paradigm is evident in Ethics and Professionalism for Healthcare Managers when considering specific issues regarding behavior and conduct to indicate best practices for standards of conduct. This concept of quality is evident in the other books, as follows: in Ethics and Management Dilemmas in Healthcare, in the discussion of the conduct and behavior of healthcare managers; in Managerial Ethics in Healthcare, in the discussion of on quality improvement and the need for best practices in the organization to foster an organizational culture that encourages ethical behavior; in Ethics in Health Administration: A Practical Approach for Decision Makers, in the need for standards of conduct in administrative practices; and in Ethics in Health Services Management, in highlighting the need for standards of conduct to guide a variety of ethical issues.

Furthermore, in addition to ethics in healthcare management, the related fields of organizational ethics and business ethics can illustrate the significance of the ethics paradigm. Three influential books are discussed: Organizational Ethics, Organizational Ethics in Health Care, and Business & Professional Ethics. Again, the concepts of identity, accountability, and quality in the ethics paradigm can help to organize the multiple topics discussed in each book.

The concept of identity is evident in the books as follows: in Organizational Ethics, in the discussion of mission and servant leadership that profoundly impacts the
organization’s identity; in *Organizational Ethics in Health Care*, in the discussion of adopting a stakeholder theory approach related to the mission of the organization; and in *Business & Professional Ethics*, in the discussion of the reputation and credibility of organizations.

The concept of *accountability* is evident in the books, as follows: in *Organizational Ethics*, in the discussion of deliberative processes of ethical decision-making; in *Organizational Ethics in Health Care*, in the discussion of approaches to moral reasoning via participative deliberation; and in *Business & Professional Ethics*, in the discussion of ethical decision-making to resolve practical dilemmas.

The concept of *quality* is evident in the books, as follows: in *Organizational Ethics*, in the discussion of performance related concerns and of ethical practices that shape ethical culture such as in marketing, finance, accounting, and human resources; in *Organizational Ethics in Health Care*, in the discussion of discusses quality improvement programs; and in *Business & Professional Ethics*, in the discussion of accounting in the public interest and managing ethical risks.

Finally, there is a prestigious collection of essays on healthcare management that underscores the significance of the ethics paradigm. This collection of essays is from the “Healthcare Management Ethics” column in the magazine *Healthcare Executive*. The collection of essays is titled “Managing Healthcare Ethically.”

The collection is divided into four sections: organizational ethical leadership, organizational ethics issues, clinical ethics issues, and an organization’s ethics resources. Most of the essays deal with practical topics. Again, the concepts of *identity*, *accountability*, and *quality* in the ethics paradigm can help to organize the multiple topics discussed in this collection, as follows. The concept of *identity* that focuses on mission is evident in the collection’s insistence that an organization’s mission, vision, and value statements require conviction and action and not mere rhetoric. The concept of *accountability* is evident in the collection’s insistence on the need for a systematic process of ethics reflection. The concept of *quality* is evident in the central focus of the collection on quality. The collection emphasizes that to achieve quality care there needs to be a strong commitment to fostering a leadership-driven culture that supports ethical actions and best practices across the organization.

In these books, some topics indicate the importance of the concept of *identity* in professional ethics, reflecting the focus on *who we are* in the ethics paradigm; other topics indicate the importance of the concept of *accountability* in professional ethics, reflecting the focus on *how we function* in the ethics paradigm; and yet other topics indicate the importance of the concept of *quality* in professional ethics, reflecting the focus on *what we do* in the ethics paradigm.

### Identity, accountability, and quality in professional ethics

Another way of illustrating the significance of the ethics paradigm for professional ethics is to consider a variety of approaches to professional ethics. Again, the concepts of *identity*, *accountability*, and *quality* in the ethics paradigm can help to organize the multiple topics that are presented. This consideration of each
concept occurs in relation to several influential books, as follows: The Elements of Ethics for Professionals, Ethical Dimensions in the Health Professions, Ethics for Health Professionals, The Helping Professional’s Guide to Ethics, Nursing Ethics and Professional Responsibility, and Public Value and Public Administration.56

First, the concept of identity that highlights who we are in the ethics paradigm is evident in The Elements of Ethics for Professionals that emphasizes integrity to nurture professionalism through respect of diversity, honoring who we are. In the Ethical Dimensions in the Health Professions, the concept of identity is evident in the discussion of professional life to focus upon personal integrity as indispensable for being competent professionally and to highlight the centrality of moral agency that pertains to all approaches to ethics. Also, in Ethics for Health Professionals, the concept of identity is evident in the professional’s concentration upon the patient as top priority at the heart of healthcare. And in The Helping Professional’s Guide to Ethics the concept of identity is evident in the explanation of professional ideals to highlight who we are in professional life. Furthermore, the concept of identity is evident in Nursing Ethics and Professional Responsibility. Here nursing as a profession is explained in terms of the nurse-patient relationship whereby professional responsibility must provide service to individuals and communities as a basic expression of who professionals are. Finally, in the book Public Value and Public Administration, the concept of identity is evident in the emphasis on what kind of society can be identified and built by public value governance as a multisector approach.

Second, the concept of accountability that highlights how we function in the ethics paradigm is evident in this book on Public Value and Public Administration. The book underscores the contribution of dialogue to develop pathways for mutual efforts of persuasion, thereby building deliberative capacity to create public value. In addition, the concept of accountability is evident in the decision-making model that is adopted in Ethics for Health Care Professionals, and in the deliberative processes for making ethical decisions in The Elements of Ethics that requires prudence for sound judgement. Also, the concept of accountability is evident in Ethical Dimensions in the Health Professions. Here, a multi-step process of ethical decision-making is explained in section one and applied in sections two and three to elucidate deliberative processes on professional roles (e.g., student scenarios, organizational dilemmas, team decisions). Furthermore, the concept of accountability is evident in The Helping Professional’s Guide to Ethics where the majority of chapters engage the importance of ethical decision-making for patient care.

Third, the concept of quality that highlights what we do in the ethics paradigm is evident in Ethics for Health Professionals. This book highlights the need for best practices in organizational conduct regarding vulnerable populations (e.g., minors, elderly), the workplace (e.g., regarding the Health Insurance Portability and Accountability Act—HIPAA), the medical record (e.g., Joint Commission requirements), liability issues (e.g., liability insurance), life and death issues (e.g., advance directives), and emerging controversial issues (e.g., stem cell research). Likewise, the concept of quality is evident in The Helping Professional’s Guide to
Ethics that discusses the need for standards of conduct when engaging practical issues such as substance abuse. Similarly, an emphasis on the concept of quality is evident in the more general book, The Elements of Ethics for Professionals. Here, most of the chapters discuss excellence in advancing standards of conduct to ensure that professionals act prudently. This means that professionals must show respect and compassion by acting in a beneficent manner, avoiding harm or abuse and supporting social justice. Furthermore, the concept of quality is evident in Nursing Ethics and Professional Responsibility. The latter half of the book discusses best practices in advanced practice specialty areas. These areas deal with neonates, children and adolescents, women’s health, adult-gerontological health, psychiatric and mental health, the anesthesia and perioperative period, palliative care and end-of-life care. Finally, the concept of quality is evident in the book Public Value and Public Administration, where measurement and assessment encourage best practices for standards of conduct.

In sum, the concepts of identity, accountability, and quality in the ethics paradigm provide a framework to organize the disparate issues that arise in various approaches to professional ethics.

Conclusion

This chapter concludes the theoretical perspective of the book. The discussion has considered how the ethics paradigm provides a framework for applied analysis to foster consistency of ethics discourse in clinical ethics, organizational ethics, and professional ethics. The ethics paradigm facilitates a uniform way of enlightening these established fields in a coherent manner that does not require formal ethics training or expertise. The robust framework of the ethics paradigm is now applied to the emerging field of governance ethics. The subsequent chapters present an applied perspective by addressing crucial ethical challenges for boards of directors in healthcare organizations. The book ends with a brief concluding chapter on how this approach to governance ethics can foster virtuous organizations in healthcare. Discourse on virtue ethics explains that individuals can become virtuous by connecting moral character, practical wisdom, and laudable actions. Similarly, the ethics paradigm enables an organization to become virtuous by connecting moral character (via the concept of identity, who we are), practical wisdom (via the concept of accountability, how we function), and action (via the concept of quality, what we do).

Notes


Professional ethics


44 ACHE, *Ethics Committee*, www.ache.org/abt_ache/committee_function.cfm


46 ACHE, *Strategic Plan*, www.ache.org/abt_ache/planning.cfm


Select readings


4 Governance structure

Introduction

The theoretical perspective in the previous chapters presented the ethics paradigm that is used as a guide for governance ethics in the subsequent chapters. The discussion now pursues an applied perspective by considering pivotal topics to encourage greater board accountability in healthcare organizations.

There is a growing awareness among boards and CEOs of nonprofit healthcare systems of the need for a consistent approach to governance ethics. The complexity of contemporary healthcare presents intricate dilemmas that increasingly require effective governance. The treatment of applied topics here will help boards to function not merely adequately but superbly in their ethical oversight.

The analysis engages several landmark reports by one of the co-authors of this book that have shaped discourse on governance effectiveness. These reports represent unprecedented access to boards and CEOs in healthcare nationally. One report, discussed in this chapter on governance structure and in a later chapter on patient safety, is based on access to 14 of the largest 15 nonprofit health systems in the United States. That report is referred to as the Governance Structure Report. Another report is discussed in the chapter on community benefit, referred to as the Community Health Systems Report. Other reports are discussed in the chapter on community health, one referred to as the Community Health Report, the other referred to as the Leadership Report.

Each of the following chapters begins with an explanation of the need for the pivotal topic under consideration, such as the governance structure of boards in this chapter. Then the concepts of identity, accountability, and quality provide a framework for the applied analysis. These concepts represent the foundation component (reflecting who we are), the process component (reflecting how we function), and the practice component (reflecting what we do) of the ethics paradigm (Table 1.1).

In the analysis, the concepts of the ethics paradigm organize core features of effective governance from these landmark reports and the scholarly literature. The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. Because the hallmarks represent necessary moral attributes

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Table 1.1  Ethics paradigm

<table>
<thead>
<tr>
<th>Components</th>
<th>Foundation component</th>
<th>Process component</th>
<th>Practice component</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>Environment of healthcare</td>
<td>Organizational oversight</td>
<td>Organizational culture</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>Identity: who we are</td>
<td>Accountability: how we function</td>
<td>Quality: what we do</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Organizational stewardship of mission</td>
<td>Decision-making via participative deliberation</td>
<td>Best practices for standards of conduct</td>
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of governance ethics, they entail an obligation to be adopted by boards. In turn, the associated moral imperatives represent necessary endeavors to foster the hallmarks under consideration. The ethics paradigm organizes multiple topics on board oversight of governance structure, as follows.

First, the foundation component of the ethics paradigm deals with the identity of an organization, reflecting the leitmotif who we are, thereby highlighting board competence and board role as hallmarks of governance ethics. In turn, these hallmarks denote associated moral imperatives: board competence denotes a moral imperative regarding oversight of term limits and board composition; and board role denotes a moral imperative concerning oversight of defined responsibilities and board effectiveness.

Second, the process component of the ethics paradigm addresses the accountability of the organization, reflecting the leitmotif how we function, thereby highlighting board evaluation and succession planning as hallmarks of governance. In turn, these hallmarks denote associated moral imperatives: board evaluation denotes a moral imperative regarding oversight of fair evaluation processes; and succession planning denotes a moral imperative concerning oversight of system planning and continuous updating.

Third, the practice component of the ethics paradigm engages quality in an organization, reflecting the leitmotif what we do, thereby highlighting leadership collaboration and system-wide strategy as hallmarks of governance ethics. In turn, these hallmarks denote associated moral imperatives: leadership collaboration denotes a moral imperative regarding oversight of working relationships; and system-wide strategy denotes a moral imperative concerning oversight of transformational change and strategic planning. Before considering these hallmarks of governance ethics, it is helpful to explain the need for oversight of board structure.

**Need for oversight of board structure**

The governance structure of boards of directors is crucial for effective trustee oversight. Hence, the applied discussion in the book begins with this pivotal topic to prepare the groundwork for other such topics on governance ethics in the applied chapters. At the heart of the discussion of board accountability in governance
ethics is the need for continuous evaluation and evidence-based improvements. Without a properly designed governance structure, boards will be ineffective and thereby compromise their accountability.

It is worth noting at the outset that the ethics paradigm aligns well with a major report by the Panel on the Independent Sector. The panel’s recommendations concentrated upon several issues that are significant for the analysis in this chapter. The panel’s discussion of board commitment is akin to the foundation component in the ethics paradigm that deals with stewardship, focusing on organizational identity. The panel’s interest in the relation between healthcare organizations and their communities is akin to the process component in the ethics paradigm concerning decision-making, focusing on organizational accountability. Finally, the panel’s interest in practice standards is akin to the practice component in the ethics paradigm related to best practices, focusing on organizational quality. The applied analysis begins with discussing hallmarks of governance ethics connected with the foundation component of the ethics paradigm.

Context of foundation-related governance ethics hallmarks

The concept of identity in the ethics paradigm (reflecting who we are) emphasizes the importance of organizational stewardship. This focus on identity and stewardship is especially pertinent within health systems that combine evidence-based research with value-promoting practices. Boards need to develop health systems that integrate research results (such as quality improvement, comparative effectiveness research, or public health standards) with healthcare practices. There are ongoing deliberations about better integrating medical research and clinical care, presenting a leadership opportunity for boards. These deliberations reflect a trend toward health systems, urged by the Institute of Medicine, to improve the development and application of evidence in healthcare. This transformation means that healthcare systems should steward research and practice to nurture institutional mission in promoting justice in healthcare while effectively addressing the surrounding environment.

The complexity of the healthcare environment presents the context for discussing foundation-related governance ethics hallmarks. Boards must deal with the healthcare environment as the critical context of their oversight. This environment demands transformational changes in health systems while preserving core values to shape their organizations and the future of healthcare. These changes impact the identity and stewardship of health systems as caring organizations. This complex environment is especially pertinent for accountable care organizations targeted by the 2010 Affordable Care Act and its continuing evolution focusing on patient-centered care. An example of this change is the shift from care focused primarily on individuals to care that is attuned to the health of the community. These transformational changes will require health systems to address the needs of aging populations, to provide a greater emphasis on preventing illness, and to
promote the health of the communities served. As a result, organizations increasingly will be concerned with the well-being of their communities rather than treating healthcare merely as a business transaction, thereby underscoring the organizational tension between mission and margin.\textsuperscript{13}

Because of the increasing need for services and the demanding constraints on resources, healthcare leaders must improve in evidence-based and measurable ways. Boards must comprehend how the healthcare environment impacts their communities and influences their duties and responsibilities. The topics discussed in the following sections continue to be prevalent in the American Hospital Association’s 2019 \textit{National Healthcare Governance Survey Report}.\textsuperscript{14}

Within this context of the challenging healthcare environment, the foundation component of the ethics paradigm focuses on the concept of identity, reflecting the leitmotif \textit{who we are}. This concept emphasizes stewardship to enhance an organization’s mission in healthcare. Here, the ethics paradigm organizes core features of effective governance from one of the landmark reports mentioned earlier, the \textit{Governance Structure Report}, to highlight hallmarks of governance ethics and their associated moral imperatives.

The concept of identity focuses on \textit{who the board is}, thereby highlighting board competence and board role as hallmarks of governance ethics. In turn, these hallmarks denote associated moral imperatives: oversight of board competence denotes a moral imperative regarding oversight of term limits and board composition; and oversight of the board role denotes a moral imperative concerning oversight of defined responsibilities and board effectiveness. These are discussed in what follows.

\textbf{Board competence: foundation-related governance ethics hallmark}

Board competence is the first hallmark of governance ethics regarding the foundation component of the ethics paradigm. To situate the significance of this hallmark, it is worth referring to the Blue Ribbon Panel on Healthcare Governance. This panel published an historic report on governance to explore ways of enhancing board effectiveness. The Panel emphasized the increasing interest in competency-based governance. Specifically, the panel flagged competencies of individual members and competencies of the board as a team and provided guidance for educational resources in the field.\textsuperscript{15} In a similar manner, the landmark \textit{Governance Structure Report} (that guides this chapter) emphasized the importance of boards insisting on governance design and policies that enable them to perform their responsibilities. To achieve this, boards also must have independence, diversity, and ideally the involvement of clinicians.\textsuperscript{16}

The concept of identity in the ethics paradigm highlights board competence as a governance ethics hallmark by drawing attention to \textit{who we are} (as a board that serves a health system). In turn, this hallmark denotes an associated moral imperative regarding oversight of term limits and board composition.
Moral imperative: board oversight of term limits and board composition

On the one hand, there should be formal limits on terms served and on the number of voting members. The number of consecutive terms for board members should be restricted to encourage the development of expertise and different perspectives. Naturally, staggered terms and transition planning are needed to minimize losing too many experienced members in a short time. Frequently, terms are three years with a limit of three consecutive terms. In the Governance Structure Report, 79 percent of the large health systems adopted term limits. At the same time, the number of voting members on the board should be restricted to meet the specific needs of the organization. On this point, the Internal Revenue Service (IRS) has an interesting perspective. That is, the IRS states that nonprofit boards should be large enough to represent a sufficiently broad public interest with appropriate skills and resources, while not being so large as to hinder decision-making.

In the Governance Structure Report, there was 100 percent support regarding limits on the number of voting members of their boards; the voting terms and voting members reflected the size of the board. A range of 9–17 voting members for hospital and health system boards was recommended in a 2007 Blue Ribbon Panel report. Most of the system boards (72 percent) in the Governance Structure Report were in line with the recommendations of this Blue Ribbon Panel, but some were significantly larger: three of the 14 ranged from 18 to 28 voting members, with one outlier having 60 voting members. Excluding the outlier, the median size of these health systems was 15 voting members. In contrast, at that time there were 12 or fewer voting members in America’s Standard and Poor’s 500 boards.

On the other hand, board size impacts the composition of the board which includes its independence, diversity, and engagement with clinicians. The importance of these for board and organizational performance is well recognized. Each of these topics is worth closer scrutiny.

To begin, on independence, the board charter (establishing its independence) has been identified as a significant factor in good governance in publicly traded companies for some time. To maintain integrity, the critical nature of independence requires the board to avoid so-called groupthink that can arise out of mistaken allegiance to fellow board members or groups rather than the organization’s best interests. On the issue of board independence, the Governance Structure Report indicated general agreement that from two-thirds to a majority of board members should be independent. The report explained that 60 percent of the members of the system boards were independent board members. However, the six secular health systems in the study had 82 percent of independent membership in contrast to 49 percent of independent membership among the faith-based systems. The faith-based percentage seems to have reflected a substantial proportion of board members being affiliated with previous or current religious sponsors.

Next, on the issue of board diversity, the Governance Structure Report indicated there should be appropriate experience and skills to perform the fiduciary
duties effectively. This observation included members with diverse backgrounds including ethnic, racial, and gender perspectives. Diversity can significantly improve the ethical reputation of the organization within the community, not least because a multi-cultural society needs multi-cultural leaders. Diversity also can result in better care insofar as individuals from diverse communities can represent the beliefs and preferences of those communities. There is an obvious obligation to narrow the gaps that appears to persist. Increasing diversity in leadership is a core element in a national effort to eliminate healthcare disparities: the other elements are increasing the collection of race, ethnicity, and language data as well as increasing cultural competency training. The Governance Structure Report documented the following outcomes: 17 percent of the systems’ board members were non-Caucasian, with similar proportions in the secular and faith-based systems. The proportion of women on boards of the faith-based systems was 40 percent, with only 21 percent of women serving on the boards of the secular systems.

Furthermore, the Governance Structure Report emphasized the significance of clinician engagement by the board. The participation of physician leaders is as an effective executive and governance practice with approximately 20 percent of hospital and health system boards being physicians. As physicians serve on boards, it is important to note the need for ethical scrutiny of potential conflicts of interest that unfortunately characterize the medical profession internationally. The role of clinicians in healthcare governance is widely accepted. This role help proactively align hospitals and community physicians in long-term partnerships; these partnerships can cultivate an ethical culture of relationship building to improve patient care and outcomes.

Also, clinician engagement should include nurses. For example, a critical report of the Institute of Medicine encourages the engagement of nurses on healthcare boards. There is a growing realization of the need to increase the professional representation of nurses on boards, especially given the focus by boards on clinical issues like quality care and patient safety. At the time of the Governance Structure Report, national studies indicated that nurses comprised only about 6 percent of nonprofit hospital and community health system boards. In this report, 14 percent of the board members were physicians, and 6 percent of the board members were nurses. However, on the secular boards, physicians comprised 18 percent of the board compared to 11 percent of faith-based boards, whereas nurses comprised 9 percent of faith-based boards compared to 2 percent of the secular boards. Thirteen percent of the CEOs and boards in this study group indicated that their board composition was about right, whereas 28 percent indicated that more clinical expertise would be beneficial. Subsequent studies have indicated that the proportion of nurses as voting board members has ranged from 2 to 6 percent.

Board role: foundation-related governance ethics hallmark

Board role is the second hallmark of governance ethics regarding the foundation component of the ethics paradigm. The concept of identity (with its focus on
stewardship) in the ethics paradigm highlights board role as a governance ethics hallmark by drawing attention to *who we are* (as a board that serves a health system). In turn, this hallmark denotes an associated moral imperative regarding board oversight of defined responsibilities and board effectiveness. The topics discussed here are consistent with recent national surveys.

**Moral imperative: board oversight of defined responsibilities and board effectiveness**

On the one hand, defined responsibilities are indispensable for efficient governance. The governance functions of nonprofit boards of hospitals and health systems are widely documented and accepted. There remains considerable concern about board effectiveness in performing these functions. To bolster effective governance, there is general recognition that boards need to be proactive, well organized and engaged, with a clearly delineated committee design. In the *Governance Structure Report*, significant consistency in board roles emerged: all the systems’ boards should have clearly defined responsibilities described in a written document (e.g., in a bylaws provision or a policy statement), formally adopted by the system board. In contrast, a study of 114 nonprofit community health systems published in 2009 reported only 72 percent of boards meeting this standard.

On the other hand, board effectiveness requires boards to have an executive committee as part of their governance. In this report, 13 of the 14 systems had an executive committee of their board, with 82 percent reporting that executive committees have two principal functions: to act between board meetings on routine, non-strategic matters that require formal board action; and to be a sounding board for the CEO who seeks informal governance counsel, such as on board meeting priorities. However, these executive committees do not serve as a decision-making body on substantive issues.

In the *Governance Structure Report*, 64 percent of the health systems reported holding executive sessions as part of every board meeting, with the remaining 36 percent having executive sessions at some board meeting but not always. Moreover, all the systems’ boards in this report had standing board committees to deal with audit and compliance, executive compensation, and financial matters. Also, this report indicated that nearly all the systems’ boards assigned clear oversight responsibilities to standing board committees on patient care quality and safety, board education and development, and system-wide strategy and planning functions. However, only 43 percent of the systems’ boards had standing committees with clear oversight responsibility for system-wide community benefit policies. Finally, when CEOs and board members in this report were asked about the perceived effectiveness of the board committees, a strong majority perceived their board committees as well organized and effective, though approximately a third of the board members indicated there was room for improvement.

In sum, the foundation component of the ethics paradigm highlights board competence and board role as hallmarks of governance ethics. By focusing on
identity in the ethics paradigm, these hallmarks denote associated moral imperatives: board competence denotes a moral imperative regarding board oversight of term limits and board composition; and board role denotes a moral imperative concerning oversight of defined responsibilities and board effectiveness. The next section considers the process component of the ethics paradigm that focuses on the concept of accountability to highlight process-related hallmarks of governance ethics.

Context of process-related governance ethics hallmarks

The concept of accountability in the ethics paradigm (reflecting how we function) emphasizes the importance of decision-making via participative deliberation. This focus on accountability requires boards to be attentive to organizational oversight as the context for assessing their responsibilities.

Organizational oversight in healthcare institutions presents the context for considering decision-making processes that engage all relevant stakeholders. These stakeholders include system-level relations with the local operating units. There should be a constructive relationship between stakeholders and large-scale organizations. Hence, accountability is crucial for corporate responsibility and effective governance. Not surprisingly, the concept of accountability has elicited significant professional and government scrutiny that is likely to increase. This increased interest occurs in part because the internal processes of boards vary significantly between high- and low-performing hospitals nationally. The process component of the ethics paradigm highlights the importance of accountability. At the heart of board accountability in governance ethics is the need for continuous evaluation and evidence-based improvements.

An important aspect of organizational oversight in healthcare institutions is the relationship that organizations have with the communities they serve. Non-profit hospitals and health systems are created and exist principally to serve communities by providing services to those in need. The board, in concert with the organization’s management team, acts to ensure that the organization’s resources are employed prudently. After all, board holds these resources in trust for the community and other stakeholders. Being accountable to this trust is at the core of the mission of healthcare organizations. The challenge is that communities typically have not established formal requirements or expectations for nonprofit health organizations. Hence, solid mechanisms or procedures typically are not in place to demonstrate the healthcare organization’s accountability to the community. This contrasts noticeably with the formal requirements or expectations of regulatory agencies, accrediting bodies, payers, and other organizational entities to which nonprofit hospitals and systems are accountable. The increasing need for protocols to respond to the communities or populations served by healthcare organizations underscores the importance of participative decision-making aligned with the concept of accountability in the process component of the ethics paradigm. The board’s approach to participative decision-making is indispensable for an organization’s performance. In the Governance Structure Report, 63 percent
of board members and 57 percent of CEOs indicated that boards were actively engaged in decision-making processes, with the board and the management team being willing to challenge each other constructively.\textsuperscript{55}

Within this context of organizational oversight in healthcare institutions, the process component of the ethics paradigm focuses on the concept of \textit{accountability}, reflecting the leitmotif \textit{how we function}. This concept emphasizes decision-making via participative deliberation in the healthcare organization. Here, the ethics paradigm organizes core features of effective governance from the \textit{Governance Structure Report} to highlight hallmarks of governance ethics and their associated moral imperatives.

The concept of \textit{accountability} focuses on \textit{how the board functions}, thereby highlighting board evaluation and succession planning as hallmarks of governance ethics. In turn, these hallmarks denote associated moral imperatives: board evaluation denotes a moral imperative regarding board oversight of fair evaluation processes; and succession planning denotes a moral imperative concerning board oversight of system planning and continuous updating. These are discussed in subsequent sections.

**Board evaluation: process-related governance ethics hallmark**

Board evaluation is the first hallmark of governance ethics regarding the process component of the ethics paradigm. The concept of \textit{accountability} in the ethics paradigm highlights board evaluation as a governance ethics hallmark by drawing attention to \textit{how we function} (as a board). In turn, this hallmark denotes an associated moral imperative regarding board oversight of fair evaluation processes.

**Moral imperative: board oversight of fair evaluation processes**

To undertake an effective evaluation process requires clear-mindedness regarding the different levels of accountability that boards must honor. As social institutions chartered to serve the needs of their patients and communities, the boards of nonprofit health systems have multiple fiduciary duties. Boards have a responsibility to understand these accountabilities and ensure they are met. There are three broad categories of these accountabilities that hospital and health system boards must ensure are fulfilled.\textsuperscript{56}

One category includes accountabilities that are mandated by parties with financial, ownership, and/or regulatory authority. These parties (some in the private sector, some governmental) have the power to specify requirements and standards that healthcare organizations must meet. These parties must apply sanctions if they fail to do so. One form of mandated accountability involves healthcare institutions with a parent organization that holds ultimate legal control. For instance, in many faith-based health systems, the boards of local or “market-based” organizations are accountable to and controlled by a parent system, which, in turn, may
be directly accountable to a sponsoring body such as a religious congregation or federation. Other examples of parties to whom hospitals and health systems have mandated accountability include the following: the Center for Medicare and Medicaid Services (CMS) establishes “Conditions for Participation” in the Medicare program and payment rules; state agencies engage licensure and regulatory authority; and the IRS has the authority to prescribe requirements that nonprofit hospitals and systems must meet for tax-exempt status. Revisions made in 2007 to the IRS Form 990, “Return of Organizations Exempt from Income Tax,” and related schedules have expanded the information that must be submitted by nonprofit healthcare institutions and now is publicly available.

Another category of accountabilities, while important and often essential, includes those that are voluntary in nature. For example, to be accredited by the Joint Commission (until 2007 known as the Joint Commission on Accreditation of Healthcare Organizations), hospitals must meet the prescribed requirements and standards, provide extensive information, and submit to review processes, all of which can consume substantial resources. However, the vast majority of nonprofit hospitals conclude that the benefits of accreditation outweigh the costs and, therefore, elect to be accountable to the accrediting body for meeting its requirements. Similarly, hospitals that want to offer medical residencies, advanced nursing certification, and/or other formal educational programs must accept accountability to the various bodies that review and certify these programs. In the healthcare field, there are numerous voluntary programs of this nature, each with its own requirements, standards, and accountability protocols.

A further category of board accountabilities deals with relationships with the communities served. Nonprofit health systems exist primarily to serve communities. Hence, governing boards, along with management, have a stewardship role to address these healthcare needs.

For nonprofit hospitals and health systems, these categories of accountability involve the following: (1) complying with many sets of requirements and standards, often duplicative and sometimes contradictory; (2) submitting large amounts of information to numerous external parties; and (3) dealing with formal sanctions, penalties, and/or criticism when any of these parties believe the hospital or health system has not fully met their requirements or standards. Further, these accountabilities are often fulfilled separately without any coordinating mechanism that would provide a clear picture of the full range of accountabilities and their influence on healthcare cost and quality or impact on community needs. Few hospital or health system boards have ready access to a complete list of the external parties to whom the organization they govern has some form of accountability, much less a solid understanding of the multiplicity of requirements those parties expect the organization to meet. Boards must fulfill their responsibility for the communities their healthcare organizations serve. Hence, boards need to understand the range of voluntary accountabilities and requirements their organizations have agreed to meet. This board responsibility is to ensure that organizational resources are being allocated and used prudently and effectively in a manner that supports the healthcare mission of their organizations.
However, there must be fair evaluation processes. The concept of accountability in the ethics paradigm emphasizes the importance of board evaluation. There have been notable achievements resulting from board evaluations. A national study of public companies in 2011 reported 91 percent of companies regularly conduct full board evaluations with 83 percent undertaking evaluations of board committees. Also, a survey of 81 health systems reported that 92 percent of the system boards had a formal evaluation process of performance at least every two years. There remain significant challenges. A board can claim compliance by merely using a formulaic checklist that adopts general assessment processes that are not organization specific. But such compliance with generic evaluation expectations is unlikely to improve its effectiveness significantly. Rather, assessment processes need to emphasize an ongoing evaluation of board performance. This performance includes the board’s commitment to specific action or change resulting from the process. In other words, an ongoing objective evaluation must be combined with follow-up actions to improve board performance.

The Governance Structure Report emphasizes these points. In the report, around 86 percent of the boards conduct some formal board evaluation every year or every two years. However, the results were lower concerning the more stringent standard of implementing follow-up action after formal board evaluation. Only 52 percent of the board members and CEOs reported that their board evaluations resulted in actions that substantially changed the board. Approximately 32 percent reported the board evaluations did not result in substantial changes and the others being unsure. Moreover, only 30 percent of system leaders (boards and CEOs) considered their current board evaluation processes to be “excellent,” with 54 percent indicating the evaluation process in place currently was “somewhat beneficial.” The Governance Structure Report emphasizes that effective governance requires a thorough assessment of board evaluation processes and practices. Such a rigorous approach will improve the effectiveness of boards, board committees, and board leadership. This emphasis upon board evaluation reflects the focus on accountability in the process component of the ethics paradigm.

A required board duty is to have an objective evaluation of the CEO’s performance. This process includes making the original appointment and establishing performance expectations in advance with clearly defined goals. For example, a national survey of public companies reported that 70 percent of boards collaborate with their CEOs to establish both financial and non-financial goals. Studies of hospital and health system boards report that most boards use a formal process for evaluating CEO performance. However, a study by the American Hospital Association’s Center for Healthcare Governance had more gloomy news. The study indicates that 82 percent of CEOs did not receive at their appointment clear performance expectations, and 66 percent reported that no formal evaluation process occurred at the end of the first year. This study illustrates why there are serious concerns about the rigor and efficacy of CEO evaluation.

In contrast, the Governance Structure Report mentions signs of effectiveness that can be a model for others. This report found that boards regularly evaluated
their CEO’s performance in relation to pre-established criteria. And 75 percent of system leaders (boards and CEOs) reported that the board CEO evaluation process produced clear performance expectations and assessed CEO performance fairly. Interestingly, the report also mentioned that for 50 percent of the systems the board compensation committee led the evaluation process, with the board chair either serving on this committee or working closely with it in the evaluation process.\footnote{70}

**Succession planning: process-related governance ethics hallmark**

Succession planning is the second hallmark of governance ethics regarding the process component of the ethics paradigm. The concept of *accountability* in the ethics paradigm highlights succession planning as a governance ethics hallmark by drawing attention to *how we function* (as a board). In turn, this hallmark denotes an associated moral imperative regarding board oversight of system planning and continuous updating. Succession planning is construed as comprising the board, board leadership positions, and senior management positions including clinical positions.

**Moral imperative: board oversight of system planning and continuous updating**

On the one hand, effective succession planning needs to be cognizant of the crucial relation between system-level and local planning. Board accountability requires the allocation of roles, responsibility, and authority to local units or organizations in the health system: this distribution between system-level and local leadership is crucial for effective governance.\footnote{71} In the *Governance Structure Report*, approximately 85 percent of the systems had adopted an organizational model with overall governance assigned to a system-level board and local boards with limited decision-making authority. All these systems have a board document that allocated governance responsibility and decision-making authority between the system and local units. Nearly all the boards and CEOs agreed that such an allocation requires continuous efforts to improve accountability. For example, if hospital-level boards are replaced with regional boards, the traditional linkages hospital boards had with their communities can be diminished. As a result, there could be potential communications and accountability issues. However, typically the accountability of boards (including accountability mechanisms) to the communities served are not expressed or codified in detail. This suggests a significant arena for further governance effectiveness.\footnote{72}

On the other hand, effective succession planning at the system and local levels needs to have continuous updating. This involves defining leadership needs (especially as they evolve to fit the internal and external environmental changes), assessing current talent, implementing a leadership development program, and systematic planning to identify individuals for future leadership roles. Not surprisingly, major organizations dedicate considerable scrutiny to leadership
succession planning as a crucial component of effective governance. However, there are serious issues. For example, in 2011 the National Association of Corporate Directors undertook a survey of public companies, reporting that only one-third had a formal CEO succession plan. Also in 2011, a survey of CEOs reported only 44 percent of hospitals with a succession plan for their CEO. Also, in 2011 a study by the Governance Institute identified only 41 percent of participating hospitals and health systems have an explicit process for board leadership succession planning for board officers and committee chairs. In the Governance Structure Report, 43 percent of the systems have some form of succession planning for board leadership and senior management positions including the CEO. Undoubtedly, succession planning in the healthcare field needs improvement. The Governance Structure Report indicates that most CEOs and board leaders recognize that developing and sustaining succession plans in a systematic manner is indispensable for effective governance. Leadership succession planning for boards, board leadership, and senior management should be a system-wide strategic priority.

In sum, the process component of the ethics paradigm highlights board evaluation and succession planning as hallmarks of governance ethics. By focusing on accountability in the ethics paradigm, these hallmarks denote associated moral imperatives: board evaluation denotes a moral imperative regarding board oversight of fair evaluation processes; and succession planning denotes a moral imperative concerning board oversight of system planning and continuous updating. The next section considers the practice component of the ethics paradigm that focuses on the concept of quality to highlight practice-related hallmarks of governance ethics.

**Context of practice-related governance ethics hallmarks**

The concept of quality in the ethics paradigm (reflecting what we do) emphasizes the importance of best practices for standards of conduct. This focus on quality requires boards to be attentive to organizational culture as the context for assessing their responsibilities. For example, just as healthy organizational culture requires trust and confidence between the CEO and the board, that same culture can reinvigorate the public’s trust. This relationship between governance oversight and improved hospital performance is emerging as an internationally prominent issue.

Organizational culture reflects a pattern of beliefs and traditions that have shaped practices and prevail when the board convenes to carry out its duties. Board culture distinguishes an effective board from an ineffective board. For example, the unfortunate but well-known case of Enron indicates the damage of a passive management-driven board culture with low expectations and standards. This passive environment fails to ask hard questions or detect egregious irregularities or unethical conduct. Another example of the negative impact that a passive board culture can have on an organization is the fallout over falsified emission standards in cars manufactured by different companies.
Organizational culture provides the crucial context for an organization’s success. A healthy culture, nurtured by board practices, will result in an ethical climate or ethical tone that integrates ethics across the organization. This ethical climate should be just and fair, requiring the organizational leadership’s engagement. This culture also should integrate core values with organizational well-being. Organizational culture has a significant impact on strengthening ethical behavior. That is, organizational culture is necessarily grounded in ethics: boards need to ensure that an ethical climate permeates the organization. Board improvement of the ethical culture requires the board’s support of an effective ethics program across the entire organization. To cultivate this culture also requires the board to openly discuss ethics and the use of ethics resources across the organization. In this manner, as the board promotes organizational culture it will also nurture an ethics-driven atmosphere throughout the organization. In turn, this creates a pervasive caring tone.

Organizational culture provides the context for effective performance through best practices for standards of conduct. To nurture a healthy culture there need to be a board commitment to high-performance standards and a willingness to take decisive action. Of course, each board is responsible for creating its own culture. The Governance Structure Report emphasizes that boards should undertake an objective appraisal to determine practical steps to improve their organizational culture as a crucial part of board performance.

Within this context of organizational culture, the practice component of the ethics paradigm focuses on the concept of quality, reflecting the leitmotif what we do. This concept emphasizes best practices for standards of conduct. Here, the ethics paradigm organizes core features of effective governance from the Governance Structure Report to highlight hallmarks of governance ethics and their associated moral imperatives.

The concept of quality focuses on what boards do, thereby highlighting leadership collaboration and system-wide strategy as hallmarks of governance ethics. In turn, these hallmarks denote associated moral imperatives: board oversight of leadership collaboration denotes a moral imperative regarding oversight of working relationships; and board oversight of system-wide strategy denotes a moral imperative concerning oversight of transformational change and strategic planning. These are discussed in the following sections.

**Leadership collaboration: practice-related governance ethics hallmark**

Leadership collaboration is the first hallmark of governance ethics regarding the practice component of the ethics paradigm. This hallmark includes the respective responsibilities of the CEO and the board. Also, the hallmark includes executive support for organizational culture in a trust based reciprocal relationship. The concept of quality in the ethics paradigm highlights leadership collaboration as a governance ethics hallmark by drawing attention to what we do (as a board). In turn, this hallmark denotes an associated moral imperative regarding board oversight of working relationships.
Moral imperative: board oversight of working relationships

On the one hand, a robust organizational culture indicates the importance of leadership collaboration between the CEO and the board that contributes to other leadership roles in the organization. This entails, according to the Governance Structure Report, having a CEO with exceptional leadership and management skills who works in tandem with board leadership. That is, there must be a mutual understanding about the respective roles of governance and management, especially to develop excellent board-management relations. Formal written descriptions of the respective duties of the CEO and the board chair help immensely. These should be approved by the board and updated regularly. In the Governance Structure Report, 100 percent of the systems had formal, written descriptions (adopted by the board) of the CEOs position, and 85 percent of the boards had adopted formal position descriptions for the board chair. Also, 91 percent of board members and 86 percent of CEOs indicated there was solid agreement among board members of the distinctions between the CEO’s role and the board chair’s role. Furthermore, the same number indicated an excellent relationship between the CEO and the board chair.

On the other hand, CEOs should provide strong support for good working relationships regarding governance, manifested directly in the caliber of staff support provided for the board. How boards are supported by senior staff provides an interesting insight into the CEOs commitment to strong governance by cultivating a healthy board culture. In the Governance Structure Report, 91 percent of the boards and 100 percent of the CEOs reported that standing committees of the board have senior staff support. A high level of CEO support is needed not only for the role of governance in general but also to build trust-based board-CEO relationships. Again, in the Governance Structure Report nearly all board members indicated CEO support as being consistently high. The report indicated 90 percent of the boards having working relationships with the CEO as being excellent, with the following insights concerning board culture. Nearly all the boards and CEOs considered their boards as demonstrating a commitment to their system’s mission (93 percent) and honoring their conflict of interest and confidentiality policies (board members, 93 percent; CEOs, 86 percent). The report indicated 75 percent of board members and 71 percent of CEOs perceived an atmosphere of mutual trust among board members. Moreover, 74 percent of board members and 93 percent of CEOs reported that the board closely tracks the health system’s clinical and financial performance taking appropriate action when performance does not meet targets. However, only 57 percent reported board leadership holding board members to high standards of performance, and around 50 percent indicated that robust engagement and respectful disagreement was encouraged. Clearly, these are issues that warrant concerted board attention.

System-wide strategy: practice-related governance ethics hallmark

System-wide strategy is the second hallmark of governance ethics regarding the practice component of the ethics paradigm. System-wide strategy includes
approaches that result in continuous performance improvement across the organization. The concept of *quality* in the ethics paradigm highlights system-wide strategy as a governance ethics hallmark by drawing attention to what we do (as a board). In turn, this hallmark denotes an associated moral imperative regarding board oversight of transformational change and strategic planning.

**Moral imperative: board oversight of transformational change and strategic planning**

On the one hand, focusing upon transformational change as a key characteristic of system-wide strategy has been a required aspect of corporate governance theory. Of course, transformational change must be consistent with an organization’s mission. Effective boards focus careful attention on system-wide strategies and key priorities. Focusing on possibilities that will generate transformational change will require the use of board time and effort wisely. The *Governance Structure Report* indicates that the way board meetings are organized and how time is allocated, such as on transformational matters, are indicative of board effectiveness. Moreover, boards with broader expertise have been correlated with responding better not only to the complex environment that hospitals face but also to their strategic focus. Globally, the transformational role of the board will significantly influence its capability for strategic action.

On the other hand, transformational change cannot occur without strategic planning. Boards are often criticized for concentrating on short-term issues such as current operating performance and not on strategic issues confronting the organization. Surveys of boards in public companies and nonprofit organizations often rank strategic planning and oversight as one of the top priorities of the board. Recent research indicates that the shift of boards to strategic approaches is not occurring sufficiently. Healthcare organizations, especially via their boards, should be accountable with appropriate transparency to the communities they are chartered to serve. The *Governance Structure Report* is attentive to the time and energy that boards devote to strategic issues. The effectiveness of the changes should be evaluated with a commitment to best practices for continual quality improvement. Some examples of mechanisms to improve the strategic focus of the board include the following: using a consent agenda format for board meetings; having board retreats; dedicating time at every board meeting to a specific challenge concerning the organization’s future direction; and placing board discussion on strategic issues as the first segment in every board meeting.

Furthermore, strategic planning is a crucial aspect of effective governance. In the *Governance Structure Report*, all the health system boards were engaged in a process of reforming board practices to accelerate a shift to a strategic focus addressing system-wide concerns. The combined estimate of boards and CEOs about the amount of board time dedicated to strategic thinking and planning at the time of this study varied in different health systems from a low of 15 percent to a high of 53 percent with a mean estimate of 30 percent. Of course, boards must provide oversight of system operations and performance. They need to increase their engagement with system-wide strategy with related strategic challenges.
and opportunities. As boards dedicate more time and energy to strategic changes (which will be crucial for organizational survival and success), there will be an increased need for forthright assessment regarding continuous quality improvement of board performance. For example, there should be a standing board committee with oversight responsibility for system-wide policies and programs on priorities in the realm of population health.\textsuperscript{108} Also, the \textit{Governance Structure Report} indicated that only one-third of boards and CEOs in the 14 systems felt their system board meetings were well organized in a consistent manner and strategically focused. However, all these health systems expressed commitment to increase energy and time devoted to strategic issues.\textsuperscript{109}

In sum, the practice component of the ethics paradigm highlights leadership collaboration and system-wide strategy as hallmarks of governance ethics. By focusing on \textit{quality} in the ethics paradigm, these hallmarks denote associated moral imperatives: leadership collaboration denotes a moral imperative regarding board oversight of working relationships; and system-wide strategy denotes a moral imperative concerning board oversight of transformational change and strategic planning.

\textbf{Conclusion}

The chapter has highlighted hallmarks of governance ethics with associated moral imperatives regarding governance structure of boards in healthcare organizations. The contribution of the ethics paradigm can be summarized in this manner.

First, in the context of the challenging healthcare environment, the foundation component of the ethics paradigm focuses on stewardship to enhance an organization’s mission in healthcare as crucial for effective governance. This component deals with the \textit{identity} of an organization, reflecting the leitmotif \textit{who we are}, thereby highlighting board competence and board role as hallmarks of governance ethics. In turn, these hallmarks denote associated moral imperatives: board competence denotes a moral imperative regarding board oversight of Term limits and board composition; and board role denotes a moral imperative concerning board oversight of defined responsibilities and board effectiveness.

Second, in the context of organizational oversight in healthcare institutions, the process component of the ethics paradigm focuses upon decision-making to encourage participative deliberation in organizations. This component addresses the \textit{accountability} of the organization, reflecting the leitmotif \textit{how we function}, thereby highlighting board evaluation and succession planning as hallmarks of governance. In turn, these hallmarks denote associated moral imperatives: board evaluation denotes a moral imperative regarding board oversight of fair evaluation processes; and succession planning denotes a moral imperative concerning board oversight of system planning and continuous updating.

Third, in the context of organizational culture in healthcare, the practice component of the ethics paradigm focuses on best practices to develop standards of conduct. This component engages \textit{quality} in an organization, reflecting the leitmotif \textit{what we do}, thereby identifying leadership collaboration and system-wide
strategy as hallmarks of governance ethics. In turn, these hallmarks denote associated moral imperatives: leadership collaboration denotes a moral imperative regarding board oversight of working relationships; and system-wide strategy denotes a moral imperative concerning board oversight of transformational change and strategic planning.

This chapter has applied the ethics paradigm to highlight hallmarks of governance ethics regarding board structure, denoting associated moral imperatives. The next chapter adopts the same approach to discuss hallmarks of governance ethics concerning community benefit.

Notes


5 Previous research on governance in nonprofit hospitals and community health systems contributed to the design of this study. For previous research data, see: L. Prybil, et al., Governance in High-Performing Organizations: A Comparative Study of Governing Boards in Not-for-Profit Hospitals (Chicago, IL: Health Research and Educational Trust, 2005); L. Prybil, et al., Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives (Chicago, IL: Grant Thornton LLP, 2008); L. Prybil, et al., Governance in High-Performing Community Health Systems (Chicago, IL: Grant Thornton LLP, 2009).

6 L. Prybil et al., The Evolving Accountability of Nonprofit Health System Boards (Chicago, IL: AHA Center for Healthcare Governance, 2013).


Governance structure


A coalition of healthcare associations is involved in this initiative, Equity of Care, including the American Association of Medical Colleges, the American College of Healthcare Executives, the American Hospital Association, and the Catholic Health Association. See: www.equityofcare.org.

Governance Structure Report, 6, 10–12.


Governance Structure Report, 6, 14.


See: F. Entin, J. Anderson, K. O’Brien, The Board’s Fiduciary Role: Legal Responsibilities of Healthcare Governing Boards (Chicago, IL: The Center for Healthcare...


72 *Governance Structure Report*, 18–20, 44.


78 *Governance Structure Report*, 45, 57–58 (also, 6, 18, 27–28).


Governance structure

93 Governance Structure Report, 37–38, 45, 58.
95 Governance Structure Report, 18, 21.
96 Governance Structure Report, 37, 40.
100 Governance Structure Report, 18, 35, 42–43.


*Governance Structure Report*, 37, 55.

**Select readings**


5 Governance of community benefit

Introduction

This chapter applies the ethics paradigm to discuss hallmarks of governance ethics regarding board oversight of community benefit. Community benefit is a pivotal issue for governance ethics. Dealing properly with community benefit advances the health of many but dealing poorly with it undermines public confidence in healthcare organizations.

In the analysis of the applied chapters, the concepts of the ethics paradigm organize core features of effective governance from landmark reports and the scholarly literature. The landmark report by one of the co-authors of this book that shapes the discussion in this chapter is referred to as the *Community Health Systems Report.* The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. Because the hallmarks represent necessary moral attributes of governance ethics, they entail an obligation to be adopted by boards. In turn, the associated moral imperatives represent necessary endeavors to foster the hallmarks under consideration.

The ethics paradigm organizes multiple topics on board oversight of community benefit, as follows. First, the foundation component of the ethics paradigm deals with the identity of an organization, reflecting the leitmotif who we are, thereby highlighting board engagement as a hallmark of governance ethics for community benefit. In turn, this hallmark denotes an associated moral imperative of board oversight of the standing committee structure. Second, the process component of the ethics paradigm addresses the accountability of the organization, reflecting the leitmotif how we function, thereby highlighting effective communication as a hallmark of governance ethics for community benefit. In turn, this hallmark denotes an associated moral imperative regarding board oversight of community needs assessment. Third, the practice component of the ethics paradigm engages quality in an organization, reflecting the leitmotif what we do, thereby highlighting board oversight of organizational performance as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative regarding board oversight of continuous improvement.

Each of the applied chapters begins with an explanation of the need for the pivotal topic under consideration, such as governance of community benefit here.

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Again, the concepts of identity, accountability, and quality provide a framework for the applied analysis. These concepts represent the foundation component (reflecting who we are), the process component (reflecting how we function), and the practice component (reflecting what we do) of the ethics paradigm (Table 1.1).

The interest in community benefit from the perspective of board oversight has been discussed for many years in national healthcare organizations. Hence, before considering hallmarks of governance ethics regarding this topic, it is helpful to explain the need for the community benefit standard.

**Need for board oversight of community benefit**

Community benefit can be described as a form of public trust that is linked with nonprofit hospitals obtaining tax-exempt status. The community benefit standard includes a provision of care for the poor (charity care) but also must be thought of in larger terms to include the promotion of health. This is a significant ethical issue. For example, in the absence of strong federal regulation regarding community benefit programs in nonprofit hospitals, states are intervening to raise standards other than merely meeting Internal Revenue Service (IRS) requirements (discussed later). This need for board oversight of community benefit reflects an indispensable obligation of governance in healthcare organizations. This obligation in part reflects the history of providing charitable care in healthcare in the USA and in part reflects the role of healthcare organizations being good corporate citizens.

Not surprisingly, ethical discourse on this need highlights the strain between altruistic service to the community being served (community solidarity) and the fiduciary duty for the healthcare organization to stewardship of its resources (resource allocation). This strain recalls the tension between mission and margin that is at the heart of governance ethics.

There are many IRS guidelines related to tax-exempt status. Notably, in 1969, the IRS issued Revenue Ruling 69–545. The purpose was to justify an organization’s tax-exempt status by creating the community benefit standard regarding nonprofit hospitals being exempt from federal income tax under section 501(c)(3) of the IRS Code. The determination of this status changed from providing charity
care to providing community benefit. The ruling provided the context for establishing the community benefit standard that continues today.9

This ruling let hospitals qualify for tax-exempt status if they engaged in the promotion of health. The standard could be met through a variety of measures including the following: if a hospital operates an emergency room that is available for all irrespective of the ability to pay; or, if a hospital uses surplus funds to advance education, training, and research or make improvements in patient care. In 1992, the IRS issued hospital audit guidelines to monitor the implementation of this expanded interpretation. This ongoing monitoring by the IRS was accompanied by scrutiny from voluntary healthcare organizations, local governments, and different states. The Community Health Systems Report suggested that cumulatively this scrutiny created a growing sense of consternation with what was occurring.10

In 2007 there were substantial revisions to the IRS Form 990, specifically Schedule H for hospitals. According to the IRS, Schedule H was intended to “combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care.”11 For nonprofit healthcare institutions, the revised Form 990 and Schedule H required much more extensive information about charity care (referred to in Schedule H as “financial assistance”) and other aspects of community benefit than in the past. The redesigned form consisted of a common document to be completed by all tax-exempt organizations with a series of schedules to combat lack of transparency and encourage consistency in reporting. These revisions phased in during 2008 and 2009.12 The revision required tax-exempt organizations to submit reports annually with more information about community benefit services including charity care. The American Hospital Association provides a Schedule H community benefit report.13

Subsequently, the Patient Protection and Affordable Care Act of March 2010 amended the IRS code by adding Section 501(r)(3). This section required every hospital facility operated by a 501(c)(3) organization to undertake a community health needs assessment. This had to occur at least every three years. The hospitals were required to develop an implementation strategy to address the identified community needs making the results available to the public.14 These new requirements had substantial impact on nonprofit hospitals and healthcare systems.15 Moreover, the Patient Protection and Affordable Care Act promoted the development of Accountable Care Organizations (ACOs) to improve the health status and the care efficiency of a defined population.16 The goal of community assessment was to address population health, specifically to bridge the well-documented quality chasm between individual patient care and public health.17 Naturally, this endeavor required a lot better communication and coordination between healthcare providers and public health agencies.18

Over the following years there emerged an increasing need for data to support community benefit investment in nonprofit healthcare.19 Robust oversight and clear direction for community benefit programs have become an essential component of effective governance.20 In light of the provisions of IRS Code Section 501(r)(3), especially regarding community benefit programs, it became urgent for
governing boards to make further progress regarding community benefit plans in nonprofit health systems. That is why the Community Health Systems Report (that is discussed further in this chapter) highlighted the need for an increased focus by boards. This focus should be on system-wide community benefit programs and community health needs to be properly accountable to the communities and populations they serve. The report recommends focusing on “meeting the emerging benchmarks for good governance with respect to their systems’ community benefit responsibilities.” By comparing the structures, practices, and cultures of boards with established benchmarks for good governance, the report contributed in a pivotal manner to assessing and enhancing board effectiveness. A significant outcome of the report is that community benefit requires improved board oversight: “concerted board-level attention to this area is necessary and important.” In the report, several critical differences were identified as being statistically significant between boards in high-performing community health systems and both mid-range and low-performing systems.

The discussion now applies the ethics paradigm to organize core features of effective governance regarding community benefit. This discussion focuses on the Community Health Systems Report and the scholarly literature. The relevance of ethics for board oversight of community benefit has been longstanding. The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. The applied analysis begins with discussing hallmarks of governance ethics connected with the foundation component of the ethics paradigm.

**Board engagement: foundation-related governance ethics hallmark**

The foundation component of the ethics paradigm, in the context of the challenging environment of healthcare, focuses on stewardship to enhance an organization’s mission as crucial for effective governance. This component depicts the *identity* of an organization, reflecting the leitmotif *who we are*. That is, the concept of *identity* in the ethics paradigm emphasizes the importance of organizational stewardship.

The principle of stewardship connected with an organization’s mission requires the organization to respect the trust it receives from the community. This highlights the trust relation between communities and hospitals. A guiding principle to increase trust and confidence is to “be who we say we are” in terms of reflecting and implementing the hospital’s mission. Stewardship protects and enhances the integrity of the organization, ensuring that mission responsiveness permeates the organization to meet actual needs, such as should occur in community benefit programs.

It is crucial to interpret the principle of stewardship as a foundation for an organization’s mission rather than construing the principle as merely providing operational directions for management functions. If the principle of stewardship is reduced merely to management functions related to fiscal responsibility,
as important as these functions are, the organization can lose sight of its core mission of healing patients and building trusting communities. Of course, effective implementation of these management functions as enactments of stewardship are necessary for the success of an organization. However, that implementation should always reflect the more basic mission that the principle highlights. In other words, when management functions are detached from the underlying organizational mission, a reductive understanding of these functions can compromise the trust in the communities served.

Improvement of community benefit services and programs via more effective board oversight should not be reduced to merely being a matter of better accounting or more efficient management, far less being merely a matter of legal compliance. Rather, community benefit is an essentially ethical endeavor insofar as it reveals the core commitment of the board to steward the organization’s fundamental mission as a tax-exempt organization that is committed to serving its community. Hence, boards must effectively discharge their governance oversight of community benefit practices. Healthcare mission includes the commitment to heal patients, to build trust with communities, and to improve quality of lives by decreasing health disparities, enhancing health status, and assuring healthcare access. In this mission, health systems and hospitals have an inherent responsibility to assess and improve the health of their communities as well as providing care and treatment for their patients. A good example of this connection between organizational mission and community benefit is articulated by the Catholic Health Association: “sustaining community benefit programs requires that healthcare organizations have a clear mission to serve their communities and a solid community benefit program infrastructure.”

The concept of identity in the ethics paradigm (reflecting the leitmotif who we are) emphasizes the importance of organizational stewardship. This focus requires boards to be attentive to the challenging healthcare environment as the context for considering their responsibilities. The concept of identity highlights board engagement as a hallmark of governance ethics for community benefit. This concept draws attention to who the board is in relation with its organization. In turn, this hallmark denotes an associated moral imperative regarding board oversight of the standing committee structure. These are discussed later.

To understand board engagement as a hallmark of governance ethics regarding community benefit, it is important to underscore the role of the board in nonprofit governance. Board engagement includes having a well-organized structure with defined duties to routinely scrutinize community benefit issues. The Community Health Systems Report highlighted gaps with regard to established benchmarks for good governance. The report indicated that only 70 percent of all community health system boards in the report have formal discussions on a regular basis about community benefit responsibilities and programs. However, 90 percent of high-performing system CEOs indicated that their boards engage in such discussions. This information indicated a gap in the mid-range systems (of which 72 percent reported such discussions) and a more significant gap in low-performing systems (of which only 36 percent reported such discussions).
There is need for robust board engagement regarding community benefit responsibilities. Highlighting board engagement as a hallmark of governance ethics underscores a mission-related duty of the board: that is, to inspire its healthcare organization to serve its communities. This focus upon robust engagement enables boards to clarify their responsibilities and to develop strategies for effective governance. Board engagement understood in this manner should provide excellence in leadership with specific oversight of community benefit. This governance responsibility has been widely recognized. For example, from early in the debate on community benefit, the Catholic Health Association emphasized this responsibility of the board. That is, the board’s must ensure that the organization’s community benefit mission is fulfilled, upholding the community’s interest as being paramount.34

Moral imperative: board oversight of the standing committee structure

Oversight of board engagement is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of the standing committee structure. Committee structure helps to clarify the board’s identity (who the board is) in the face of community benefit challenges. The responsibilities of nonprofit governing boards in healthcare organizations are widely recognized, and there are established expectations for the design of boards. Despite this well-established knowledge about effective governance regarding the make-up of a board, there remain serious concerns about board effectiveness. As a result, public dismay over board oversight continues, especially with regard to nonprofit healthcare. A proactive role in governance is generally evident in the committee structure and yields more effective boards, connecting the caliber of governance with organizational success. Hence, board oversight in its committee structure constitutes a standard of good governance. In other words, board engagement that is manifest in its committee structure leads to governance effectiveness.

A well-organized committee structure with clearly defined duties is one of the keys to effective governance. Hence, board engagement typically should require a standing committee for effective oversight, working with the entire board appropriately. This committee oversight can guarantee that community benefit remains a high priority aligned with the organization’s mission. In this sense, boards must ensure the organization’s fidelity to its nonprofit healthcare mission.

The Community Health Systems Report indicated that only 40 percent of community health systems had standing board committees with clearly assigned oversight responsibility for community benefit policies and programs (50 percent in high-performing systems; 42 percent in mid-range systems; and 18 percent in low-performing systems). Such a surprisingly low figure reflects poorly on organizational stewardship. The low figure appears to be connected with the report’s findings that many boards did not routinely deliberate about community benefit issues. Also, the low figure suggests that boards did not have a board-adopted policy and plan for community benefit. The absence of a standing committee to serve as a governance focal point had an obvious impact. That is, there
was not sufficient advocacy or championing for community benefit, potentially preventing this pivotal topic from being included in the board’s ongoing agenda.

In sum, the foundation component of the ethics paradigm highlights board engagement as a hallmark of governance ethics. By focusing on identity in the ethics paradigm (dealing with who the board is), this hallmark denotes an associated moral imperative regarding board oversight of the standing committee structure.

**Effective communication: process-related governance ethics hallmark**

The concept of accountability in the ethics paradigm (reflecting the leitmotif how we function) emphasizes the importance of decision-making via participative deliberation. This focus requires boards to be attentive to organizational oversight as the context for assessing their responsibilities. The concept of accountability highlights effective communication as a hallmark of governance ethics for community benefit. To meet this charge, boards should be designed to have processes for communication with diversity of thinking. The concept draws attention to how the board functions in the organization. In turn, this hallmark denotes an associated moral imperative regarding board oversight of community needs assessment to plan appropriate resource allocation and program development. These are discussed in the following sections.

Regarding effective communication as a hallmark of governance ethics, board oversight is needed internally and externally. The *Community Health Systems Report* highlighted the need for boards to actively collaborate both internally (such as with system management teams) and externally with other organizations and constituencies to undertake a reliable and ongoing community needs assessment. Internally, board oversight must ensure that, through effective communication, community benefit programs are integrated across the organization. Community benefit staff typically integrate and coordinate their activities across the organization to properly serve its communities. Externally, relevant community members and agencies need to be included in communication about services. Increased board accountability can occur by reinforcing effective communication between nonprofit organizations and their communities. This focus on effective communication will foster robust responses to expectations regarding community benefit.

**Moral imperative: board oversight of community needs assessment**

Board oversight of effective communication is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of community needs assessment. This imperative reflects the concept of accountability in the ethics paradigm. Professional associations have urged healthcare organizations to develop formal processes that deal with community needs assessment. Yet the *Community Health Systems Report* indicated that only 29 percent of all community health systems collaborate on an ongoing basis with other local
organizations in this regard. This collaboration refers to formal assessment processes designed to determine community needs to which systems resources should be allocated. However, 70 percent of the high-performing system CEOs reported that their health systems collaborate with other local organizations in assessing community needs on a regular basis. This information indicated a significant gap in the mid-range systems (of which only 27 percent reported undertaking such a needs assessment) and low-performing systems (of which only 9 percent reported undertaking such a needs assessment).49

As legal fiduciaries of the community, boards must conduct and communicate their governance activities to ensure that community interests are being protected. This concern is especially pertinent for unmet health needs and vulnerable populations,50 such as typically occurs in community benefit practices. Deliberating on community needs is a distinguishing aspect of this hallmark of governance ethics, consistent with longstanding expectations of national associations. For example, the Catholic Health Association emphasized that “Community benefit programs are designed to address specific community health needs.”51 Hence, community needs assessment constitutes an ethical imperative as a defining feature of the decision-making processes in effective communication.

In sum, the process component of the ethics paradigm highlights board engagement as a hallmark of governance ethics. By focusing on accountability in the ethics paradigm (dealing with how the board functions), this hallmark denotes an associated moral imperative regarding board oversight of community needs assessment.

Organizational performance: practice-related governance ethics hallmark

The concept of quality in the ethics paradigm (reflecting the leitmotif what we do) emphasizes the importance of best practices for standards of conduct. This focus requires boards to be attentive to organizational culture as the context for assessing their responsibilities. The concept of quality highlights organizational performance as a hallmark of governance ethics for community benefit. In turn, this hallmark denotes an associated moral imperative regarding board oversight of continuous improvement. These are discussed later.

The purpose of focusing upon best practices in this component of the ethics paradigm is to shed light on the need to weave policy and planning with performance for effective board oversight of community benefit. This oversight constitutes a threshold responsibility that reveals the ethical caliber of the organization and of the board. The reason for this threshold responsibility is that community benefit is not just one item among a litany of other competing demands in a healthcare organization. Rather, community benefit practices are at the foundation of the mission of nonprofit healthcare. They are required by state statutes and IRS revenue rulings and they are ethically obligatory from the perspective of social responsibility.

Regarding organizational performance as a hallmark of governance ethics, board oversight is needed to combine policy and action planning. The Community
Health Systems Report highlighted the need for boards to develop a specific strategy for oversight of community benefit. This strategy should combine policy and planning with action, including measurable objectives for effective reporting. There should be clear measurement tools to both collect and analyze relevant data. This undertaking should identify the organizational objectives in clear and measurable terms. The goal is to ensure that reporting and accountability mechanisms are in place both to track progress and to provide reports on a regular basis. Such conduct demonstrates that boards are committed to governance effectiveness regarding community benefit. Despite this obvious need for a board strategy to develop a policy and plan with performance reports, the data identified worrisome gaps, as follows. 

To begin, the Community Health Systems Report indicated that only 60 percent of community health system boards had adopted a formal written policy to define guidelines for their community benefit programs. However, 90 percent of high-performing system CEOs reported that they had a formal written policy. This information indicated a gap in the mid-range systems (of which only 60 percent report having such a policy) and a more significant gap in low-performing systems (of which only 27 percent report having such a policy).

Next, the Community Health Systems Report indicated that only 34 percent of community health system boards had adopted a formal community benefit plan with measurable system wide objectives. However, 50 percent of high-performing system CEOs reported that they had a formal community benefit plan. This information indicated a gap in the mid-range systems (of which only 36 percent report having a specific plan) and a more significant gap in low-performing systems (of which only 9 percent report having a specific plan).

Furthermore, the Community Health Systems Report indicated that only 68 percent of community health system boards were presented regularly with performance data on community benefit. The data referred to measurable system wide objectives regarding its community benefit program. However, 90 percent of high-performing system CEOs reported that they regularly receive this performance data. This information indicated a gap in the mid-range systems (of which 70 percent report regularly receiving such performance data) and a more significant gap in low-performing systems (of which only 36 percent report regularly receiving such performance data).

This hallmark of governance ethics focuses on the ethical conduct of the board’s oversight of organizational performance with accompanying measurable objectives. This hallmark engages the responsibility of the board to provide adequate programs and services for community benefit. The endeavor here is to plan and monitor outcomes toward established goals and objectives with periodic reports.

This need for board oversight is consistent with longstanding expectations among professional associations. For example, the Catholic Health Association has focused on planning for performance reports: “We believe that vigilance in how we plan, evaluate, and report community benefit is more important than ever;” to assist its members, the association provided a detailed guide by adopting a public health approach to program evaluation. Also, the association has
encouraged the development of evidence-based community benefit endeavors.\textsuperscript{57} Dashboard technology provided an example of the emphasis upon assessing and monitoring. Regarding community benefit program outcomes, dashboard technology has been adopted to consolidate data from disparate systems in meaningful ways in a consistent and accessible manner.\textsuperscript{58}

Board oversight of organizational performance requires measurement outcomes for the community.\textsuperscript{59} It is indispensable to provide thorough reports to communities on a regular basis.\textsuperscript{60} As boards adopt this approach, performance evaluations need to apply to the boards themselves just as other occurs with other responsibility reviews (such as on governance structures). These best practices and standards of conduct contribute to high quality board oversight.\textsuperscript{61}

\textit{Moral imperative: board oversight of continuous improvement}

Board oversight of organizational performance is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of continuous improvement. This imperative reflects the concept of quality in the ethics paradigm. To understand the moral imperative of continuous improvement regarding community benefit, it can be helpful to return to the \textit{Governance Structure Report} (undertaken several years after the \textit{Community Health Systems Report}).\textsuperscript{62} The \textit{Governance Structure Report} highlights the need for board oversight of continuous improvement regarding community benefit by focusing on the following threshold items: the need to improve oversight of (1) standing board committees for community benefit programs; (2) formal goals and planning guidelines for community benefit programs; (3) collaboration with local public healthcare organizations concerning community benefit programs; and (4) local organizations.

To begin, there is a clear need for a practical policy about board oversight of community benefit programs. A well-organized committee structure having clearly defined duties with knowledgeable and engaged members is a key to effective governance.\textsuperscript{63} The \textit{Governance Structure Report} highlighted the need to assign oversight responsibility for governance functions to standing board committees. The report recorded the number and proportion of boards in its study population that assigned oversight responsibility for seven core governance functions to standing board committees. Across the board, large health systems were more likely than hospitals to have standing committees with oversight responsibility for these important functions. For several functions, this practice was virtually universal among these large systems. However, less than a majority had standing board committees with oversight responsibility for system-wide community benefit policies and programs.\textsuperscript{64} This information indicated the need for continuous improvement of board oversight.

Also, the \textit{Governance Structure Report} emphasized that board planning must adopt formal goals and guidelines for community benefit programs. The interviews with board leaders and CEOs in the report included several questions regarding their system’s community benefit policies and programs. A pivotal
issue was if a board adopted a formal, written statement that defines overall goals and guidelines for the system’s community benefit program. Comparing the findings for Catholic systems to the other large systems, the report indicated that boards in most of the Catholic systems had adopted a formal policy as compared to only a few of the other systems. Moreover, the report indicated that most of the system boards had adopted a written, formal statement defining overall goals and guidelines for the system’s community benefit program. However, only half of the systems required their local organizations to adopt formal community benefit plans that identified specific priorities and strategies. This information indicated the need for continuous improvement of board oversight.

Furthermore, the Governance Structure Report underscored the need for collaboration with local public healthcare organizations. For example, in the report only 6 percent of boards and CEOs reported that their board requires collaboration between the system’s facilities and local public health agencies. One way was mentioned to gauge the participating systems’ stance on coordination between their local delivery organizations and public health agencies. That is, the board members and CEOs were asked if their system’s board required their local organization to collaborate with local public healthcare organizations in their vicinities. The information shows that such requirements were quite uncommon. Only one of the 14 large systems, a secular organization, had established a policy requiring all of its local organizations to collaborate with local public healthcare organizations in assessing community needs and setting community benefit program priorities. However, there was recognition of the nationwide need for greater focus on prevention and population health. In light of this recognition, many board members and CEOs expressed support for the idea of promoting stronger coordination and between their local leadership teams and public healthcare organizations. Again, this information indicated the need for continuous improvement of board oversight.

Finally, formal community benefit plans could be adopted by the local organizations of health systems, if that would provide value depending on arrangements with the parent system. In the foreseeable future, public and private organizations in nearly all sectors of American society face serious financial constraints. Hence, these organizations must establish resource allocation priorities very carefully. Over many years, uncompensated care (charity care and bad debt, but not Medicaid or Medicare underpayment costs) in hospitals across the USA increased significantly. This trend affected the availability of resources for other community benefit activities. As a result, developing formal plans and setting clear priorities for community benefit programs emerged as indicators of effective governance and management in healthcare organizations. In the Governance Structure Report, CEOs and board leaders were asked this crucial question: if their system’s board required their local organizations to develop and adopt a formal community benefit plan that identifies specific priorities for its program. The report indicated that 67 percent of these large systems directed their local leadership teams to develop formal plans with priorities, strategies, and metrics for their community benefit programs. In several instances, they specified that local plans
must address certain system-wide priorities. Once more, this information indicated the need for continuous improvement of board oversight.

The outcome of this analysis is to emphasize ethical imperative of continuous improvement regarding community benefit. Pressure will increase upon nonprofit healthcare organizations. The provisions of IRS Code Section 501(r)(3) will continue, and resources will become further constrained. Hence, continuous improvement regarding community benefit programs will be indispensable for governance ethics. Specifically, there will be an increased need for ongoing assessment of community health needs, careful prioritization of those needs, and adoption of formal community benefit plans. These plans must be part of board oversight at both the local and system levels of nonprofit health systems.

In sum, the practice component of the ethics paradigm highlights organizational performance as a hallmark of governance ethics. By focusing on quality in the ethics paradigm (dealing with what the board does), this hallmark denotes an associated moral imperative regarding board oversight of continuous improvement.

**Conclusion**

The chapter has highlighted hallmarks of governance ethics with associated moral imperatives regarding community benefit. The contribution of the ethics paradigm can be summarized in this manner.

First, in the context of the challenging healthcare environment, the foundation component of the ethics paradigm focuses on stewardship to enhance an organization’s mission as crucial for effective governance. This component deals with the identity of an organization, reflecting the leitmotif *who we are*, thereby highlighting board engagement as a hallmark of governance ethics for community benefit. In turn, this hallmark denotes an associated moral imperative of board oversight of the standing committee structure.

Second, in the context of organizational oversight in healthcare institutions, the process component of the ethics paradigm focuses upon decision-making to encourage participative deliberation in organizations. This component addresses the accountability of the organization, reflecting the leitmotif *how we function*, thereby highlighting effective communication as a hallmark of governance ethics for community benefit. In turn, this hallmark denotes an associated moral imperative regarding board oversight of community needs assessment.

Third, in the context of organizational culture in healthcare, the practice component of the ethics paradigm focuses on best practices to develop standards of conduct. This component engages quality in an organization, reflecting the leitmotif *what we do*, thereby highlighting board oversight of organizational performance as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative regarding board oversight of continuous improvement.

This chapter has applied the ethics paradigm to highlight hallmarks of governance ethics regarding community benefit, denoting associated moral imperatives. The next chapter adopts the same approach to discuss hallmarks of governance ethics concerning community health.
Notes


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23 Community Health Systems Report, 42.


25 Community Health Systems Report, 12.


31 ABA Coordinating Committee on Nonprofit Governance, Guide to Nonprofit Corporate Governance in the Wake of Sarbanes-Oxley (Chicago, IL: American Bar Association, 2007).
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32 Community Health Systems Report, 41–42.
33 Community Health Systems Report, 21, table 17.
38 L. Prybil, et al., Governance in High-Performing Organizations: A Comparative Study of Governing Boards in Not-for-Profit Hospitals (Chicago, IL: Health Research and Educational Trust, 2005).
41 Governance Institute, Striving for Excellence: Health System Governance at the Dawn of the New Millennium (The Governance Institute, 2002), 28–29.
44 Community Health Systems Report, 10–12, table 8.
45 Community Health Systems Report, 42.
51 Catholic Health Association, A Guide for Planning & Reporting Community Benefit (St. Louis, MO: Catholic Health Association, 2008), 8.
52 Community Health Systems Report, 42.
53 Community Health Systems Report, 23–24, table 19.
54 Community Health Systems Report, 24, table 20.
55 Community Health Systems Report, 2, table 21.
See: Catholic Health Association, *A Guide for Planning & Reporting Community Benefit* (St. Louis, MO: Catholic Health Association, 2008), 5, 10–11; Catholic Health Association, *Evaluating Community Benefits Programs* (St. Louis, MO: Catholic Health Association, 2009), adopting a systematic approach to evaluating and improving programs that applies public health program evaluation to community benefit programs.


Community Health Systems Report, 42. Also see: “‘Community Connections’ Helps Keep Health System Close to Those It Serves,” *AHA News* 45 (13) (June 22, 2009): 7.


*Governance Structure Report*, 34.


Select readings


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Introduction

This chapter applies the ethics paradigm to discuss hallmarks of governance ethics regarding community health. The previous chapter on community benefit stressed that community needs assessment is an indispensable ethical imperative. This chapter discusses the much broader issue of community health that similarly requires an ongoing needs assessment.

There is an abundance of literature on public health ethics. Typically, the literature discusses generic approaches to ethics (such as on norms, codes, autonomy, consent, equity, fairness, justice and social value), or considers the political and legal context (authority, constraints, public/individual tensions), to discuss issues about public health. The issues have a vast spectrum including these topics: addiction, biosecurity, behavior, conflicting interests, disease, disability, disadvantage, environmental and occupational health, epidemiology, genetics, global health, health promotion, health communication, health evaluation, health inequities, population health, harm reduction, immunization, infectious disease, reproduction, research, risk reduction, safety, screening, setting priorities, surveillance, vaccinations, violence, vulnerability, welfare. However, the focus that occurs in this chapter is gaining increased attention—the collaboration between hospitals, health systems, and public health agencies to enhance community health as part of a multi-sector effort that is needed. This multi-sector approach should include a broad range of stakeholders, including the business sector, educational institutions, and social service organizations, in addition to healthcare organizations and public health agencies. This multi-sector approach is advocated strenuously in a 2019 report from the National Academies of Science, seeking health improvement through public and private efforts in cross-sector collaborative action. Also, a 2019 report from the US Surgeon General on community health encourages multi-sector collaboration so that businesses can be community change-makers and forces for health. Community health is a governance priority.

In the analysis of the applied chapters, the concepts of the ethics paradigm organize core features of effective governance from landmark reports and the scholarly literature. There are two pivotal reports by one of the co-authors of this book that shape the discussion in this chapter regarding community health. The reports focus on hospital and public health collaboration, the first is referred

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to as the *Community Health Report*, and the second is referred to as the *Leadership Report*. These reports deal with cooperative endeavors to improve community health with outcomes that have significant implications for governance ethics. The reports call for boards and executive leadership in nonprofit health systems to assume a substantial role in multi-sector initiatives to measure and improve community health across the nation. There is substantial evidence that hospitals play a crucial role in successful multi-sector partnerships focused upon improving community health.

The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. Because the hallmarks represent necessary moral attributes of governance ethics, they entail an obligation to be adopted by boards. In turn, the associated moral imperatives represent necessary endeavors to foster the hallmarks under consideration.

The ethics paradigm organizes multiple topics on board oversight of community health, as follows. First, the foundation component of the ethics paradigm deals with the *identity* of an organization, reflecting the leitmotif *who we are*, thereby highlighting board oversight of partnership engagement as a hallmark of governance ethics for community health. In turn, this hallmark denotes an associated moral imperative of board oversight of the mission and structure of community health partnerships. Second, the process component of the ethics paradigm addresses the *accountability* of the organization, reflecting the leitmotif *how we function*, thereby highlighting partnership consensus as a hallmark of governance ethics for community health. In turn, this hallmark denotes an associated moral imperative regarding board oversight of collaboration within community health partnerships. Third, the practice component of the ethics paradigm engages *quality* in an organization, reflecting the leitmotif *what we do*, thereby highlighting partnership performance as a hallmark of governance ethics for community health. In turn, this hallmark denotes an associated moral imperative regarding board oversight of performance improvement in community health partnerships.

Each of the applied chapters begins with an explanation of the need for the pivotal topic under consideration, such as governance of community health here. Again, the concepts of *identity*, *accountability*, and *quality* provide a framework for the applied analysis. These concepts represent the foundation component (reflecting *who we are*), the process component (reflecting *how we function*), and the practice component (reflecting *what we do*) of the ethics paradigm (Table 1.1).

*Table 1.1 Ethic paradigm*

<table>
<thead>
<tr>
<th>Components</th>
<th>Foundation component</th>
<th>Process component</th>
<th>Practice component</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>Environment of healthcare</td>
<td>Organizational oversight</td>
<td>Organizational culture</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>Identity: who we are</td>
<td>Accountability: how we function</td>
<td>Quality: what we do</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Organizational stewardship of mission</td>
<td>Decision-making via participative deliberation</td>
<td>Best practices for standards of conduct</td>
</tr>
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</table>
The interest in partnerships that improve community health has become a major concern for nonprofit healthcare systems. Hence, before considering hallmarks of governance ethics regarding this topic, it is helpful to explain the need to advance community health partnerships.

**Need to advance community health partnerships**

The context of this discussion is the disconcerting paradox that the USA spends nearly 18 percent of the nation’s gross domestic product on healthcare, much more than other developed nations. The *Community Health Report* and the *Leadership Report* noted how much the USA lags on many metrics of population health, having extensive disparities in healthcare services. To improve the health status of communities and society, it is inadequate to concentrate only on access to medical services and quality patient care. Rather, the delivery of healthcare services needs to go beyond treating individuals to being better integrated with well-established principles of public health. This approach involves more attention being given to the environment, lifestyles, prevention, early detection and treatment, and reliable determinants of health. Collectively, these factors have approximately a 90 percent greater impact in determining the health status of individuals and population groups. There needs to be considerable improvement in cooperation between health delivery, public health, and community stakeholders. Above all, governing boards have a critical role in reflecting their commitment to community health improvement in their organizations’ strategic plan, priorities, and resource allocation.

The Patient Protection and Affordable Care Act (ACA) of 2010 included a provision that led to action by the Internal Revenue Service (IRS). The ACA amended the IRS Code by adding Section 501(r). The new IRS requirement mandates every hospital operated by a 501(c)(3) organization to conduct a needs assessment regarding community health, with an implementation strategy to address priorities. Occurring at least every three years, this assessment may involve multiple hospitals working together to yield a joint report. In other words, the IRS provisions encourage relationships between hospitals, public health agencies, and others to assess these needs, to set priorities, and develop implementation strategies. This requirement of the IRS can help hospitals strengthen the justification of maintaining their tax-exempt status. Also, Public Health Accreditation Board standards encourage multi-sector collaboration in health needs assessment.

There is an increasing awareness of the need for effective communication and collaboration among health delivery organizations, the public health sector, and other multi-sector initiatives interested in the improvement of community health. This awareness is a rediscovery of an insight articulated in 1932, nearly a century ago, by the Committee on the Costs of Medical Care when it emphasized that it is a folly to deal in a separate manner with medical services and public health. The inherent difficulty of achieving successful collaborative arrangements probably contributed to the schism between the sectors of healthcare and public health from the 1930s. Also, there were many other factors that contributed to this schism,
including the following: the dominance of employer-sponsored health insurance plans during World War II (e.g., Blue Cross/Blue Shield) focusing almost entirely on medical and hospital services; the infusion of enormous resources by the creation of Medicare and Medicaid into the medical and hospital sectors; progress in medical science and technology that generated an increasing demand for new procedures; and the asymmetry in funding and prestige of private-sector medicine and hospitals in relation to public health. Not surprisingly, there resulted differences in priorities, lack of mutual understanding, and cultural rifts.17

Fortunately, since the 1990s there has been increased awareness of significance of collaboration in the health arena, especially regarding community health.18 This awareness is apparent in groups working together in a voluntary manner for a mutual interest. By illustration, in 1994 two major associations created a joint endeavor: the American Medical Association and the American Public Health Association established the Medicine/Public Health Initiative. While this initiative did not endure, the purpose was to consider why medicine and public health functioned so separately and independently and to explore opportunities for closer working relationships.19 Subsequently, many reports by prominent organizations advocated for collaborative models to create a collective impact in medicine and public health.20

There are multiple rationales to support this shift from a narrow focus on individual patients to a broader focus that integrates communities into the nation’s health agenda. Concentrating on the medical needs of individuals should be expanded to include population health approaches, as discussed in the Community Health Report and the Leadership Report. Reflecting this paradigm shift from treating individuals to engaging communities, there could be an acceleration of new alliances focused upon community health.21 There are many studies that indicate an urgency to align improving community health with restraining healthcare expenditures.22 Efforts over the long term to restrain the nation’s health expenditures while improving community health will require much more comprehensive strategies that address behavior, education, the environment, and so forth.23 This scenario led the Institute for Healthcare Improvement to establish a triple aim in healthcare: simultaneously to address the quality of patient care, to improve population health, and to reduce per capita costs of care across the public and private sectors of society. To achieve these aims, there are significant challenges that require integrating the measurement of population health status with the design of long-term multi-sector collaboration and the development of value-based payment systems focused on outcomes.24 To address these aims by concerted efforts that recognize the multiple determinants of health outcomes, there needs to be better communication and coordination across all related public and private sectors.25

From the outset, it should be noted that failure occurs with almost half of the alliances, coalitions, and partnerships with two or more organizations. The Community Health Report and the Leadership Report indicate that in studying cross-sector collaborative initiatives for community health across the nation, only about half succeeded.26 The success rate can increase significantly, up to 80 percent,
when these collaborative arrangements incorporate a set of core characteristics and related indicators. The characteristics are delineated in terms of these categories: vision, mission, values; goals and objectives; partners; organizational structure; leadership; partnership operations; program success and sustainability; and performance evaluation and improvement.27

These reports considered successful partnerships between hospitals, public health agencies, and community stakeholders committed to improving the health of their communities. In the Community Health Report, the selected alliances were required to have been in operation for two years with successful performance and with diversity in location, form, and focus. Using qualitative analysis, the report determined findings and patterns from which it developed recommendations that are discussed later.28 In the Leadership Report, the study examined five nonprofit health systems committed to community health improvement. The report engaged with multi-sector efforts to measure and improve the health of the communities they serve. The recommendations are discussed in the following sections.29

The discussion now applies the ethics paradigm to organize core features of effective governance regarding community health. The discussion focuses on the Community Health Report, the Leadership Report, and the scholarly literature. The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. The applied analysis begins with discussing hallmarks of governance ethics connected with the foundation component of the ethics paradigm.

It is useful to note that the hallmarks of governance ethics regarding community health are designed in connection with the hallmarks of governance ethics regarding community benefit. That is, the focus in the previous chapter was on board engagement, effective communication, and organizational performance. The focus continues in this chapter’s discussion of partnership engagement, partnership consensus, and partnership performance as hallmarks of governance ethics.

Partnership engagement: foundation-related governance ethics hallmark

The foundation component of the ethics paradigm, in the context of the challenging environment of healthcare, focuses on stewardship to enhance an organization’s mission as crucial for effective governance. This component depicts the identity of an organization, reflecting the leitmotif who we are. The concept of identity highlights partnership engagement as a hallmark of governance ethics for community health. This concept draws attention to who the board is. In turn, this hallmark denotes an associated moral imperative regarding board oversight of the mission and structure of community partnerships. These are discussed later.

To understand partnership engagement as a hallmark of governance ethics, it is helpful to note that often crises in the community spark concerted action. Such action is designed to address needs that instigate different community health coalitions via partnership engagement.30 The Community Health Report and the Leadership Report explained that these coalitions can provide guidance
for other organizations and communities interested in developing their own outreach. Addressing population health constitutes a moral imperative at local, state, and national levels. These partnership efforts should be ongoing, not just a one-time occurrence. When faced with urgent need in the health of a community, visionary and inspirational leaders are sought to generate collective action via partnership engagement. These individuals can provide instrumental leadership in founding an alliance and in contributing to its success insofar as well-qualified and dedicated personnel are designated to manage partnerships. To create a cohesive coalition, these leaders need to articulate and communicate around a common understanding of the concepts, definitions, and principles of population health. Effective communication requires mutual understanding of key concepts and terms. A significant obstacle to multi-sector collaboration in partnership engagement has been the differences in respective interpretations of the concept of population health, using the same words with different meanings. For the public health sector, the concept refers to health outcomes of a group and their distribution within the group. From this perspective, the impact of education, the environment and socioeconomic influences affect the health status of a population in addition to their access to quality medical services. In contrast, the medical and hospital sectors all too often understood population health in relation to patients served by their organizations.

The Community Health Report and the Leadership Report emphasized that having a trust-based relationship grounded in honesty and respect among the founding institutions is critical for a successful alliance. Collective action has become increasingly productive for community development. Often a tradition of community cooperation lies behind new partnership engagement to foster community health. These types of established relations must be preserved through excellent communications and assessment as the group moves from planning to operations. To nurture this rapport new groups must have a culture and values that are substantively compatible and congruent, even though they typically will not be identical. In contrast, a primary cause for failure can be lack of trust. These leaders and relationships cultivate a growing awareness of a fundamental change that recognizes the need for prevention, early diagnosis and treatment, and the promotion of wellness. This shift has created an emerging pattern that acknowledges the need for more attention to population health by engaging the following: improved understanding; better communication with the public health community; and coordinated action to improve community health with cooperation between private and public sectors. Partnership engagement brings communities and organizations together in programs and activities can generate collective interest while building community spirit and social capital. These efforts to improve community health serve an important social role by enabling group action aimed at population health improvement.

Board oversight of partnership engagement is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of the mission and structure of community partnerships. The mission and the structure of these partnerships can be distinct, though typically are closely related.
Moral imperative: board oversight of mission and structure of community partnerships

Board oversight of the mission of community partnerships is indispensable. The Community Health Report and the Leadership Report acknowledged the daunting challenges that must be faced both in the start-up years and in on-going operations of community partnerships. To address these challenges effectively they must emphasize the importance of mission, vision, and values, including their alignment with clear goals and objectives. These must focus on improving community health with firm support of the partnering organizations, be clearly stated, and be communicated widely. The identity of each collaboration helps to connect its mission with accompanying problems, while seeking to build community recognition, credibility, and respect. In the Leadership Report and the Community Health Report, the coalitions were generally relatively small entities without much history in community service. However, they had well-known organizational partners in the community, such as hospitals. This experience highlights the need to find ways to inform communities (such as by formal reports and community presentations) about these transformational endeavors that impact them all.41 A clear mission statement is decisive for engaging the scope of these alliances, driving direction, strategies, and services, and bolstering community support with effective outreach. The mission statement is amplified by a strategic plan that guides a tangible course of action. Of course, these require ongoing review and improvement in content and format, especially regarding goals, objectives, and evaluation protocols.42 However, because of the combination of health needs in communities and limited organizational capabilities, efforts to improve community health should have a defined mission, strategically and pragmatically indicating priority needs to inspire interest, engagement, and support. There can be a mission dissonance between coalition members when some may be traditionally focused on individual patients or related patient groups, whereas others may primarily address community health. Here, it is pivotal to sustain fidelity to population health outreach.43 Well-designed coalitions with multiple stakeholders can be a catalyst for collective action regarding community health needs, using evidence-based experience to build on success. That is, community-powered problem solving creates synergy for a collective impact addressing complexity.44 But having an unrealistic purpose that is not sufficiently pragmatic can compromise progress toward maintaining momentum and sustaining commitment.45

Also, board oversight of the structure of community partnerships is crucial. In the Leadership Report and the Community Health Report, it is evident that the mission of the coalition should shape its organizational structure, which in turn impacts the likelihood of success. A durable structure is crucial for carrying out the mission and goals of these coalitions. Typically, organizational models have a comparatively informal structure in contrast to corporate structures such as those with 501(c)(3) status. Generally, most appear to be open-ended regarding future possibilities to accommodate emerging needs.46 Of course, there are many forms of collaboration with varying purposes, ranging from informal and non-binding
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to formal and legal arrangements. The organization’s documents should articulate the key features of the partnership, especially its mission, goals, and core policies. Two observations can be made generally about the structure of these partnerships.

On the one hand, the Community Health Report and the Leadership Report explained that having one or more anchor institutions to build multi-sector participation with common interests in community health can contribute to long-term survival and success. Working together on programs and initiatives around a common cause is not necessarily contrary to competition in other areas. Several examples can be highlighted. A coalition of big ten institutions was established in 1958. It was called the Committee on Institutional Cooperation and is now referred to as the Big Ten Academic Alliance (BTAA). The alliance has undertaken a number of initiatives. One purpose of this collaboration was to seek interventions that improve health equity. This partnership with these universities illustrates the role of educational institutions regarding population health. In 2013, a public-private learning collaborative was established by the Association of State and Territorial Health Officials (ASTHO). This alliance sought to improve hypertension control, contributing to a national goal of the Department of Health and Human Services of preventing 1 million heart attacks and strokes. Another example is a multi-state collaborative, founded in 2009 with many states working together. With the Millbank Memorial Fund as an anchor institution providing support, the principal focus of collaborative efforts has been multi-payer primary care transformation. Yet another example is MaineHealth, a nonprofit health system based in Portland that supports extensive Healthy Community programs. Anchor institutions should be able to offer stable support, economic and otherwise. Successful collaborative partnerships for community health can be inspiring. These collaboratives emphasize the importance of not relying only on health sector organizations to meet the enormous challenges facing community health. The leadership of business, education, and government sectors is indispensable. On the other hand, the Community Health Report and the Leadership Report urged that antecedent informal connections should develop a formal affiliation agreement to address the complex issues involved around policies, strategy, budget, etc. Examples of these formal agreements are creating a steering committee or a leadership council. It is very helpful to establish a designated body that is empowered by the leading institutions with a succinct and simple written charter that is updated regularly to deal with these core functions: the coalition’s vision, mission, and values with accompanying goals and objectives; the composition, responsibilities, and authority of the policy-setting body; and the powers and decisions that are restricted to the main institutions in the alliance. The charter should define the leadership role and responsibilities with regular updating. The designated body, such as a partnership board, has the responsibility and authority to adopt policies and approve initiatives supporting the coalition’s mission. This oversight will enable a coalition to be more robustly engaged in identifying priorities and strategies focused on action for community health improvement. The board should be comprised of individuals who have demonstrated interest and expertise in population health,
can provide effective direction, monitor progress and adopt action plans to ensure ongoing progress. Also, standing committees for oversight of the coalition should be established by the participating health departments or hospitals. Tax exempt status is not required, but certainly preferred. This is because the tax-exempt status of nonprofit hospitals requires the provision of community benefit to provide measurable contributions that improve the populations served. Similarly, public health departments have statutory authority and accountability for community health in the populations that they serve.56

Hence, the governing boards and executives in nonprofit hospitals, health systems, and local health departments could establish standing board committees with oversight responsibility for their respective organization’s role in population health improvement. Of course, it may not be necessary to have a standing committee for each partnership, with oversight responsibility being assigned to a board with a broader charge. The committees can address high-priority health needs, honor the social roles of their constituent organizations, and work together to improve the health of the populations they serve.57

In sum, the foundation component of the ethics paradigm highlights partnership engagement as a hallmark of governance ethics. By focusing on identity in the ethics paradigm (dealing with who the board is), this hallmark denotes an associated moral imperative regarding board oversight of the mission and structure of community partnerships.

**Partnership consensus: process-related governance ethics hallmark**

The concept of accountability in the ethics paradigm (reflecting the leitmotif how we function) emphasizes the importance of decision-making via participative deliberation. This focus requires boards to be attentive to organizational oversight as the context for assessing their responsibilities. The concept of accountability highlights partnership consensus as a hallmark of governance ethics for community health. To meet this charge, boards should be designed to have processes for consensus building. The concept draws attention to how the board functions in the organization. In turn, this hallmark denotes an associated moral imperative regarding board oversight of collaboration within community partnerships. These are discussed in what follows.

To understand partnership consensus as a hallmark of governance ethics, it is helpful to note that excellent communication channels are required among the partners, staff and community. The Community Health Report and the Leadership Report explained that consensus-building efforts must focus on substantive community engagement, support, and input to identify all relevant needs. These channels need to be clear, transparent, and effective to foster consensus about the work of the coalition. This culture requires mutual respect and trust, with the members having compatible values and dedication to build the coalition together.58 This requires all involved, especially staff, to share ownership of the partnership, be open and transparent with each other, and demonstrate long-term commitment to
its vision, mission, and values. In this environment, the alliance should focus on programs in which they have expertise or can efficiently secure required talent externally. Naturally, conflicts can occur. In an environment of decision-making in these consensus-oriented coalitions, there must be well-established mechanisms to proactively identify and resolve concerns.59

The Community Health Report and the Leadership Report emphasized that the coalition needs to have someone in charge of partnership operations to lead the deliberative processes required for action. Typically, the title of executive director (or similar names) devotes a considerable amount of work time to management of the coalition. This occurs either with or without significant technical support depending on each arrangement. A significant challenge is that the director usually has limited or no formal authority over the coalition members or over others who are affiliated and upon whom the alliance depends. Hence, the director relies on influence or persuasion for managing programs and personnel who are classically volunteers. This is similar to the challenges that a director encounters in managing nonprofit associations with many volunteers.60 Although some coalitions have a strong anchor institution, most involve a much looser model that adopts a consensus style of direction, even though they may evolve into a more structured approach.61 Because the director is essential for success, deliberative processes need to be adopted that reflect a model of servant leadership that makes progress through consensus-building. There is a significant amount of literature on this topic of servant leadership that centers around character, empathy, moral authority, systems thinking, and skilled communication.62 In building a partnership consensus for community health, leaders have substantive responsibility but limited decision-making authority. Here, autocratic or hierarchic approaches are replaced with an approach based on teamwork and consensus-building, involving many in decision-making, and supporting workers while developing the institution.63

**Moral imperative: board oversight of collaboration within community partnerships**

Board oversight of partnership consensus is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of collaboration within community partnerships. Collaboration can flourish by adopting decision-making processes that foster participative deliberation. Unfortunately, a substantial proportion of organizational alliances are not successful, especially when there are many members accompanied with diffuse and complex decision-making processes. Hence, there is significant need for board oversight of decision-making processes to foster collaboration.

This collaborative approach can enable community partnerships to have an enduring impact over time for engaging a range of other parties from both public and private sectors. In other words, collaborative decision-making via participative deliberation can encourage the participation of many different sectors in partnerships for community health. Certainly, hospitals and public health departments and related stakeholders should typically be among the principal partners.
However, many other community organizations should be engaged insofar as they share a commonality of interest for the health of the community, such as school systems, health plans, and the business community. Also, including local, state, and federal government agencies can be productive by incorporating health considerations in their decision-making processes. Similarly, in the private sector professional associations at state and national levels should encourage these collaborative partnerships.

The Community Health Report and the Leadership Report showed that successful collaborative partnerships for community health require broad-based and multi-sector support. For example, there is a solid body of evidence that hospitals and health systems are a key component of successful multi-sector partnerships for community health. Also, there is extensive literature on multi-sector collaboration within community health partnerships. These alliances can be very effective in addressing community health needs, serving the public interest and well-being. In other words, cooperation between professions can develop relational collaboration through organizational partnerships for the public good. Adopting decision-making processes that encourage participative deliberation enables these collaborations to flourish.

In sum, the process component of the ethics paradigm highlights partnership consensus as a hallmark of governance ethics. By focusing on accountability in the ethics paradigm (dealing with how the board functions), this hallmark denotes an associated moral imperative regarding board oversight of collaboration within community partnerships.

**Partnership performance: practice-related governance ethics hallmark**

The concept of quality in the ethics paradigm (reflecting the leitmotif what we do) emphasizes the importance of best practices for standards of conduct. This focus requires boards to be attentive to organizational culture as the context for assessing their responsibilities. The concept of quality highlights partnership performance as a hallmark of governance ethics for community health. In turn, this hallmark denotes an associated moral imperative regarding board oversight of performance improvement in community partnerships. These are discussed in what follows.

To understand partnership performance as a hallmark of governance ethics, it is helpful to recognize the need for best practices. That is, collaborations for community health must relate to established best practices. The Community Health Report and the Leadership Report urged that partnership performance should be reviewed using evidence-based assessment. Successful coalitions must regularly monitor and measure outcomes in relation to their organizational goals and objectives using reliable metrics with a timeline for achievement. This should be a recurring process whereby progress reports are provided to the partners, community and key stakeholders. These reports should have accompanying actions that contribute to assessing partnership performance. Recurring assessments should
be based on the best science available to review the following: community health measures to be addressed, objectives and targets to be achieved, and metrics and tools to monitor progress.69

The Community Health Report and the Leadership Report explained that demonstrating successful partnership performance requires an expansive review of issues, including the following: engaging the support of the community; considering the length of time in operation; prioritizing community needs combined with strategies to address them; and examining evidence of long-term impact on community health.70 All of this requires a wide-reaching perspective of the health landscape. Of course, access to quality services is indispensable and accounts for the major share of health expenditures in the USA. However, the economic, physical, and social environment must also be addressed.71 Hence, efforts to develop community health must combine multiple facets: selecting from the broad range of interacting influences; establishing priorities; developing approaches for implementation; and designing standards to assess organizational performance. Each community’s needs should be instrumental in shaping the focus and functions of a coalition and in guiding coalition outcomes.72

Moral imperative: board oversight of performance improvement in community partnerships

Board oversight of partnership performance is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of performance improvement in community partnerships. From the Community Health Report and the Leadership Report there emerges two critical requirements for performance improvement that meets the needs of coalitions: the metrics selected to monitor progress by considering measurable impacts; and the resources to meet the needs identified. Naturally, there are considerable challenges when considering these together.73 It is crucial to scientifically connect health yardsticks with evidence-based strategies and sufficient resources. Fortunately, there is reliable information to gauge the burden of disease, injuries, and risk that can guide allocating assets and efforts. Aligning impacts and resources is indispensable.74

One critical requirement for performance improvement deals with impact. On this topic, the issue of effective assessment measures, using benchmarks of quality to improve population health, has been acknowledged for a long time.75 However, objective evidence of the impact of collaborative arrangements for community health appears all too thin.76 To be effective it is crucial to have a common understanding of population health to facilitate benchmarking, comparative evaluation, and mutual understanding.77 In the Community Health Report and the Leadership Report, an agreed perspective enables participants to clarify how health status is assessed in a realistic manner.78 To achieve these, it can be helpful to adopt leading health indicators presented in a ten-year plan by the US Department of Health and Human Services. Some of these indicators examined include the following: access to health services; clinical and preventive services; environmental quality; injury and violence; maternal, infant, and child health; mental health; nutrition,
physical activity, and obesity; oral health; reproductive and sexual health; social determinants; substance abuse; and tobacco.\textsuperscript{79}

In the \textit{Community Health Report} and the \textit{Leadership Report}, performance improvement in community health coalitions presents a serious challenge. The challenge is evident when considering infant mortality or the prevalence of cardiovascular disease where advances require a lot of time and effort.\textsuperscript{80} There must be well-reasoned priorities in selecting determinants and measures (intermediate and long-term) to track improvements in community health. Of course, it is challenging to select specific community needs when assessing them means examining flawed linkages between determinants and measures of population health, perceptions of health needs, and intervention efficacy.\textsuperscript{81} However, performance improvement reviews require evidence-based strategies to compile pertinent data as a basis for factual evaluation. Sound data will contribute to addressing significant gaps in evaluating achievements in community health.\textsuperscript{82}

An example of a successful multi-sector approach is the Health of New Ulm Project in Minnesota on cardiovascular risk factors. In this project, the electronic health record system in the town’s medical center provided an ideal repository for surveillance and registry data on community-wide cardiovascular disease.\textsuperscript{83}

Despite the widely recognized difficulty in generating data for sustained improvement, especially on mortality and morbidity, several features have shown themselves to provide reliable information. Partnerships with a focus on a single community health need (such as reducing heart attacks), or on a narrow set of needs, can perform better than affiliations with more comprehensive, far-reaching missions. Such coalitions have a relatively less difficult challenge and they can more easily demonstrate positive results. Second, coalitions tend to be successful when they adopt benchmarks for performance improvement, approaches to achieve them, and ways to make assessments. Third, alliances can flourish when they recognize that a complex collection of issues contribute to performance improvement in community health. This recognition enables organizations to connect basic determinants, intermediate steps, and outcomes (even though more research on these links is needed).\textsuperscript{84} Through performance improvement reports, community health partnerships can gain credibility and earn respect of key stakeholders. This credibility and respect can be nurtured by developing, regularly updating, and disseminating impact statements using evidence to present the effect of the partnership in relation to its available resources and incurred costs. Doing so highlights for partners, funders, the community and other stakeholders the value proposition of the partnership. These efforts demonstrate the benefits being provided and the progress being made and offers a compelling case for further investment and inspires community interest and support.\textsuperscript{85}

The other critical requirement for performance improvement deals with resources. The \textit{Community Health Report} and the \textit{Leadership Report} underscore that the long-term survival of a coalition for community health requires financial sustainability. Different funding levels for collaborative partnerships significantly influence how community health initiatives can advance. This influence includes the design and operation of a coalition, the volume and intensity of supported
activities with associated costs, the size of the population served, and the mix of other in-kind support. Significant attention needs to be dedicated to finances, including the value of in-kind contributions within a coalition’s organizations, to avoid becoming vulnerable to financial instability. Deliberate plans are needed to broaden and diversify sources for funding support with the partners identifying resource requirements (regarding both personnel and funding), building sufficient capital and operating budgets, and securing those resources. Unfortunately, there is limited financial support for multi-sector collaborative initiatives focusing on community health. Moreover, health departments tend to be lightly funded even as they encounter great challenges. Faced with this disconcerting reality, leaders in hospitals and public health must develop their own funding strategies for multi-sector collaboration to improve community health. Fundraising is a major challenge for most of these endeavors.

The Community Health Report and the Leadership Report suggest that a key strategy to financial stability deals with involving anchor institutions. Large healthcare organizations or robust health departments, and indeed many other organizations can be anchor institutions for multi-sector partnerships focused on improving community health. These partnerships could benefit greatly by more participation of business organizations. Various forms of support can be very helpful for these multi-sector partnerships. However, financial resources from the business community, health plans, and healthcare providers is necessary to sustain the partnerships.

These institutions can provide long-term commitment to a coalition’s mission with solid long-term financial (but not necessarily complete funding) and in-kind support for community health initiatives. By illustration, hospitals and health systems have in the past directed community benefit funds, required by their tax-exempt status, to support services for uninsured or under-insured patients. Increasingly, they tend to apply a considerable portion of these funds to support affiliated multi-sector community health partners. This increase has been influenced by the Affordable Care Act and the Public Health Accreditation Board standards that call for collaborative efforts to engage community health needs. Or, there could be other resources for ongoing financial support. These resources include the following: health plans with leaders who appreciate the need to focus resources on population health; local employers who recognize the value of a coalition for their community; and local government’s investment in the welfare of the community. Major local employers and health plans can provide robust support for community health initiatives. However, when there is low level of engagement by them as principal partners or major funders, concern is justified.

Having one or more organizational partners make a commitment in this manner is a fundamental strategy for sustainability. Of course, this sort of continuing support will depend upon continuous performance improvement by partnerships to demonstrate a measurable and compelling impact on community health.

Even in these scenarios, the Community Health Report and the Leadership Report recognize that additional financial support is typically necessary such as grants from local, state, and national sources, both private and governmental. The availability of federal or foundation grant programs can provide a catalyst
for a partnership to address community health initiative. This catalyst support can focus on a start-up or provide short-term support, but rarely does it provide durable support.\(^9\) The upside is that personnel are highly dedicated with lots of talent. Personnel also contribute significantly to creating social capital by making connections between the coalition members and the community. However, reliance on grant support can constrain a coalition, restricting long-term plans as well as the stabilization of staff support. Coalitions for community health ordinarily rely extensively on volunteers and staff from the organizational members. Nonetheless, heavy reliance on volunteers can cause substantial turnover, thereby stressing full-time staff and requiring continuing recruitment efforts for succession planning.\(^9\) Without grant renewal or securing an equivalent funding source, the future of a coalition will be in jeopardy. Because resources are crucial for performance improvement of coalitions for community health, it is time for government agencies via public policy and many others to establish more public-private alliances. From the policy perspective, examples might be local and state government funding, state-level policies supporting hospital and public health cooperation, and federal-level programs that stimulate successful public-private partnerships. Perhaps more sustainably, financial resources from the business community, health plans, and healthcare providers are indispensable if these alliances are to be sustained and flourish.\(^9\)

In sum, the practice component of the ethics paradigm highlights partnership performance as a hallmark of governance ethics. By focusing on quality in the ethics paradigm (dealing with what the board does), this hallmark denotes an associated moral imperative regarding board oversight of performance improvement in community partnerships.

**Conclusion**

The chapter has indicated hallmarks of governance ethics with associated moral imperatives regarding the community health. The contribution of the ethics paradigm can be summarized in this manner.

First, in the context of the challenging healthcare environment, the foundation component of the ethics paradigm focuses on stewardship to enhance an organization’s mission as crucial for effective governance. This component deals with the identity of an organization, reflecting the leitmotif *who we are*, thereby highlighting board oversight of partnership engagement as a hallmark of governance ethics for community health. This hallmark connects with the hallmark of board engagement in the previous chapter. In turn, this hallmark denotes an associated moral imperative of board oversight of the mission and structure of community health partnerships.

Second, in the context of organizational oversight in healthcare organizations, the process component of the ethics paradigm focuses upon decision-making to foster participative deliberation in organizations. This component addresses the accountability of the organization, reflecting the leitmotif *how we function*, thereby highlighting partnership consensus as a hallmark of governance ethics for
community health. This hallmark connects with the hallmark of effective communication in the previous chapter. In turn, this hallmark denotes an associated moral imperative regarding board oversight of collaboration within community health partnerships.

Third, in the context of organizational culture in healthcare, the practice component of the ethics paradigm is to focus on best practices to develop standards of conduct. This component engages quality in an organization, reflecting the leitmotif what we do, thereby highlighting partnership performance as a hallmark of governance ethics for community health. This hallmark connects with the hallmark of organizational performance in the previous chapter. In turn, this hallmark denotes an associated moral imperative regarding board oversight of performance improvement in community health partnerships.

This chapter has applied the ethics paradigm to identify hallmarks of governance ethics regarding community health, denoting associated moral imperatives. The next chapter adopts the same approach to discuss hallmarks of governance ethics concerning patient care.

Notes


12 Leadership Report, 4; Community Health Report, 3–4, 38. Also see: M. Soto, Population Health in the Accountable Care Era (Washington, DC: AcademyHealth, 2013); Association for Community Health Improvement, Trends in Hospital-Based Population Health Infrastructure (Chicago, IL: Health Research and Educational Trust, 2013).


16 L. Prybil, et al., A Perspective on Public–Private Collaboration in the Health Sector (Washington, DC: National Academy of Medicine, 2015), 1, referring to: The Committee on the Costs of Medical Care, Medical Care for the American People (Chicago, IL: The University of Chicago Press, 1932), 47.
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28 *Community Health Report*, 38–44.


30 *Community Health Report*, 10, 16, 29.

31 *Community Health Report*, 28, 30, 38.
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32 Leadership Report, 34; Community Health Report, 42.
36 Leadership Report, 33; Community Health Report, 6, Appendix A, 49; Appendix C, 65–66.
42 Leadership Report, 32; Community Health Report, 16–17, 30.
45 Leadership Report, 33; Community Health Report, 40.
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46 Leadership Report, 33; Community Health Report, 13.
51 Community Health Report, Appendix C, 74–75. Also see: www.milbank.org/programs/primary-care-transformation.
52 Community Health Report, Appendix C, 74–75. Also see: MaineHealth Healthy Communities; MaineHealth Health Index.
57 Leadership Report, 4; Community Health Report, 43–44; Appendix A, 48; Appendix C, 69–70.
58 Health Research and Educational Trust, Creating Effective Partnerships to Build a Culture of Trust (Chicago, IL: Health Research and Educational Trust, 2016).
59 Community Health Report, 6, and Appendix A, 49.
60 Community Health Report, 17–18.
61 Leadership Report, 5; Community Health Report, 32.


Leadership Report, 32; Community Health Report, Appendix A, 49.


Leadership Report, 32; Community Health Report, 18.

Leadership Report, 32; Community Health Report, 20–21.


Leadership Report, 32; Community Health Report, 30.


Leadership Report, 6; Community Health Report, 20.


84 Community Health Report, 21, 34.
85 Leadership Report, 33; Community Health Report, 42–43.
86 Leadership Report, 33; Community Health Report, 26, 28.
87 Leadership Report, 33; Community Health Report, 43; Appendix A, 49.
93 Community Health Report, 10, 29, Appendix C, 97–98.

Select readings

Health Research and Educational Trust. 2016. Creating Effective Partnerships to Build a Culture of Trust. Chicago, IL: Health Research and Educational Trust.


# 7 Governance of patient care quality

## Introduction

The previous two applied chapters addressed community-related topics (community benefit and community health). This chapter and the next chapter apply the ethics paradigm to discuss hallmarks of governance ethics regarding patient care quality and patient safety. The significance of board oversight of quality and safety is widely recognized. For example, the Joint Commission provides guidelines on what boards need to know about these pivotal issues.\(^1\) Also, the Agency for Healthcare Research and Quality and the Institute for Healthcare Improvement provide ongoing resources.\(^2\) In ethics studies just over a decade ago, board oversight of patient care quality and patient safety was not prominent,\(^3\) but now they are recognized as essential governance responsibilities.\(^4\) Although patient care quality and patient safety are discussed together in the literature, this chapter and the next deal with them separately to focus on their distinctive issues related to governance ethics.

In the analysis in the applied chapters, the concepts of the ethics paradigm organize core features of effective governance from landmark reports and the scholarly literature. Instead of a formal report, there is a study by one of the co-authors of this book that shapes the discussion in this chapter. The study is referred to as the *Accountability Study*.\(^5\) The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. Because the hallmarks represent necessary moral attributes of governance ethics, they entail an obligation to be adopted by boards. In turn, the associated moral imperatives represent necessary endeavors to foster the hallmarks under consideration.

The ethics paradigm organizes multiple topics on board oversight of patient care quality as follows. First, the foundation component of the ethics paradigm deals with the *identity* of an organization, reflecting the leitmotif *who we are*, thereby indicating board transparency as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative concerning board oversight of the development of trust to support patient care quality. Second, the process component of the ethics paradigm addresses the *accountability* of the organization, reflecting the leitmotif *how we function*, thereby indicating board responsiveness as a hallmark of governance ethics. In turn, this hallmark denotes an


Table 1.1 Ethics paradigm

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<th>Components</th>
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<td>Context</td>
<td>Environment of healthcare</td>
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<td>Leadership</td>
<td>Identity: who we are</td>
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<tr>
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associated moral imperative concerning board oversight of factors contributing to support patient care quality. Third, the practice component of the ethics paradigm engages quality in an organization, reflecting the leitmotif what we do, thereby indicating board oversight of mechanisms for patient care quality as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative concerning board oversight of the social contract for patient care quality.

Each of the applied chapters begins with an explanation of the need for the pivotal topic under consideration, such as governance of patient care quality here. Again, the concepts of identity, accountability, and quality provide a framework for the applied analysis. These concepts represent the foundation component (reflecting who we are), the process component (reflecting how we function), and the practice component (reflecting what we do) of the ethics paradigm (Table 1.1).

Before discussing hallmarks of governance ethics, it is helpful to explain the need for board oversight of patient care quality.

Need for board oversight of patient care quality

It is widely recognized, as indicated in the Governance Structure Report (discussed in previous chapters), that board oversight of patient care quality is an indispensable feature of effective governance. Nonetheless, the level of clinical services in hospitals and health systems needs to be improved, especially from the perspective of monitoring and improving clinical services. It has long been recognized that board oversight of patient care quality is crucial for effective governance, especially regarding system-wide measures and standards. A survey of 1,000 board chairs indicated that less than half rated oversight of patient care quality as a top priority, with only a minority of board member having any formal training in this area. There is a longstanding acknowledgment that enhancing board oversight of patient care quality nurtures the trust of communities served, with that trust reflecting improvements in care.

Over the past decade, there has been a recognition of the urgency for board oversight concerning poor performance indicators in US healthcare. Now, nearly 18 percent of the US gross domestic product is devoted to healthcare, far more than other industrialized countries for which the median figure is less than 10 percent. Healthcare spending in the USA is nearly $11,000 per person, over twice
the median figure for other industrialized nations. But the USA lags on many indicators of population health such as infant mortality and life expectancy, and there is abundant evidence of wide disparities in healthcare services.

A broad array of factors contributes to this scenario, including economic, lifestyle, political, and social issues. In this regard, the Governance Structure Report emphasized the performance of non-governmental, nonprofit health systems, which are growing in numbers, providing a large proportion of inpatient and outpatient services. Nonprofit hospitals and health systems in the private sector are regulated and/or influenced by local, state, and federal government requirements, accrediting commissions, bond rating agencies, payers, and many other external parties. Governing boards, with the assistance of their management teams, must remain updated regarding ever-changing expectations and must oversee compliance with them. As the number and size of health systems continue to grow, an increasing share of overall governance responsibility deals with system or parent boards of these health systems. The numbers in the USA are large: in 2019, the American Hospital Association indicated there are 2,968 community hospitals (of the 6,210 total of hospitals in the USA) that are part of non-government, nonprofit health systems.

Governance of large and complex healthcare organizations poses many challenges and requires high levels of expertise. To meet these challenges, there are multiple accountabilities for health system boards. There needs to be greater transparency, better responsiveness, and specific accountability mechanisms. The components of the ethics paradigm emphasize the significance of these elements regarding board oversight as being crucial for governance ethics.

The discussion now applies the ethics paradigm to organize core features of effective governance regarding patient care quality. This discussion focuses on the Accountability Study and the scholarly literature. The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. The applied analysis begins with discussing hallmarks of governance ethics connected with the foundation component of the ethics paradigm.

**Board transparency: foundation-related governance ethics hallmark**

The foundation component of the ethics paradigm, in the context of the challenging environment of healthcare, focuses on stewardship to enhance an organization’s mission as crucial for effective governance. This component depicts the identity of an organization, reflecting the leitmotif who we are. The concept of identity highlights board transparency as a hallmark of governance ethics for patient care quality. This concept draws attention to who the board is in relation with its organization. Here, transparency showcases the stewardship of the organization regarding its mission. In turn, this hallmark denotes an associated moral imperative regarding board oversight of the development of trust to support patient care quality. These are discussed in the next section.

To understand board transparency as a hallmark of governance ethics, it is crucial to recognize accountability as an indispensable characteristic of board
effectiveness regarding its fiduciary duties, as discussed in the *Accountability Study*. The necessity for and significance of transparency is widely recognized. For example, the state statutes under which both investor-owned and nonprofit corporations are chartered call for their governing boards to have overall responsibility for the organization and the services and/or products it provides. There is increasing interest by regulators and the public in how effectively boards are performing their fiduciary duties and fulfilling their broader responsibility to owners, stakeholders, and society at large.

In the healthcare field, the call for more robust board oversight is not new, as discussed in the *Accountability Study*. In 1918, as the number and social roles of hospitals were expanding, the American College of Surgeons stated, “All hospitals are accountable to the public for their degree of success . . . if the initiative is not taken by the medical profession, it will be taken by the lay public.” In today’s environment, oversight is crucially connected with transparency by governing boards of nonprofit healthcare organizations. One reason has been the large variations in healthcare services from community to community and from institution to institution. The variation is substantial, well documented, and challenging.

The existence of these problems is increasingly visible to state and federal regulators, payers, the media, and the public. Many events have brightened the spotlight on the performance of hospitals and health systems and on those who are responsible for them. Not surprisingly, there are significant concerns about the transparency of healthcare organizations. All hospital and health system boards, in concert with their clinical and executive leadership teams, must scrutinize the performance of the organization for which they are responsible to create greater transparency for board oversight of patient care quality.

**Moral imperative: board oversight of the development of trust to support patient care quality**

Oversight of board transparency is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of the development of trust to support patient care quality. This support includes the assessment and continuous improvement of patient care quality. There is a growing public interest in healthcare organizations. This interest is part of a wider public concern about the development of trust in communities that are served. This concern about trust pertains to large institutions in all sectors, such as banking, the federal government, and others. The declining trust in large institutions has created new challenges for boards. A decade ago, federal legislation and regulations tried to address this issue. For example, the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 encouraged placing more power in the hands of shareholders: the purpose was to influence the election of board members, levels of executive compensation, and other corporate decisions.

Similarly, in healthcare, calls for greater board responsiveness have become more frequent and explicit, as emphasized in the *Accountability Study*. For example, the National Association for Healthcare Quality, in conjunction with several other national associations, urged leaders of healthcare organizations to
implement structures to assure integrity in the evaluation of patient care quality. That evaluation should occur via “comprehensive, transparent, accurate data collection and reporting to internal and external oversight bodies.”\textsuperscript{26} Also, the Patient Protection and Affordable Care Act prompted hospital boards and their parent systems to heighten their focus on their responsiveness for developing and maintaining effective patient care quality control processes.\textsuperscript{27}

Failure to address these issues regarding the public’s trust is likely to result in closer scrutiny of nonprofit hospitals and health systems and could result in additional regulatory controls. This erosion of trust increasingly threatens the practice of medicine.\textsuperscript{28} These trust-related concerns could increase review of the benefits they are providing to the communities they serve, ultimately leading to increasing challenges to tax-exempt status or pressures to establish “payment in lieu of taxes” requirements.\textsuperscript{29}

Furthermore, the \textit{Accountability Study} explained that developing trust requires effective oversight as an ongoing requirement for boards and executive leaders to perform their responsibilities. Board transparency is crucial for this oversight. Boards should provide information regarding the extent to which their responsibilities have been accomplished and an explanation when they have not.\textsuperscript{30} Clarity about responsibilities is essential for sound organizational governance and management. Lack of clarity in defining responsibilities and/or demonstrating how they have been fulfilled leads to an erosion of trust on the part of the internal and external stakeholders that healthcare boards and management serve.\textsuperscript{31}

In sum, the foundation component of the ethics paradigm indicates board transparency as a hallmark of governance ethics. By focusing on \textit{identity} in the ethics paradigm (dealing with \textit{who the board is}), this hallmark denotes an associated moral imperative concerning board oversight of the development of trust to support patient care quality.

\textbf{Board responsiveness: process-related governance ethics hallmark}

The concept of \textit{accountability} in the ethics paradigm (reflecting the leitmotif \textit{how we function}) emphasizes the importance of decision-making via participative deliberation. This focus requires boards to be attentive to organizational oversight as the context for assessing their responsibilities. The concept of \textit{accountability} highlights board responsiveness as a hallmark of governance ethics for community health. The concept draws attention to \textit{how the board functions} in the organization. In turn, this hallmark denotes an associated moral imperative regarding board oversight of factors contributing to support patient care quality. These are discussed in the next section.

To understand board responsiveness as a hallmark of governance ethics, it is helpful to note the growing significance of shareholder voices. In the world of investor-owned companies, there is an ongoing discussion of the role of shareholders, the investors who hold an ownership position. The crucial issues that are being addressed deal with the following: how should shareholder voices be heard...
by those who govern and manage these organizations; what level of influence should shareholders have in the appointment and re-appointment of board members, the selection and retention of CEOs and other corporate decisions; and what are the merits of quarterly earnings and current stock prices for judging board and CEO effectiveness in relation to longer-term performance metrics. In the large and growing sector of non-governmental, nonprofit organizations, similar questions about participative decision-making are being raised.

The Accountability Study acknowledges that the public wants more board responsiveness from large institutions, both public and private. In the healthcare field the availability of information about the cost, price, and quality of services is growing. Several developments are dramatically expanding the volume of information available to the public at large, including the following: the public availability of the increasingly detailed IRS form 990 and related schedules; the release of extensive Medicare pricing data by the Center for Medicare and Medicaid Services; and investigative reporting by media. This deluge of publicly available information requires greater attention in board oversight.

**Moral imperative: board oversight of factors contributing to support patient care quality**

Oversight of board responsiveness is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of factors contributing to support patient care quality. As discussed in the Governance Structure Report, it is advisable for nonprofit hospitals and health system boards to have a standing committee with oversight responsibility for the organization’s community benefit policies and programs. This is a good example of the need for greater board responsiveness to the community as a matter of governance accountability. This trend toward greater transparency through accountability will continue. Transparency must center on the consumer who should be empowered to inquire about treatment options, risks, outcomes, and costs. Healthcare providers must respond accordingly to ensure appropriate care is delivered, with quality of care being foremost.

However, the Accountability Study also emphasized that the mere availability of more information is insufficient. Information alone cannot build public understanding or provide a solid basis for organizational accountability to the communities served. This particularly deals with information about complex subjects around healthcare services, the impact these services are having on population health, and the community benefit provided by healthcare organizations. For many citizens, this information can be difficult to interpret and comprehend without advice and assistance. The mere availability of information does not readily translate into board responsiveness about that information, especially in terms of involving patients and the community. A growing body of evidence demonstrates a wide variation in access, cost, and quality of healthcare services. Hence, there are significant public concerns about the efficiency of healthcare organizations and the accountability of their clinical, executive, and governance leadership.
Governance of patient care quality

It is well known that a substantial portion of USA healthcare expenditures is spent on services that are unneeded and/or inappropriate, leading to overtreatment, waste, and preventable harm. Also, there are well known critical reports on access, cost, and quality of healthcare services. Naturally, this information contributes to public concerns about healthcare institutions. No one can understand why prices for the same procedures for similar patients, adjusted for differences in cost of living in various locations, should vary considerably. To address these public concerns and accompanying distrust, there is an urgent need for greater responsiveness by governing boards regarding the communities they serve.

In sum, the process component of the ethics paradigm highlights board responsiveness as a hallmark of governance ethics. By focusing on accountability in the ethics paradigm, this hallmark denotes an associated moral imperative concerning board oversight of factors contributing to support patient care quality.

Board mechanisms for patient care quality: practice-related governance ethics hallmark

The concept of quality in the ethics paradigm (reflecting the leitmotif what we do) emphasizes the importance of best practices for standards of conduct. This focus requires boards to be attentive to organizational culture as the context for assessing their responsibilities. The concept of quality highlights oversight of board mechanisms for patient care quality as a hallmark of governance ethics for community health. In turn, this hallmark denotes an associated moral imperative regarding board oversight of the social contract for patient care quality. These are discussed in what follows.

To understand what is meant by board mechanisms for patient care quality as a hallmark of governance ethics, it is important to appreciate how boards can shape organizational culture. There are many opportunities for the governing boards of nonprofit health systems to cultivate a board culture that develops best practices for standards of conduct. Cultivating board culture entails boards understanding quality measurements that are critical in healthcare, such as those promoted by the Agency for Healthcare Quality and Research, by the Centers for Medicare & Medicaid Services, and by the World Health Organization. The practical mechanisms can be illustrated in relation to the hallmarks of transparency and responsiveness for governance ethics, as discussed in the previous sections.

On the one hand, boards must strategically increase their level of transparency with their constituencies, both internal and external, as discussed in the Accountability Study. Here, transparency means that boards should develop practical mechanisms for quality care related to sharing information with the communities they serve. These mechanisms would be manifest in the organization’s policies and programs designed to build their stakeholders’ understanding, support, and trust. Health systems that do not offer board transparency expose themselves to danger. The danger is to allow the media and others to assume leadership for informing and educating key stakeholders and the community. Giving the media this leeway is a risky strategy. Nonetheless, effective use of media in healthcare, including social media, can be helpful.
On the other hand, the *Accountability Study* emphasizes the importance of board responsiveness. That is, boards of nonprofit health systems need to examine how they develop deliberative processes with the communities their institutions serve with accompanying quality care mechanisms. For years, it has been customary for many, perhaps most, nonprofit hospitals and health systems to declare that they are accountable to the communities and populations they serve in their bylaws, mission statements, and other corporate documents.46 Boards must work to realize these claims.

For boards to be appropriately responsive to the communities they serve, they need to realize these claims. To do so, boards have to remain updated with the fast-moving developments around patient care quality. Much progress has been made on developing methods for defining and implementing patient-centered care, including the following: access to care; respect for patient preferences; coordination and integration of care; information and education; continuity and transition.47 Considerable work has been undertaken on the theory, methods, and tools regarding patient care quality to enlighten boards on mechanisms for quality of care from medical, nursing and legal perspectives.48 Board oversight of patient care quality is crucial for success in high reliability organizations.49 In particular, boards must be attentive to the increasing focus on diversity and inclusion regarding patient care quality.50 Quality care mechanisms for board responsiveness as effective measures of their oversight accountability are crucial,51 such as for communicating about quality care issues across the organization.52

The *Accountability Study* also explains that for geographically dispersed health systems, growth and structural changes can complicate the challenges inherent in board accountability.53 For effective governance, board responsiveness requires appropriate quality care mechanisms to address these challenges.54 Expansion into new locations through acquisition or start-ups creates a need to establish communication channels, identify and address the community’s concerns and expectations, and build mutual understanding and trust.55 Subsidiary or local boards must meet these challenges to be appropriately responsive to their communities by cooperating with their health system and its governing practices.56

Also, the *Accountability Study* notes that systems may choose to allow boards at the local level to retain some decision-making authority. These boards, especially when including community members, can serve as an important source of community input and linkage to the community. Board responsiveness requires building communications and trust between healthcare organizations and the communities they serve. To foster this responsiveness, some examples are as follows: having a governing board composed of community members; establishing advisory councils; and conducting community forums for two-way communication.57

**Moral imperative: board oversight of the social contract for patient care quality**

With robust board responsiveness, board mechanisms for patient care quality will continue to foster effective governance for the communities served by healthcare
Governance of patient care quality organizations. Oversight of board mechanisms for patient care quality is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of the social contract for patient care quality.

The concept of the social contract expresses a traditional idea in healthcare. There is a broad understanding of what the social contract entails, including being an advocacy-oriented call to action, referring to the relation between patients and providers, or broadly describing the role of medicine in society. Discussions about the social contract have been connected with policy around healthcare reform. The concept of social contract is being adopted increasingly to identify the duties and responsibilities between health organizations and care recipients, between providers and patients. For example, the Institute for Healthcare Improvement emphasizes the partnership between patients and providers.

The Accountability Study mentioned another example of this social contract in reference to quality care. There can be a formal, written commitment signed by the CEO, the board chair, the medical staff president, and the chief nurse executive. This expresses a commitment to the community regarding actions that will be taken to improve the institution’s performance with respect to patient care quality. This constitutes a practical mechanism to share the institution’s targets and performance with the community the institution serves.

The Accountability Study explains that the significance of board oversight of the social contract for patient care quality should not be underestimated. This issue highlights the need for nonprofit health systems to review, renew, and strengthen their bonds with the communities they exist to serve. This approach relies on effective mechanisms for quality care to demonstrate how boards are in practice meeting these responsibilities, especially regarding continuous evaluation and improvement. Also, this approach can establish best practices to foster trust between patients and providers. The practical mechanisms of transparency and responsiveness discussed in this chapter can provide a sturdy platform to build loyalty and to counter any erosion of public confidence in healthcare organizations. That is, these mechanisms can foster public understanding, a culture of trust, and support for the health system, its mission, and its leadership.

In sum, the practice component of the ethics paradigm suggests that board oversight of mechanisms for patient care quality is a hallmark of governance ethics. By focusing on leadership regarding quality in the ethics paradigm, this hallmark denotes associated moral imperatives concerning board oversight of the social contract for patient care quality.

Conclusion

The chapter has indicated hallmarks of governance ethics with associated moral imperatives regarding patient care quality. The contribution of the ethics paradigm can be summarized in this manner.

First, in the context of the challenging healthcare environment, the foundation component of the ethics paradigm focuses on stewardship to enhance an
organization’s mission in healthcare as crucial for effective governance. This component deals with the identity of an organization, reflecting the leitmotif who we are, thereby indicating board transparency as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative of board oversight of the development of trust to support patient care quality.

Second, in the context of organizational oversight in healthcare, the process component of the ethics paradigm is to focus upon decision-making to foster participative deliberation in institutions. This component addresses the accountability of the organization, reflecting the leitmotif how we function, thereby indicating board responsiveness as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative of board oversight of factors contributing to support patient care quality.

Third, in the context of organizational culture in healthcare, the practice component of the ethics paradigm is to focus on best practices to develop standards of conduct. This component engages quality in an organization, reflecting the leitmotif what we do, thereby indicating board oversight of mechanisms for patient care quality as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative of board oversight of the social contract for patient care quality.

This chapter has applied the ethics paradigm to identify hallmarks of governance ethics regarding patient care quality, denoting associated moral imperatives. The next chapter adopts the same approach to discuss hallmarks of governance ethics concerning the closely related topic of patient safety.

Notes


3 See: R. A. Ritvo, et al., Ethical Governance in Healthcare. A Board Leadership Guide for Building an Ethical Culture (Chicago, IL: Health Forum, Inc., 2004). In this book, just a few pages were dedicated to the problem of medical mistakes (pp. 60–63) and quality of care (pp. 61, 63).


5 L. Prybil, et al., The Evolving Accountability of Nonprofit Health System Boards (Chicago, IL: AHA Center for Healthcare Governance, Monograph Series, 2013, referred to as the Accountability Study.


14 Accountability Study, 5.

15 Accountability Study, 5.

16 Accountability Study, 5.

17 Accountability Study, 5.


19 Accountability Study, 7.


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29 Editorial, “Profit Motive: The City’s UPMC Suit will Turn on One Key Factor,” Pittsburgh Post Gazette (March 27, 2013).

30 Accountability Study, 5.

31 Accountability Study, 6.


38 Accountability Study, 10.


Accountability Study, 11.


Accountability Study, 11.


Accountability Study, 11.


Accountability Study, 11.


Accountability Study, 11–12.


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65 *Accountability Study*, 12.
66 *Accountability Study*, 12.
67 *Accountability Study*, 12–13. Also see: Health Research and Educational Trust, *Creating Effective Partnerships to Build a Culture of Trust* (Chicago, IL: Health Research and Educational Trust, 2016).

Select readings

8 Governance of patient safety

Introduction

This chapter applies the ethics paradigm to discuss hallmarks of governance ethics regarding patient safety, a pivotal topic closely connected with the discussion in the previous chapter on patient care quality. Just as there are two chapters in the book on community-related issues (community benefit and community health), there are two chapters on patient-related issues.

The connection between patient care quality and patient safety has been acknowledged for a long time. More specifically, there has been longstanding pressure in healthcare to strengthen board oversight of safety as a quality concern, requiring ethical scrutiny. In addition to safety of patients, boards have responsibility to ensure the safety of those who work in the organization and others present in the organization for other reasons. However, this chapter focuses on board oversight of patient safety. Oversight of patient safety has generated policy debates and led to enhancing self-regulation and governance responsibility, including shared responsibility between boards and medical staffs. A closer alignment emerged between hospital and medical staff leadership, connecting executive performance with safety and quality. The Joint Commission publishes requirements annually for hospital accreditation that mandate sound practices in patient safety. Despite a lot of progress regarding this alignment, patient safety, as an ethical issue related to patient care quality, continues to present significant oversight challenges for boards.

In the analysis of the previous applied chapters, the concepts of the ethics paradigm organize core features of effective governance from landmark reports and the scholarly literature. The analysis in this chapter emphasizes the scholarly literature that has developed significantly in recent years. The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. Because the hallmarks represent necessary moral attributes of governance ethics, they entail an obligation to be adopted by boards. In turn, the associated moral imperatives represent necessary endeavors to foster the hallmarks under consideration.

The ethics paradigm organizes multiple topics on board oversight of patient safety, as follows. First, the foundation component of the ethics paradigm deals with the identity of an organization, reflecting the leitmotif who we are, thereby

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highlighting board oversight of error prevention as a hallmark of governance ethics for patient safety. In turn, this hallmark denotes an associated moral imperative of board oversight of a systems approach for patient safety. Second, the process component of the ethics paradigm addresses the accountability of the organization, reflecting the leitmotif *how we function*, thereby highlighting board oversight of deliberative processes for patient safety as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative regarding board oversight of proactive deliberations for patient safety. Third, the practice component of the ethics paradigm engages quality in an organization, reflecting the leitmotif *what we do*, thereby highlighting board oversight of practical mechanisms for patient safety as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative regarding board oversight of a patient safety culture.

Each of the applied chapters begins with an explanation of the need for the pivotal topic under consideration, such as governance of patient safety here. Again, the concepts of identity, accountability, and quality provide a framework for the applied analysis. These concepts represent the foundation component (reflecting *who we are*), the process component (reflecting *how we function*), and the practice component (reflecting *what we do*) of the ethics paradigm (Table 1.1).

The significance of patient safety is now well established in medical care. However, patient safety also shapes the caliber of high-reliability organizations, including management and administration, related regulation, and ethics. All of these require continuous clinical governance and board oversight across the different areas of health. Not surprisingly, the federal government quickly developed a keen interest in this complex issue, as did the World Health Organization, establishing the World Alliance for Patient Safety. To begin the discussion, it is helpful to explain the need for board oversight of patient safety.

### Need for board oversight of patient safety

Nearly a decade ago, national surveys indicated that only half of nonprofit hospital board chairs identified clinical quality as one of the board’s top two priorities and only 74 percent of health system boards had standing committees on safety as a quality concern. At that time, the US Department of Health

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*Table 1.1 Ethics paradigm*
and Human Services presented a national quality strategy to focus on meeting the needs of patients, including patient safety.\textsuperscript{17} Also, the National Quality Forum included patient safety among its “National Priorities and Goals,” urging healthcare leaders to be intolerant of safety defects in care.\textsuperscript{18} In 2009, the Joint Commission established the Center for Transforming Healthcare to seek quality solutions for the most critical and complicated safety problems. It combined a process called \textit{Robust Process Improvement} (integrating statistical models and change management principles) with the center’s \textit{Targeted Solution Tool} to generate confidential reporting on its extranet, \textit{Joint Commission Connect}. The purpose was to compile data from organizations with solutions for resolving safety issues, through processes such as the “Lean” methodology (advancing safety through risk reduction processes).\textsuperscript{19} The Joint Commission and the National Quality Forum strenuously encouraged board oversight of patient safety. Similarly, the Patient Protection and Affordable Care Act of 2010 urged boards to provide oversight for safety as a quality care issue.\textsuperscript{20} From that time onwards it was widely recognized that governing boards hold the ultimate responsibility for patient safety. Hence, boards need to have a continuous commitment to healthcare structures, deliberative processes, and professional practices that support safe and reliable care.\textsuperscript{21} These items (structures, processes, practices) are discussed later in relation to the concepts of \textit{identity}, \textit{accountability}, and \textit{quality} in the ethics paradigm.

The \textit{Governance Structure Report}, discussed in previous chapters, also considered the topic of patient safety. The report explained that 93 percent of the boards studied indicated a standing committee with oversight responsibility for patient safety as a quality concern, with approximately 80 percent adopting system-wide measures and standards. All of the system CEOs and all of board members who were interviewed responded independently that their system board regularly received written reports on system-wide and hospital-specific performance to established measures and standards. Also, approximately 80 percent of board members and CEOs reported their system board as having adopted specific action plans in the previous 12 months to improve system performance regarding patient safety as an issue for patient care quality. Moreover, board members and CEOs reported that they devoted a substantial portion of board meeting time (median estimate of 22 percent) to strategic deliberations regarding patient safety as quality issues. Nonetheless, the report noted a significant need to clarify board roles regarding patient safety. An example was the need to better manage the enormous amount of safety data to facilitate board members to understand and perform their duties in this complex area.\textsuperscript{22}

It is abundantly clear today that patient safety as a quality issue in healthcare requires board oversight for effective governance. To merit the status of being a high performing healthcare system or hospital, it is expected as a matter of effective governance to have board oversight of their organization’s patient safety programs. The discussion now applies the ethics paradigm to organize core features of effective governance regarding patient safety. The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. The applied
analysis begins with discussing hallmarks of governance ethics connected with the foundation component of the ethics paradigm.

**Error prevention: foundation-related governance ethics hallmark**

The foundation component of the ethics paradigm, in the context of the challenging environment of healthcare, focuses on stewardship to enhance an organization’s mission as crucial for effective governance. This focus requires boards to be attentive to the healthcare environment as the context for engaging their responsibilities. This component depicts the identity of an organization, reflecting the leitmotif *who we are*. The concept of *identity* highlights board oversight of error prevention as a hallmark of governance ethics for patient safety. This concept draws attention to who the board is in relation with its organization. In turn, this hallmark denotes an associated moral imperative regarding board oversight of a systems approach for patient safety. These are discussed in what follows.

To understand board oversight of error prevention as a hallmark of governance ethics, it is helpful to emphasize that there has been extensive discourse on the causes and potential solutions for medical error. A variety of approaches emerged to prevent errors in healthcare generally, as well as in specialized settings such as in acute care, in the intensive care unit, in the emergency department, in clinical oncology, regarding anesthesia. And, clinicians quickly recognized the need to discuss medical error issues with their patients. Also, interest emerged around medical errors in clinical research trials. In particular, high profile cases of errors caught the public’s attention. There were two critical cases of error in medical treatment and medical research, each leading to death, that caused controversy: the death of Jesica Santillan after a transplant, and the death of Jesse Gelsinger in a research protocol, the first gene therapy death in the USA.

Because many cases of error resulted in litigation (such as in the Santillan and Gelsinger cases), organizational compliance measures became increasingly influential. There is an awkward paradox in healthcare in which the trained expertise of the profession, even from the best medical schools in the world, regularly encounter the reality of healthcare being error-provoking by its nature. As boards began to focus on avoiding error, the challenges for governance oversight were unambiguous.

The need to have a governance focus on medical error was spotlighted by a report from the Institute of Medicine (IOM) in 2000. The IOM report was the result of many years of scholarly studies. T. A. Brennan, L. L. Leape, and others published a threshold study in 1991, known as the Harvard Medical Practice Study, reporting data on medical error from 1984. Other studies followed, such as on the prevention of medical errors and on the liability of organizations. The publicity from many such studies on medical errors in the 1990s focused attention on the issues of who should be responsible for avoiding medical errors.

In 1997 a prestigious commission on quality was established, the President’s Advisory Commission on Consumer Protection and Quality in the Healthcare
Industry. In 1998, the IOM formed the Quality of Healthcare in America Committee to review an emerging problem, the extent of medical error in USA healthcare. In 1999 the National Quality Forum was established as a nonprofit organization to develop a national strategy for healthcare quality (it merged in 2006 with the National Committee for Quality Healthcare). And, in 2000, a list of Fortune 500 companies combined to establish The Leapfrog Group to seek improvements in healthcare. Then, also in 2000, the IOM issued its report extrapolating from results of the Harvard Medical Practice Study and from a study in Colorado and Utah in the early 1990s, to identify the estimated high number of patient deaths in USA healthcare each year as a result of medical error. Naturally, such astounding figures were disputed. But in July 2004 Health Grades Inc. (a Colorado consulting firm) suggested that the numbers of US deaths from medical error could be more than twice as high as projected by the 2000 IOM report. Most accept that the IOM figures at least indicated a very serious problem for medical care and public health alike. The IOM report wanted to invigorate a national agenda to reduce errors in healthcare. It certainly precipitated a firestorm as it sought to engage ethics with policy.

The IOM report defined medical error as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. However, not all errors result in harm to the patient. Following this line of analysis, scholars subsequently referred to errors that cause patient injury as preventable adverse events. An adverse event is an injury resulting from a medical intervention; it is not due to the original condition of the patient. For example, at the time of the IOM report some estimated that as many as one third of adverse drug events among outpatients were preventable or ameliorable.

Another study in 2002, in the Archives of Internal Medicine, reported that drug errors occurred daily in one out of five doses in a typical 300-bed hospital. The study was based on an analysis of 36 hospitals in Colorado and Georgia. The analysis focused on the problems arising from administering errors after a physician had properly prescribed for the patient. The data was shocking insofar as the study focused on properly prescribed medications; it did not deal with errors linked with the wrong prescription of a drug by a physician or the wrong filling of a prescription in the pharmacy.

The IOM report explained that medical errors can occur in any stage of care, including diagnosis, treatment and preventive care. Diagnostic errors can occur when there is a mistake or delay in clinical diagnosis, or when there is a failure to provide relevant or indicated tests, or when there is a failure to act on the results of monitoring or testing, or when there is a use of outmoded tests. Treatment errors can occur in administering a procedure or in a surgical intervention, or in avoidable delay in treatment, or in the dose or method of using a drug, or in inappropriate care for a disease. Preventative errors can occur when there is inadequate monitoring or follow-up or by not providing prophylactic treatment. Also, scholars at that time explained there could be many other forms of medical error such as can be caused by communication failure or equipment malfunction, or resulting from fatigue among clinicians, or due to infection control, arising from
using information technology, and management mistakes, etc. Moreover, medica-
tion errors could occur in the processes of prescribing, dispensing, administering,
monitoring, and system and management control.46

To effectively address medical error, there needs to be a firm grasp of the types
and causes of the problem. To explain the various types of medical error, the
original IOM report adopted the theory of errors in the work of James Reason.47
The IOM report adopted the important distinction of Reason between latent errors
and active errors. Active errors occur with frontline operators and their effects are
felt more or less immediately. Latent errors typically are removed from the opera-
ator’s control, such as by poor design. It is latent error that presents the greatest
threat. However, typical responses to errors tend to dwell on active errors insofar
as they focus upon the individuals responsible. Adopting this distinction, the IOM
differentiated between mistakes and slips or lapses. A slip or lapse occurs when
the action is not what was originally intended—that constitutes an error of execu-
tion. This does not mean that a slip or lapse is minor or unimportant—patients can
die from them too. Also, in a mistake the action happens as planned but does not
accomplish its intended outcome because the original, intended action was mis-
taken or wrong—that constitutes an error of planning. Hence, in a mistake or error
the intention is not adequate, and a failure of planning is involved.48

The main controversy of the IOM report centered around the claim that up to
98,000 patients died each year in USA healthcare resulting from medical error.
Many of those patients may have been very sick upon admission to the hospi-
tals, but they were not dying. The IOM report carried a soothing title, To Err
is Human: Building a Safer Health System.49 In 2011, the Joint Commission
estimated that approximately 10 percent of patients in acute care hospitals were
likely to be seriously harmed or killed caused by iatrogenic errors.50 At that time,
estimates for adverse events in hospitals were significantly higher than previ-
ously estimated.51

The IOM followed up on its report with other important studies. The original
IOM report in 2000 focused upon the main causes of medical error. In 2001,
the IOM published a related report, Crossing the Quality Chasm.52 This report
focused the lack of coordination in healthcare that prevents the provision of many
medical interventions already recognized and established as benefiting patients.
That is, the report addressed the environment of healthcare delivery to highlight
the problem of medical error. This report criticized the quality and delivery of
care because they can increase the probability of error.53 The study urged a recon-
figuration of healthcare delivery in a manner that would decrease medical error.

Then, in 2002 the IOM issued another follow-up report, Leadership by Exam-
ple.54 This report again focused upon medical error, arguing for urgent improve-
ment in the nation’s healthcare services, and emphasizing improvement processes
for about one third of Americans in six different government programs: Medicare
(40 million), Medicaid (42.3 million), the State Children’s Health Insurance Pro-
gram (4.6 million), the Department of Defense (8.4 million), the Veterans Health
Administration program (4 million), and the Indian Health Services program
(1.4 million). The report took the opportunity of dealing with federally funded
government programs in healthcare as an obvious starting point in the national agenda for reducing medical error. That is, the report exhorted the government in its federal programs to establish better quality standards in reporting requirements for clinical data and in purchasing standards to reward and promote higher levels of quality. Moreover, the report encouraged the development of updated delivery models in healthcare and the expansion of applied health services research to support improvement.

The IOM published further studies to update previous research and to suggest new standards of care on preventing medication errors. For example, in 2004 the IOM released another report, further confirming its initial report. The report focused on the workload of staff nurses who care for an increased numbers of patients while fighting fatigue from long working hours. Subsequent studies suggested that deaths from medical error annually in the USA are much higher than originally estimated by the IOM report, reaching to over 250,000. In 2016, a study from Johns Hopkins University estimated that more than 250,000 people die annually from medical errors in the USA, being the third leading cause of death after heart disease and cancer. Today, the estimates hover between 250,000 to 440,000 deaths caused by medical error annually in the USA. Furthermore, in 2017 the Institute for Healthcare Improvement reported that 21 percent of patients report a personal experience with medical error in the USA.

In light of this extensive reporting, board oversight of error prevention can be construed as a hallmark of governance ethics. The foundation component of the ethics paradigm, in the context of the challenging environment of healthcare, focuses on stewardship to enhance an organization’s mission as crucial for effective governance. The concept of identity in the ethics paradigm draws attention to who the board is in relation with its organization, emphasizing the need to steward the challenging reality of medical error.

**Moral imperative: board oversight of a systems approach for patient safety**

Board oversight of error prevention is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of a systems approach to patient safety. The original IOM report emphasized the need for systems to resolve underlying problems. The IOM report was widely recognized and well received.

In borrowing insights from the work of Reason, the IOM sought to address the basic problem. The report highlighted the role of systems in accidents and explained that a system can be understood as a set of interdependent elements that interact to achieve a common aim. Here, a system can refer to many different entities, such as an integrated delivery system, a multi-hospital system, a system with many partners over a wide geographical area. Also, a system can refer to a smaller unit such as an operating room or an obstetrical unit. The compromise of systems is more associated with latent failures, mentioned earlier. So, identifying and fixing latent failures contributes more substantively to creating safer
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In other words, for the IOM report, adopting the scholarship of Reason, safety typically results from the interacting components of a system. Hence, the IOM reports argued that only remediating the underlying systems (for example, improving quality standards in clinical data reporting requirements) will effectively accomplish the goals of patient safety. Accompanying the IOM reports, there emerged widespread interest in a systems approach to patient safety, such as by the National Coalition on Healthcare and the Institute for Healthcare Improvement. Similarly, the systems approach led the Agency for Healthcare Research and Quality to develop indicators for patient safety that enable healthcare organizations to track problems.

Subsequently, the shift of emphasis from individuals to systems was pursued extensively to better engage the relation between human reliability and complex systems. In particular, the impact of human factors in crisis management received considerable attention. This focus on systems led to a keen focus upon the role of human factors, such as in using medical devices, including the psychology of human cognition and action and the processes of human perception. Not surprisingly, the increased interest in a systems approach to patient safety generated concerns among clinicians and health managers, such as regarding professional liability, disclosure and apologies, no-fault reporting. Yet, the focus on a systems approach to patient safety has increased significantly in healthcare.

In sum, the foundation component of the ethics paradigm highlights board oversight of error prevention as a hallmark of governance ethics. By focusing on identity in the ethics paradigm (dealing with who the board is), this hallmark denotes an associated moral imperative regarding board oversight of a systems approach for patient safety.

Deliberative processes for patient safety: process-related governance ethics hallmark

The concept of accountability in the ethics paradigm (reflecting the leitmotif how we function) emphasizes the importance of decision-making via participative deliberation. This focus requires boards to be attentive to organizational oversight as the context for overseeing their responsibilities. The concept of accountability highlights board oversight of deliberative approaches for patient safety as a hallmark of governance ethics for community health. The concept draws attention to how the board functions in the organization. In turn, this hallmark denotes an associated moral imperative regarding board oversight of proactive deliberations for patient safety. These are discussed in the following section.

To understand board oversight of deliberative approaches as a hallmark of governance ethics, it is helpful to be aware that the dominant model for addressing medical error was referred to as the professional sanctions model, emphasizes individual culpability. This model continues to be relevant for board oversight, but mainly from the perspective of malpractice. The model tends to punish individuals for their medical errors to prevent future recurrence. However, this model can be linked with the surge of lawsuits for medical malpractice. Yet,
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despite hefty penalties and personal shame in using this model, the extent of medical errors did not diminish. This sanctions-oriented model blamed the professional for carelessness or incompetence, focusing upon the individual rather than the problem and its cause. The malpractice system in US healthcare deals with this model to deter future medical mistakes. However, with this model, resistance to open reporting of medical error has created a serious problem for quality care. That is because a malpractice environment deters open reporting by professionals because of the climate of fear and shame. Of course, tort law through compensation of victims can shed light on the need for improvements in patient safety.

By engaging the concept of accountability in the process component in the ethics paradigm, there emerges a different model for addressing medical error. This is called the patient safety model that adopts a more deliberative approach to medical error. This model addresses medical error by seeking changes in the causes of individuals making medical mistakes. By clarifying what caused the error, safeguards can be implemented to prevent recurrence. This model develops quality improvement and encourages reporting to address underlying issues that cause error. This deliberative process for patient safety (in contrast to pursuing the professional sanctions model) constitutes a hallmark of governance ethics.

Moral imperative: board oversight of proactive deliberations for patient safety

Board oversight of deliberative processes for patient safety is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of proactive deliberations for patient safety. That is, a process that is sufficiently deliberative must be proactive in its design and implementation. Some analogies can help understand this proactive characteristic. The basic issue here is to shift from fixing blame upon individual professionals to proactively fixing the systems to prevent error and promote safety.

One analogue occurs in road safety. When a specific site is associated with several car accidents, safety rails are built to prevent future crashes. Likewise, deliberative processes for safety seek to design system fixes when medical errors arise. Another well-known analogy is that of airline safety to shed light on the patient safety model. As early as the 1950s safety centers for military aviation began to focus on human factors. Likewise, drawing upon military aviation experience, civilian aviation adopted more comprehensive approaches to safety. Civilian aviation began to implement accident investigations, incident reporting, and research for continuous quality improvement. Consequently, the Federal Aviation Administration (FAA) assumed regulatory oversight with the responsibility of ensuring flight safety. It became the task of an independent federal agency, the National Transportation Safety Board (NTSB), to conduct accident investigations, making recommendations to the FAA for regulatory action. At the heart of its success is the process of confidential incident reporting that is conducted through the National Aeronautics and Space Administration (NASA) Safety Reporting System.
Hence, after civilian airlines were freed from regulatory reprisals for reporting pilot error and near misses, pilot cooperation soared. The extensive, confidential reporting and subsequent remedies in the airline industry resulted in much improved safety for passengers, as has been extensively documented since the IOM report. Hence, after civilian airlines were freed from regulatory reprisals for reporting pilot error and near misses, pilot cooperation soared. The extensive, confidential reporting and subsequent remedies in the airline industry resulted in much improved safety for passengers, as has been extensively documented since the IOM report.

A similar system in healthcare could encourage self-reporting of mistakes and close calls with confidential assurances. In 2010 the Joint Commission explained the importance of close calls and sentinel events: they provide information about active or latent mistakes; they yield data about contributing factors; they highlight points of failure. This approach facilitates investigations with less anxiety about liability claims. Such an approach is likely to encourage system implementation of preventative measures and appropriate compensation for victims.

Another analogy is occupational health to exemplify how an industry can become safer over time. The Occupational Safety and Health Act of 1970 created the Occupational Safety and Health Administration (OSHA) and its research arm, the National Institute for Occupational Safety and Health. The purpose of OSHA is to encourage the reduction of workplace hazards and to implement new or existing safety and health programs by undertaking the following: providing research in occupational health and safety; maintaining record-keeping systems; developing training programs; and enforcing mandatory standards for job safety and health.

These analogies provide valuable lessons for safety in healthcare from the perspective of governance ethics. There needs to be better board oversight of relating safety concerns with the need to improve performance. Patient safety strategies need to include a focus on appropriate organizational and national leadership, development of a relevant knowledge base, and dissemination of knowledge in a timely manner throughout the industry. The FAA and OSHA dedicated government agencies with regulatory responsibility for safety that is separate from the agencies responsible for research. The research entities can generate reports that are useful to the regulatory authorities as they set standards. Also, aviation and occupational health recognized the need to expand the knowledge base on safety as well as to establish dissemination processes for this new knowledge. And substantial resources were provided to support these initiatives in aviation and occupational health. Adequate resources were indispensable for steady improvement over time. In other words, safety improvements were not the result of a one-time effort; rather, results occurred through an ongoing commitment of resources and leadership.

A similarly cohesive effort is needed by governance boards to foster a proactive process. This what is meant here by proactive deliberations for patient safety. The lessons in other industries suggest that to decrease medical errors a patient safety model designed around proactive deliberations may have more success than a reactive and punitive professional sanctions model. The basic problem with the professional sanctions model is that it tends to be reactive by blaming individuals for medical error. In such a mindset, medical mistakes tend to be hidden from families and patients to minimize the threat of litigation, and risk management...
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focuses on reducing pecuniary penalties rather than reducing risks to the patient of future error. These are not the paving stones for sound governance in healthcare organizations. There is a distinction between risk management and patient safety. The distinction reflects the difference between responding to errors versus creating a safe environment that explores past failure to create defenses against future failure. Of course, because of human frailty, there will continue to be medical mistakes that result from malice or malpractice, deserving of appropriate lawsuits and penalties. In contrast, a patient safety model focuses on proactive deliberations to create systems that prevent medical errors.

In sum, the process component of the ethics paradigm highlights board oversight of deliberative processes for patient safety as a hallmark of governance ethics. By focusing on accountability in the ethics paradigm (dealing with how the board functions), this hallmark denotes an associated moral imperative regarding board oversight of proactive deliberations for patient safety.

Practical mechanisms for patient safety: practice-related governance ethics hallmark

The concept of quality in the ethics paradigm (reflecting the leitmotif what we do) emphasizes the importance of best practices for standards of conduct. This focus requires boards to be attentive to organizational culture as the context for implementing their responsibilities. The concept of quality highlights board oversight of practical mechanisms for patient safety as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative regarding board oversight of a patient safety culture. These are discussed in the next section.

To understand board oversight of practical mechanisms for patient safety as a hallmark of governance ethics, it is helpful to emphasize the significance of root cause analysis. This approach has elicited extensive discussion,81 being adopted in many different fields,82 as well as in healthcare.83 The approach has been adopted by the Joint Commission as part of its efforts to develop mechanisms for patient safety.84 One step in the process of root cause analysis is assigning a team to assess the causal factors that underlie (actual or potential) sentinel events. The Joint Commission describes a sentinel event as an unexpected occurrence involving death or serious injury (physical or psychological), or the risk thereof,85 as explored in its publication.86 Another step in the process is to study the problem comprehensively by integrating these steps: identifying relevant risk reduction strategies; evaluating proposed actions and designing a plan for improvement; ensuring acceptability of the action plan; implementing the improvement plan; developing measures of effectiveness and ensuring their success; and effectively communicating the results.87

Not surprisingly, root cause analysis has become a well-established and widely adopted mechanism to improve patient safety. This emphasizes why board oversight of practical mechanisms for patient safety is a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative regarding board oversight of patient safety culture.
Moral imperative: board oversight of a patient safety culture

Developing a culture of patient safety is indispensable for the improvement of organizational culture in healthcare.88 Similarly, organizational culture has a significant impact on patient safety, as it does on the workplace in healthcare generally.89 The IOM report (To Err Is Human) explained this organizational culture as including the following: provide leadership; respect human limits in the design process; promote effective team functioning and communication; anticipate the unexpected; and create a learning environment.90 Each of these is considered as necessary for governance ethics.

To begin, the role of leadership—clinical, executive, and governance—is crucial for cultivating a healthy culture of safety.91 The respective roles of clinical leaders, executive leaders, and the board should be clear, mutually understood, and closely coordinated in order to be effective. Effective leadership for patient safety necessarily includes team building that includes the following: making patient safety a priority corporate objective; making patient safety the responsibility of everyone, such as by endorsing non-punitive solutions; making clear assignments for and expectation of safety oversight; providing human and financial resources for systems redesign; and developing mechanisms for identifying and dealing with unsafe practitioners, emphasizing the new focus of safety upon systems. When assigning a team, several items must be addressed: staff should be assured of the objectivity of any organizational improvement that occurs, such as the identification and reduction of risks instead of any assignment of blame to individuals; and leaders should empower their teams to make recommendations for change, providing appropriate practical resources. These issues enable team work to improve patient safety.92

Also, it is necessary to respect human limits in the design process, such as by the following: designing jobs for safety, including being attentive to work hours and loads, staffing ratios, and sources of distraction, fatigue or sleep deprivation; avoiding reliance on memory, such as by adopting the use of protocols and checklists whenever appropriate; using constraints and forcing functions to guide users to the next action or decision and to structure critical tasks; avoiding reliance on vigilance (because attention spans are limited), simplifying key processes (to minimize problem solving), and standardizing work processes (to reduce reliance on memory and enabling newcomers to use devices safely).93

Furthermore, designing processes of care to anticipate the unexpected is indispensable for a culture of safety. Designing processes of care require the following: adopting a proactive approach that anticipates threats to safety; planning before accidents occur, such as via the automation of tasks that are repetitive and time consuming; and anticipating recovery, such as by making mistakes visible when possible, making it easy to reverse operations, and making it difficult to perform non-reversible operations.94

Finally, an organizational culture of safety requires the creation of an effective learning culture, including data technology and machine learning, that includes
the following: using simulations whenever possible, such as for training, for problem solving and for crisis management; encouraging reporting of mistakes and hazardous conditions to collaborate in problem solving and ensure there are no reprisals for reporting failures; and ensuring that communication flows freely. In an effective learning-culture there should appropriate feedback about mistakes, such as via reporting of events, understanding what occurred and why it occurred, developing and implementing recommendations for improvements, and tracking changes for subsequent assessment of their effectiveness.95

In a manner that is complementary to the original IOM report’s approach to developing a culture of safety, the Joint Commission provides ongoing guidance to cultivate a culture of safety through its national patient safety goals, its Journal on Quality and Patient Safety, its publication The Source for accreditation and certification compliance, its official newsletter, The Joint Commission Perspectives, and other resources.96 Most significantly, the Joint Commission has emphasized the importance of board oversight of patient safety.97

In sum, the practice component of the ethics paradigm highlights board oversight of practical mechanisms for patient safety as a hallmark of governance ethics. By focusing on quality in the ethics paradigm (dealing with what the board does), this hallmark denotes an associated moral imperative regarding board oversight of patient safety culture.

**Conclusion**

This chapter has highlighted hallmarks of governance ethics with associated moral imperatives regarding patient safety. The contribution of the ethics paradigm can be summarized in this manner.

First, in the context of the challenging healthcare environment, the foundation component of the ethics paradigm focuses on stewardship to enhance an organization’s mission in healthcare as crucial for effective governance. This component deals the identity of an organization, reflecting the leitmotif who we are, thereby indicating board oversight of error prevention as a hallmark of governance ethics for patient safety. In turn, this hallmark denotes an associated moral imperative concerning board oversight of a systems approach for patient safety.

Second, in the context of organizational oversight in healthcare, the process component of the ethics paradigm is to focus upon decision-making to foster participative deliberation in organizations. This component addresses the accountability of the organization, reflecting the leitmotif how we function, thereby indicating board oversight of deliberative processes for patient safety as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative concerning board oversight of proactive deliberations for patient safety.

Third, in the context of organizational culture in healthcare, the practice component of the ethics paradigm is to focus on best practices to develop standards of conduct. This component engages quality in an organization, reflecting the leitmotif what we do, thereby indicating board oversight of practical mechanisms for patient safety as a hallmark of governance ethics. In turn, this hallmark
denotes an associated moral imperative concerning board oversight of a patient safety culture.

This chapter has applied the ethics paradigm to identify hallmarks of governance ethics regarding patient safety, denoting associated moral imperatives. As boards pursue their governance responsibilities for communities (community benefit and community health) and for patients (patient care quality and patient safety), scenarios can arise in which partnership arrangements can conflict with an organization’s mission. The next chapter considers these problems that boards encounter regarding conflicted collaborative arrangements in healthcare organizations.

Notes


5 C. A. Goeschel, *Quality, Patient Safety, and Boards of Trustees: Implications for Creating Safer Healthcare* (Dr. Sci Dissertation, Tulane University School of Public Health and Tropical Medicine, 2010).


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34 The Institute of Medicine, *To Err is Human: Building a Safer Health System* (Washington, DC, National Academies Press, 2000).


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49 The Institute of Medicine, To Err is Human: Building a Safer Health System (Washington, DC: National Academies Press, 2000).
50 Joint Commission, The Value of Close Calls in Improving Patient Care. Learning How to Avoid and Mitigate Patient Harm (Oakbrook Terrace, IL: Joint Commission Resources, 2011), Foreword.


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Select readings


9 Governance of conflicted collaborative arrangements

Introduction
This chapter continues the approach of applying the ethics paradigm to a pivotal problem for governance ethics: how boards of directors may permissibly navigate complex dilemmas involving conflicted collaborative arrangements in healthcare organizations. As boards pursue their governance responsibilities for communities (community benefit and community health, as discussed in Chapters 5 and 6) and for patients (patient care quality and patient safety, as discussed in Chapters 7 and 8), scenarios can arise in which collaborative arrangements can conflict with an organization’s mission. The following discussion explains how to distinguish between wrongful complicity and legitimate cooperation with other institutions when there is a fundamental conflict over basic values related to an organization’s mission. In such conflicted scenarios, the goal is to maintain quality care services in any new collaborative arrangement.

In the previous analysis, the concepts of the ethics paradigm organize core features of effective governance from landmark reports and the scholarly literature. The analysis in this chapter emphasizes the scholarly literature to explain the nuances of the ethical principle of cooperation that is discussed in this chapter. The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. Because the hallmarks represent necessary moral attributes of governance ethics, they entail an obligation to be adopted by boards. In turn, the associated moral imperatives represent necessary endeavors to foster the hallmarks under consideration.

The ethics paradigm organizes multiple topics on board oversight of conflicted collaborative arrangements, as follows. First, the foundation component of the ethics paradigm deals with the *identity* of an organization, reflecting the leitmotif *who we are*, thereby highlighting board oversight of organizational reputation as a hallmark of governance ethics in conflicted collaborative arrangements. In turn, this hallmark denotes an associated moral imperative of board oversight of organizational flexibility. Second, the process component of the ethics paradigm addresses the *accountability* of the organization, reflecting the leitmotif *how we function*, thereby highlighting board oversight of institutional negotiations as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative regarding board oversight of the process of cooperation. Third, the

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practice component of the ethics paradigm engages *quality* in an organization, reflecting the leitmotif *what we do*, thereby highlighting board oversight of collaborative arrangements as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative regarding board oversight of maintaining quality care services.

Each of the applied chapters begins with an explanation of the need for the pivotal topic under consideration, such as governance of conflicted collaborative arrangements here. Again, the concepts of *identity*, *accountability*, and *quality* provide a framework for the applied analysis. These concepts represent the foundation component (reflecting *who we are*), the process component (reflecting *how we function*), and the practice component (reflecting *what we do*) of the ethics paradigm (Table 1.1).

The need for collaborative arrangements has expanded exponentially in healthcare over recent decades. To begin the discussion, it is helpful to explain the need for the moral principle of cooperation.

### Need for a moral principle of cooperation

Boards encounter occasions when their healthcare organization creates a collaborative arrangement with other institutions that undertake activities deemed to be immoral, even though such actions may be legal. As boards oversee their own organization based on the principle of stewardship, their focus is not merely to maintain the fiscal viability of the organization but also to nurture its mission. This duty of stewardship entails a serious responsibility to avoid what the organization deems to be wrong, that is, avoiding wrongful complicity with conflicting values in another institution. Nonetheless, in the complex arena of a secular and pluralistic democracy, there is a myriad of values that different organizations have. Surprisingly often, boards must navigate the difficult shoals of conflicting values between organizations to benefit from a variety of collaborative arrangements. 

This dilemma in governance ethics raises a crucial distinction between wrongful complicity and legitimate cooperation. The following analysis explains two common circumstances. One situation is when the board of organization A becomes involved with actions that it deems to be immoral (but not illegal) in organization B. Another situation is when organization A is under duress, such as by government pressure, regarding the provision of services that are deemed
by the organization to be immoral (such as some types of reproductive services). What should a board do in such situations to steward its own organizational values and mission?

Different analogies are discussed to shed light on these difficult scenarios. The chapter explains the ethical principle of cooperation to present options that boards can pursue. The principle is most explicitly used in Catholic healthcare that represents approximately 15 percent of acute care hospitals (owned by or affiliated with Catholicism). Hence, the examples of conflicted collaborative arrangements that are considered deal with Catholic healthcare. The point is to use this religious tradition as an example of using this ethical principle when the values of any health system (religious or secular) become conflicted in collaborative arrangements.

The discussion now applies the ethics paradigm to organize core features of effective governance regarding conflicted collaborative arrangements. The purpose is to highlight hallmarks of governance ethics that denote associated moral imperatives. The applied analysis begins with discussing hallmarks of governance ethics connected with the foundation component of the ethics paradigm.

Organizational reputation: foundation-related governance ethics hallmark

The foundation component of the ethics paradigm, in the context of the challenging environment of healthcare, focuses on stewardship to enhance an organization’s mission as crucial for effective governance. This focus requires boards to be attentive to the healthcare environment as the context for meeting their responsibilities. This component depicts the *identity* of an organization, reflecting the leitmotif *who we are*. The concept of *identity* highlights board oversight of organizational reputation as a hallmark of governance ethics in conflicted collaborative arrangements. This concept draws attention to who the board is in relation with its organization. In turn, this hallmark denotes an associated moral imperative regarding board oversight of organizational flexibility that boards must have in conflicted collaborative arrangements involving conflicting mission or values. These are discussed in subsequent sections.

To understand board oversight of organizational reputation as a hallmark of governance ethics, it is helpful to consider how the ethical principle of cooperation pertains in a common example, bank robbery. This example clarifies who is or is not a thief, illustrating the reputation so to speak of the individuals involved. The point here is that when an institution undertakes actions in conflicted collaborative arrangements, its organizational reputation is at stake.

In a bank robbery, different reputations accrue to individuals who become involved. Naturally, the individuals who enact the robbery in a bank are thieves. That is who they are, that is their “reputation.” However, what about a get-away driver? Of course, a get-away driver is complicit with the theft, even though the driver did not enter the bank. That sort of wrongful complicity occurs because the get-away driver intends the theft of the bank robber, participating in the crime albeit at some distance. The get-away driver also merits the “reputation” of being a thief.
However, another scenario can complicate this straightforward description of robbery. If the bank robber uses a gun to stop a passing car and forces the driver under duress to provide an escape, that innocent driver does not intend the theft. Nonetheless the beleaguered driver is involved in the robbery (that is, physically cooperating) by driving the car, albeit under duress of being shot. That sort of involvement or cooperation in the crime is not culpable because the driver is under unavoidable duress and does not intend the morally wrong action—despite the physical participation in the crime. This scenario is not morally wrong. In other words, the innocent driver does not merit the “reputation” of being a thief.

In ethics discourse, the distinction between these two situations has a specific terminology. In the first scenario, the planned getaway driver’s action is described as illicit formal cooperation: the driver intends to participate in the crime, albeit without entering the bank vault. This driver merits the “reputation” of being a thief. In the second scenario, the action of the enforced passerby to drive the escape car is described as justified material cooperation: the passerby does not intend the theft but under duress is physically connected with the crime by driving the escape car. This driver does not merit the “reputation” of being a thief. The point to note is that formal cooperation cannot be morally justified, whereas material cooperation can be morally justified. No court would judge the unfortunate passerby as guilty of theft; nor does moral discourse construe guilt for this sort of physical involvement with immoral behavior (the bank robbery).

This straightforward example sheds light on how boards might use this ethical principle of cooperation to guide their oversight of organizational reputation in conflicted collaborative arrangements. For example, board members in a Catholic health organization may plan to expand their services via a collaborative arrangement with another healthcare provider who has services prohibited by Catholic teaching. The need for such an arrangement must be related to external pressure upon the Catholic organization, such as needing to provide permissible services to remain competitive, despite the other organization also providing services prohibited in Catholicism. Without external duress, conflicted collaborative arrangements should not be considered. Because the services of the other organization include activities prohibited by Catholic teaching (such as some reproductive services), the “reputation” of the Catholic organization is at stake. Hence, board members must have a valid motive for considering the collaborative arrangement. For example, there is a scenario (though unlikely) where board members of a Catholic organization consider the collaborative arrangement because they want to have access to the prohibited reproductive services in the other organization. This is unacceptable. Or, the board members may plan access to other collaborative arrangement services that are permissible in Catholicism, despite the other organization providing reproductive services that Catholicism prohibits. Again, the board’s rationale to plan ahead is grounded in external duress that leads them to consider such a conflicted collaborative arrangement.

If board members intend the former (wanting the prohibited services), they intend the so-called wrongdoing. If board members intend the latter (seeking access to permissible services), they do not intend any perceived wrongdoing
in the other organization. In these scenarios, the motive of the board members shapes the “reputation” of the organization.

Board oversight of organizational reputation constitutes a hallmark of governance ethics because board actions determine the ethical caliber of conflicted collaborative arrangements. That is, boards have a duty to protect the reputation of their organization when it considers conflicted collaborative arrangements with other institutions that may have conflicting values (providing services that are prohibited by the other organization). This discussion engages the challenging environment in healthcare where market pressures require organizations to make arrangements that raise the dilemma of a conflicted collaborative arrangement.

**Moral imperative: board oversight of organizational flexibility**

Board oversight of organizational reputation in conflicted collaborative arrangements is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding oversight of organizational flexibility. This imperative refers to the flexibility that boards must have in conflicted collaborative arrangements. Boards need maneuvering room when involved with conflicting values.

Often, quandaries that emerge around conflicting organizational values in collaborative arrangement occur between secular and religiously affiliated institutions. Because Catholic healthcare holds the largest percentage of faith-based healthcare facilities in the USA, it can be useful to explore its use of the ethical principle of cooperation. This principle is useful not just for Catholic healthcare. Secular or other religiously affiliated healthcare systems may become involved with conflicted collaborative arrangements that can benefit from understanding this ethical principle. The flexibility permitted by the ethical principle of cooperation in Catholic healthcare is explained in the Ethical and Religious Directives for Catholic Health Care Services, referred to later as the Directives. These directives were revised in 2018 specifically to explain the nuances of this principle of cooperation.³ The following discussion considers how the Catholic tradition uses this principle generally, while avoiding the multiple fine distinctions that the principle has generated over centuries of use.⁴

Boards must have organizational flexibility to avoid any arrangement that contributes to what Catholicism construes as the wrongdoing of other providers. The Directives explain that “Catholic health care services . . . should avoid, whenever possible, engaging in collaborative arrangements that would involve them in contributing to the wrongdoing of other providers.”⁵ Nonetheless, the Directives recognize that at times “in pursuit of the common good, the only available candidates for collaboration are institutions that do not operate in conformity with the Church’s moral teaching.”⁶ The permissibility here refers to there being duress that requires such a collaborative arrangement and that it is undertaken to contribute to the common good.

The Directives refer to the ethical principle of cooperation when explaining that “the Catholic moral tradition provides principles for assessing cooperation with
the wrongdoing of others.” This ethical principle provides boards with the organizational flexibility to plan appropriate collaborative arrangements. The purpose is specifically “to determine the conditions under which cooperation may or may not be morally justified, distinguishing between ‘formal’ and ‘material’ cooperation.” This principle provides organizational flexibility to clarify when instances of material cooperation are morally justified or not. This approach recognizes that collaborative arrangements between Catholic institutions and entities that do not share the Catholic moral tradition present both opportunities and challenges. This organizational flexibility emphasizes that “the challenges do not necessarily preclude all such arrangements on moral grounds,” and urges “Catholic leaders to undertake careful analyses to ensure that . . . collaborative arrangements . . . abide by the principles governing cooperation.”

In sum, the foundation component of the ethics paradigm highlights board oversight of organizational reputation as a hallmark of governance ethics. By focusing on identity in the ethics paradigm (dealing with who the board is), this hallmark denotes an associated moral imperative regarding board oversight of organizational flexibility in collaborative arrangement. Boards need maneuvering room when involved with conflicting mission or values.

Institutional negotiations: process-related governance ethics hallmark

The concept of accountability in the ethics paradigm (reflecting the leitmotif how we function) emphasizes the importance of decision-making via participative deliberation. This focus requires boards to be attentive to organizational oversight as the context for overseeing their responsibilities. The concept of accountability highlights board oversight of institutional negotiations as a hallmark of governance ethics in conflicted collaborative arrangements. The concept draws attention to how the board functions in the organization. In turn, this hallmark denotes an associated moral imperative regarding board oversight of the process of cooperation. These are discussed in the next section.

To understand board oversight of institutional negotiations as a hallmark of governance ethics, it is helpful to consider an analogous scenario. The scenario deals with legislators undertaking negotiations about politics. The following discussion suggests options that boards can adopt in their institutional negotiations in conflicted collaborative arrangements.

The discussion deals with scenarios where Catholic legislators have to vote on abortion laws. It would be illicit for Catholics to vote for abortion related to activities that they undertake. Yet, surprisingly, using the principle of cooperation, Catholics may legitimately vote in favor of an abortion law or for pro-abortion legislators as a form of licit cooperation. This may seem surprising given the strenuous opposition to abortion in this religious tradition.

However, the principle of cooperation in these conflicted situations can enlighten how boards of directors in healthcare may deal with their conflicted collaborative arrangements. Two related Catholic teachings can shed light on the complex
deliberations around voting for legislation to permit abortion. The US bishops explain the nuanced Catholic stance in this way:

Decisions about political life are complex and require the exercise of a well-formed conscience aided by prudence. . . . Sometimes morally flawed laws already exist. In this situation, the process of framing legislation to protect life is subject to prudential judgment and ‘the art of the possible.’ At times this process may restore justice only partially or gradually. Pope John Paul II taught that when a government official who fully opposes abortion cannot succeed in completely overturning a pro-abortion law, he or she may work to improve protection for unborn human life, ‘limiting the harm done by such a law’ and lessening its negative impact as much as possible. Such incremental improvements in the law are acceptable as steps toward the full restoration of justice.11

The key point being made here is that Catholic legislators may vote in favor of a law permitting abortion, provided the law decreases or diminishes the reach (“limiting the harm”) of prior laws. The next quotation reiterates this stance referring to the principle of cooperation. The passage that the US bishops allude to is from the teaching of Pope John Paul II:

A particular problem of conscience can arise in cases where a legislative vote would be decisive for the passage of a more restrictive law, aimed at limiting the number of authorized abortions, in place of a more permissive law already passed or ready to be voted on. Such cases are not infrequent. . . . In a case like the one just mentioned, when it is not possible to overturn or completely abrogate a pro-abortion law, an elected official, whose absolute personal opposition to procured abortion was well known, could licitly support proposals aimed at limiting the harm done by such a law and at lessening its negative consequences at the level of general opinion and public morality. This does not in fact represent an illicit cooperation with an unjust law, but rather a legitimate and proper attempt to limit its evil aspects.12

The key point here is to highlight that the US bishops rely on the principle of cooperation to permit Catholic legislators to vote in favor of an abortion law provided it limits a more permissive law. This means that a Catholic politician who is pro-life may support laws that, while continuing to permit abortion, limit the harm of previous laws. The renowned legal scholar John Finnis has argued, “even if there is cooperation of pro-life legislators with unjust legislators in enacting just restrictive legislation, this cooperation does not involve the pro-life legislator in the wrongdoing of the unjust legislator, or any other wrongdoing.”13

The critical issue here is that the principle of cooperation permits Catholic politicians to support some types of legislation that permit abortion. Two crucial points must be noted. A Catholic politician must not intend the evil of abortion: that would constitute formal cooperation which is always illicit. Also, a Catholic
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politician may vote for an abortion law in such circumstances as a function of material connection with the abortion legislation. Here, the politician is under duress and the vote connects in a material way with the perceived wrongdoing of abortion, yet good can be achieved by voting for a law that limits the reach of prior legislation.

In this example, a Catholic politician may engage in the institutional negotiations that occur in the legislature. The politician can use the principle of cooperation to reach a collaborative arrangement (with fellow legislators), despite the law under discussion being connected with perceived wrongdoing (abortion). In this situation, the politician engages in justified material cooperation. Similarly, boards in Catholic healthcare may engage in institutional negotiations to establish a collaborative arrangement (with a fellow healthcare organization), despite the arrangement under discussion being connected with perceived wrongdoing (such as certain reproductive services). This analysis explains why board oversight of institutional negotiations constitutes a crucial hallmark of governance ethics.

Moral imperative: board oversight of the process of cooperation

Board oversight of institutional negotiations is a hallmark of governance ethics in conflicted collaborative arrangements. This hallmark denotes an associated moral imperative regarding board oversight of the process of cooperation. When boards in healthcare organizations find themselves in such conflicted collaborative arrangements, they must adopt the proper process of cooperation that is delineated by the principle of cooperation.

There is considerable discourse on the principle of cooperation to explain how to avoid wrongful complicity with conflicting values in collaborative arrangements. The Directives of the US bishops explain how the process of cooperation functions in healthcare. To begin, any collaborative arrangement must avoid formal cooperation, such as intending the perceived wrongdoing of another organization. The Directives emphasize that to use the principle of cooperation, collaborative actions of the Catholic institution must be scrutinized carefully: “a Catholic institution must ensure neither its administration nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures.”

Furthermore, the Directives emphasize that in such a process of cooperation the “acquisition, governance, or management” undertaken by a Catholic institution in conflicted collaborative arrangements require meticulous care in planning:

It is not permitted to establish another entity that would oversee, manage, or perform immoral procedures. Establishing such an entity includes actions such as drawing up the civil bylaws, policies, or procedures of the entity, establishing the finances of the entity, or legally incorporating the entity.

The point here is to avoid subtle or nuanced maneuvers that can entail formal cooperation. The explicit mention of governance here emphasizes the oversight
responsibility of boards for these arrangements and their proper use of the process of cooperation in applying the principle of cooperation.

Another analogy can help to guide the process of cooperation. This analogy returns to the arena of voting that has elicited much attention with regard to the principle of cooperation. This analogy deals with Catholics voting for politicians who support legislative actions prohibited in Catholicism, such as abortion. The question is whether Catholic voters may vote for a pro-abortion politician who supports abortion legislation. The process of cooperation functions in this way. A Catholic voter may not directly support abortion legislation by intending it for its own sake: that would be formal cooperation and thereby immoral. The US bishops make this clear in their 2007 Pastoral Letter.

A Catholic cannot vote for a candidate who takes a position in favor of an intrinsic evil, such as abortion or racism, if the voter’s intent is to support that position. In such cases a Catholic would be guilty of formal cooperation in a grave evil.\(^\text{17}\)

The nuanced question, then, is whether a Catholic voter may vote for a pro-abortion politician because of the politician’s stance on other important issues. The principle of cooperation permits this. The US bishops explain that Catholic voters may evaluate the issue of abortion within a broader political landscape.

A candidate’s position on a single issue is not sufficient to guarantee a voter’s support. Yet a candidate’s position on a single issue that involves an intrinsic evil, such as support for legal abortion . . . may legitimately lead a voter to disqualify a candidate from receiving support.\(^\text{18}\)

There is a subtle point being made here by the Bishops. A single issue dealing with a perceived harm like abortion “may legitimately lead a voter” to withdraw support. The single issue “may” but does not necessarily require a voter to withdraw support insofar as other issues can legitimately be considered in voting. That is, the process of cooperation can justify voting for a pro-abortion politician based on other relevant issues.

This point was made by Cardinal Joseph Ratzinger as Prefect of the Congregation of the Doctrine of the Faith (who later became Pope Benedict XVI) when he applied the principle of material cooperation. Cardinal Ratzinger explained that the justification of a vote like this would be an example of the process of cooperation. He explained: “A Catholic would be guilty of formal cooperation in evil . . . if he were to deliberately vote for a candidate precisely because of the candidate’s permissive stand on abortion and/or euthanasia.” On the other hand, he clarified: “When a Catholic does not share a candidate’s stand in favor of abortion and/or euthanasia, but votes for that candidate for other reasons, it is considered remote material cooperation, which can be permitted in the presence of proportionate reasons.”\(^\text{19}\)

This analogy can clarify for boards how the process of cooperation functions when they are engaged with conflicted collaborative arrangements. On the one
hand, a Catholic “voter’s intent” may not support a candidate’s stance on a prohibited action like abortion. Likewise, board members in a Catholic organization may not plan collaborative arrangements if they do so to gain access to prohibited services: that constitutes “formal cooperation in evil.” On the other hand, it is permissible when a Catholic “votes for that candidate for other reasons” (distinct from the perceived wrongdoing like abortion). Similarly, in conflicted collaborative arrangements, board members may enact provisions that focus on “other reasons” in the collaboration that are distinct from the perceived wrongdoing: that constitutes “material cooperation.” Briefly, the process of cooperation is designed to maintain a fundamental distinction between legitimate and wrongful complicity.

In sum, regarding conflicted collaborative arrangements the process component of the ethics paradigm indicates board oversight of institutional negotiations as a hallmark of governance ethics. By focusing on accountability in the ethics paradigm, this hallmark denotes an associated moral imperative concerning board oversight of the process of cooperation. Crucially, the process of cooperation must avoid wrongful complicity with conflicting values.

**Collaborative arrangements: practice-related governance ethics hallmark**

The concept of quality in the ethics paradigm (reflecting the leitmotif what we do) emphasizes the importance of best practices for standards of conduct. This focus requires boards to be attentive to organizational culture as the context for implementing their responsibilities. The concept of quality highlights board oversight of conflicted collaborative arrangements as a hallmark of governance ethics regarding this topic. In turn, this hallmark denotes an associated moral imperative regarding board oversight of maintaining quality care services. These are discussed in the next section.

To understand board oversight of conflicted collaborative arrangements as a hallmark of governance ethics, it is necessary to be attentive to the importance of external duress upon the Catholic organization. There numerous types of collaborative arrangements. At the foundation of collaborative arrangements when there are conflicting values between the institutions, the principle of cooperation cannot be adopted unless there is clear external duress. The different types of duress can range from financial stress to geographical distribution. In all cases, there must be external duress to justify a Catholic organization collaborating with another institution that does not follow Catholic teaching.

An example of the external duress that boards must endure is when Catholic organizations need to deal with a government mandate. For example, in 2010 healthcare reform was signed into law by President Barack Obama, achieving a goal of extending health insurance to most of the US population, many of whom previously lacked health insurance. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 by President Obama, along with the Health Care and Education Reconciliation Act of 2010, signed on March 30,
2010. Together these constituted the health care reform accomplishment of the Democratic 111th Congress. This achievement of extending health care insurance and access to tens of millions of citizens who previously had none was consistent with Catholic teaching on social justice.

The critical problem here deals with a government mandate regarding practices that conflict with Catholic teaching. The mandate was from the Department of Health and Human Services related to implementing the Affordable Care Act. The mandate required institutions, including health care organizations, to provide their employees with access to contraception services. However, for Catholic organizations, these services conflict with Catholic teaching.

The principle of cooperation can defuse the controversy by providing boards in Catholic organizations a way to plan collaborative arrangements to address this government mandate for contraception coverage. There are Catholic organizations that provide their employees with a health plan through an insurance company. Also, there are Catholic organizations that are self-insured, though they may use insurance companies to service their health plan and insurance claims. In both situations, the principle of cooperation can justify practices that resolve the problem related to the government’s contraception mandate.

The resolution using the principle of cooperation can be described in this way. A Catholic organization informs a mandate-related authority that the organization cannot provide contraception services. The mandate-related authority informs the insurance company for the Catholic organization. Then the insurance company contacts the employees of the Catholic organization to provide contraception coverage separate from and not coordinated by the Catholic organization. This slightly convoluted arrangement means that the government mandate is honored without the Catholic organization having to engage in contraception related practices. This is an example of using the principle of cooperation in an effective manner. On the one hand, the Catholic organization remains at a distance, not intending the perceived wrongdoing. There is no formal cooperation. The organization simply informs the mandate-related authority of its stance against contraception. On the other hand, the Catholic organization remains materially connected insofar as contraception coverage is provided via the organization’s insurance company. This is justified based on the principle of material cooperation in light of the external duress of the government mandate.

**Moral imperative: board oversight of maintaining quality care services**

This type of clean-hands arrangement between a Catholic organization and its insurance company underscores the importance of board oversight of conflicted collaborative arrangements. Board oversight of conflicted collaborative arrangements is a hallmark of governance ethics. This hallmark denotes an associated moral imperative regarding board oversight of maintaining quality care services.

When boards in health care become involved in conflicted collaborative arrangements, the measures that they pursue are designed to focus on maintaining
quality care services. The rationale for dealing with other organizations that do not comport with Catholic teaching is to extend services that maintain and enhance the quality services already provided. The purpose of the principle of cooperation is to retain this focus while creating distance from prohibited services in the other institution.

It is important to note the various aspects of maintaining quality care services that are mentioned by the US bishops. The Directives acknowledge the contribution of collaborative arrangements between Catholic organizations and other institutions in health care. This contribution includes many issues: to further the mission of caring for the suffering and sick; to influence the healing profession; to provide a continuum of health care; to present a model of responsible stewardship of limited resources; to provide more equitable access to basic care; to enhance the quality of care; to continue a Catholic institution or the presence of a health care facility in a given area.24

Furthermore, the Directives emphasize that in using the principle of cooperation, leaders of health care organizations must ensure they protect the mission of health care (that is, maintaining quality care services):

Even when there are good reasons for establishing collaborative arrangements that involve material cooperation with wrongdoing, leaders of Catholic healthcare institutions must assess whether becoming associated with the wrongdoing of a collaborator will risk undermining their institution’s ability to fulfill its mission of providing health care.25

In sum, the practice component of the ethics paradigm highlights board oversight of conflicted collaborative arrangements as a hallmark of governance ethics. By focusing on quality in the ethics paradigm (dealing with what the board does), this hallmark denotes an associated moral imperative regarding board oversight of maintaining quality care services. It is crucial to maintain these services for quality in patient care when there are conflicting circumstances.

Conclusion

The chapter has identified hallmarks of governance ethics with associated moral imperatives regarding conflicted collaborative arrangements. The contribution of the ethics paradigm can be summarized in this manner.

First, in the context of the challenging health care environment, the foundation component of the ethics paradigm focuses on stewardship to enhance an organization’s mission in health care as crucial for effective governance. This component deals with the identity of an organization, reflecting the leitmotif who we are, thereby identifying board oversight of organizational reputation as a hallmark of governance ethics in conflicted collaborative arrangements. In turn, this hallmark denotes an associated moral imperative concerning board oversight of organizational flexibility. Boards need this maneuvering room in conflicted collaborative arrangements involving conflicting mission or values.
Second, in the context of organizational oversight in health care, the process component of the ethics paradigm is to focus upon decision-making to foster participative deliberation in organizations. This component addresses the accountability of the organization, reflecting the leitmotif how we function, thereby identifying board oversight of institutional negotiations as a hallmark of governance ethics. In turn, this hallmark denotes an associated moral imperative concerning board oversight of the process of cooperation. The process of cooperation must avoid wrongful complicity with conflicting values.

Third, in the context of organizational culture in health care, the practice component of the ethics paradigm is to focus on best practices to develop standards of conduct. This component engages quality in an organization, reflecting the leitmotif what we do, thereby identifying board oversight of collaborative arrangements as a hallmark of governance ethics. In turn, this hallmark denotes associated moral imperatives concerning board oversight of maintaining quality care services. It is crucial to maintain these services for good quality patient care when there are conflicting circumstances.

The ethics paradigm clarifies an over-arching problem for boards of directors in health care when faced with conflicted collaborative arrangements: how to distinguish wrongful complicity and legitimate cooperation with other organizations when conflicting values are involved. The ethical principle of cooperation can resolve these complex dilemmas. The principle of cooperation enables boards of directors to robustly engage complex value dilemmas that arise and to astutely find solutions that foster their organizational mission, decision-making processes, and professional practices (reflecting the concepts of identity, accountability, and quality in the ethics paradigm). By upholding organizational integrity, especially in such difficult circumstances, boards can foster virtue in their organizations, as discussed in the next chapter.

Notes


15 Directives, Part Six, number 73.
16 Directives, Part Six, number 74–75.
17 United States Conference of Catholic Bishops (USCCB), Forming Consciences for Faithful Citizens (Washington, DC: USCCB, 2009), #34. Also, Cardinal J. Ratzinger made a similar point in 2004: “A Catholic would be guilty of formal cooperation in evil . . . if he were to deliberately vote for a candidate precisely because of the candidate’s permissive stand on abortion and/or euthanasia.” See: Cardinal J. Ratzinger, “Worthiness to Receive Holy Communion,” The Wanderer Press 137 (29) (July 15, 2004), final note.
18 Forming Consciences, #42: The US bishops also quote a Vatican doctrinal note: “It must be noted that a well-formed conscience does not permit one to vote for a political program or an individual law which contradicts the fundamental contents of faith and morals,” Congregation for the Doctrine of the Faith, “Doctrinal Note on Some Questions Regarding the Participation of Catholics in Political Life,” no. 4, in, United States Conference of Catholic Bishops, Readings on Catholics in Political Life (Washington, D.C: USCCB, 2006).
23 Directives, Part One, page 7.
Conflicted collaborative arrangements


Select readings
10 Governance and virtuous organizations

The discussion in this book is designed to provide guidance regarding governance ethics in healthcare organizations. The content is both theoretical and applied. The goal is to foster greater board oversight, focusing on the need for continuous evaluation and evidence-based improvements. The theoretical chapters (chapters 1–3) explain the ethics paradigm designed for this book (Table 1.1). The ethics paradigm presents a framework to guide discourse by providing a structure that coalesces relevant data to interpret specific issues. The core structure of the ethics paradigm revolves around basic features of ethics: who we are, how we function, what we do. These features form a leitmotif throughout the study. These basic features generate the three components of the ethics paradigm. Each component is related to specific governance contexts. The foundation component (reflecting the leitmotif who we are) operates within the context of engaging the healthcare environment. The process component (reflecting the leitmotif how we function) operates within the context of undertaking organizational oversight. The practice component (reflecting the leitmotif what we do) operates within the context of fostering organizational culture.

The theoretical perspective presents the ethics paradigm as being in alignment with clinical ethics, organizational ethics, and professional ethics. The purpose of engaging the ethics paradigm with these established fields is to apply it to governance ethics as an emerging field in healthcare. The subsequent applied chapters begin with a discussion of the governance structure of boards, followed by board oversight of community-related issues (community benefit and community health) and patient-related issues (patient care quality and patient safety). These topics are pivotal for governance ethics because they have contributed in no small measure to undermining public confidence in healthcare organizations. In turn, these topics lead to an over-arching ethical problem for healthcare governance that deals with conflicted collaborative arrangements: how to distinguish wrongful complicity from legitimate cooperation with activities in other organizations.

In these applied chapters, the concepts of the ethics paradigm organize core features of effective governance from landmark reports and the scholarly literature. That is, the concepts of identity, accountability, and quality provide a framework for the applied analysis, representing the foundation, process, and practice.
The purpose of the applied analysis is to highlight hallmarks of governance ethics that denote associated moral imperatives. Because the hallmarks represent necessary moral attributes of governance ethics, they entail an obligation to be adopted by boards. In turn, the associated moral imperatives represent necessary endeavors to foster the hallmarks under consideration.

In this concluding chapter, it can be instructive to consider how governance ethics can foster virtuous organizations in healthcare. To grasp how organizations can be virtuous, it can be helpful to turn to discourse on virtue ethics. Basically, virtue ethics focuses on developing the moral character of individuals in terms of practical wisdom generating laudable actions that foster happiness. Discussions about the theory and practice of virtue have a rich history, especially celebrating respect for human nature. This history typically focuses on vision rather than duty to foster moral education and to nurture positive character traits. It is important to note that virtues, reasons and obligations are closely connected, highlighting the link between character, moral agency, and moral roles. Virtues have become critical in understanding how to foster leadership in an organization, working effectively with others in the dynamics of a team-oriented group environment. Ethics, and especially the virtue of prudence, are at the heart of effective leadership, and virtue discourse provides a critical guide in defining moments. Also, virtue ethics fostering character is crucial for leadership in organizational culture regarding both professional practice and policy development. For example, humility is seen by many as a foundational virtue for successful decision-making in corporations. Moreover, the virtue of prudence is crucial for decision making in healthcare and for the formation of health professionals. Considerations about virtue ethics include social ethics, business ethics, and corporate governance, each contribution different ways to foster a sense of virtuous organizations. Referring to an organization as being virtuous denotes its institutional integrity.

Organizations can be considered to be virtuous when they foster institutional integrity by applying the ethics paradigm. That is, the concept of individuals being virtuous can be transferred analogously to organizations being virtuous. The pathway for an individual to be virtuous connects moral character, practical wisdom, and laudable actions, as mentioned earlier. Similarly, the ethics paradigm can enable an organization to become virtuous in this manner: by connecting the

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Table 1.1 Ethics paradigm

components of the ethics paradigm. The purpose of the applied analysis is to highlight hallmarks of governance ethics that denote associated moral imperatives. Because the hallmarks represent necessary moral attributes of governance ethics, they entail an obligation to be adopted by boards. In turn, the associated moral imperatives represent necessary endeavors to foster the hallmarks under consideration.
focus on moral character with the concept of identity; by connecting the focus on practical wisdom as a decision making process with the concept of accountability; and by connecting the focus on laudable actions with the concept of quality.

The foundation component of the ethics paradigm helps to address a pervasive concern in healthcare organizations that was mentioned at the outset of the book, the destructive tension between margin and mission. The ethics paradigm emphasizes that stewardship of an organization requires enhancing its mission as a function of its identity, highlighting the moral character of the organization (thereby reflecting the leitmotif who we are). Governance ethics requires that margin should be calibrated in connection with the mission of the organization. Here, a virtuous organization will enable its mission to flourish in the context of the challenging environment of healthcare.

The process component of the ethics paradigm helps to address another pervasive concern in healthcare that was mentioned at the outset of the book, distrust of healthcare organizations, both public and private. The ethics paradigm emphasizes that decision-making in an organization requires enhancing participative deliberation as a function of its accountability, highlighting the practical wisdom of the organization (thereby reflecting the leitmotif how we function). Governance ethics requires that organizational success should be calibrated in connection with enhancing public trust in healthcare organizations. Here, a virtuous organization will encourage participative decision-making to cultivate public confidence in the context of its organizational oversight.

The practice component of the ethics paradigm helps to address an increasingly recurring concern in healthcare organizations, collaborative arrangements where values of the organization must be protected to uphold institutional integrity. The ethics paradigm emphasizes best practices to guide standards of conduct as a function of quality, highlighting the laudable actions of the organization (thereby reflecting the leitmotif what we do). Governance ethics requires that collaborative arrangements, especially when conflicted, respect the values of the organization. Here, a virtuous organization will implement standards of conduct to foster a healthy organizational culture.

These three components of the ethics paradigm clarify how an organization can be virtuous at a general level, by fostering mission, by cultivating public trust, and by pursuing collaborative arrangements with integrity. At a more practical level, organizations can be deemed to be virtuous by respecting the hallmarks and moral imperatives of governance ethics presented in the applied chapters. A summary of the pivotal topics in the applied chapters can provide a specific pathway for organizations to be virtuous. That is, by engaging these hallmarks and moral imperatives, boards can develop their healthcare institutions to be virtuous organizations.

In the applied chapters, the discussion begins by considering board structure as a pivotal topic for governance ethics. The analysis applies the foundation, process, and practice components of the ethics paradigm, as follows. The foundation component focusing on identity highlights two hallmarks with accompanying moral imperatives. Oversight of board competence is a hallmark of governance
ethics with an associated moral imperative regarding oversight of term limits and board composition. Also, oversight of the board role is a hallmark of governance ethics with an associated moral imperative regarding oversight of defined responsibilities and board effectiveness. Furthermore, the process component focusing on accountability highlights two hallmarks with accompanying moral imperatives. Oversight of board evaluation is a hallmark of governance ethics with an associated moral imperative regarding oversight of fair evaluation processes. Also, oversight of succession planning is a hallmark of governance ethics with an associated moral imperative regarding oversight of system planning and continuous updating. Finally, the practice component focusing on quality highlights two hallmarks with accompanying moral imperatives. Oversight of leadership collaboration is a hallmark of governance ethics with an associated moral imperative regarding oversight of working relationships. Also, oversight of system-wide strategy is a hallmark of governance ethics with an associated moral imperative regarding oversight of transformational change and strategic planning.

The discussion continues in the applied chapters by considering board oversight of community benefit as a pivotal topic for governance ethics. Regarding the foundation component focusing on identity, oversight of board engagement is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of the standing committee structure. Regarding the process component focusing on accountability, oversight of effective communication is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of community needs assessment. Regarding the practice component focusing on quality, oversight of organizational performance is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of continuous improvement.

Subsequently, when dealing with community issues, the discussion continues by considering board oversight of community health as a pivotal topic for governance ethics. Each of the three components of the ethics paradigm highlights a hallmark with an accompanying moral imperative. Regarding the foundation component focusing on identity, oversight of partnership engagement is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of the mission and structure of community health partnerships. Regarding the process component focusing on accountability, oversight of partnership consensus is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of collaboration with community health partnerships. Regarding the practice component focusing on quality, oversight of partnership performance is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of performance improvement in community health partnerships.

After considering two community-related issues (community benefit and community health), the applied chapters then focus on patient-related issues (patient care quality and patient safety). The discussion begins by considering board oversight of patient care quality as a pivotal topic for governance ethics. Regarding the foundation component focusing on identity, oversight of board transparency is a hallmark of governance ethics. There is an associated moral imperative regarding
oversight of the development of trust to support patient care quality. This support includes the assessment and continuous improvement of patient care quality. Regarding the process component focusing on accountability, oversight of board responsiveness is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of factors contributing to support patient care quality. Regarding the practice component focusing on quality, oversight of board mechanisms for patient care quality is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of the social contract for patient care quality.

In the next applied chapter on patient-related issues, the discussion continues by considering board oversight of patient safety as a pivotal topic for governance ethics. Regarding the foundation component focusing on identity, oversight of error prevention is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of a systems approach for patient safety. Regarding the process component focusing on accountability, oversight of deliberative processes for patient safety is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of proactive deliberations for patient safety. Regarding the practice component focusing on quality, oversight of practical mechanisms for patient safety is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of a patient safety culture.

Having discussed community-related issues and patient-related issues regarding governance ethics, the applied chapters finish by considering board oversight of conflicted collaborative arrangements as a pivotal topic for governance ethics. Regarding the foundation component focusing on identity, oversight of organizational reputation is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of organizational flexibility. Regarding the process component focusing on accountability, oversight of institutional negotiations is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of the process of cooperation. Regarding the practice component focusing on quality, oversight of collaborative arrangements is a hallmark of governance ethics. There is an associated moral imperative regarding oversight of maintaining quality care services.

In sum, this concluding chapter explains that organizations can be deemed to be virtuous when they foster institutional integrity by applying the ethics paradigm. At a general level, the three components of the ethics paradigm clarify how an organization can be virtuous, by fostering mission, by cultivating public trust, and by pursuing collaborative arrangements with integrity. At a more practical level, by engaging the ethics paradigm in the applied chapters, boards can develop their healthcare institutions as virtuous organizations when they respect the hallmarks and moral imperatives of governance ethics.

This approach to governance ethics in healthcare organizations provides a practical guide for boards of directors in a manner that will enable patients and communities to respect their clinicians, their healthcare institutions, and the underlying fairness of the healthcare system.
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