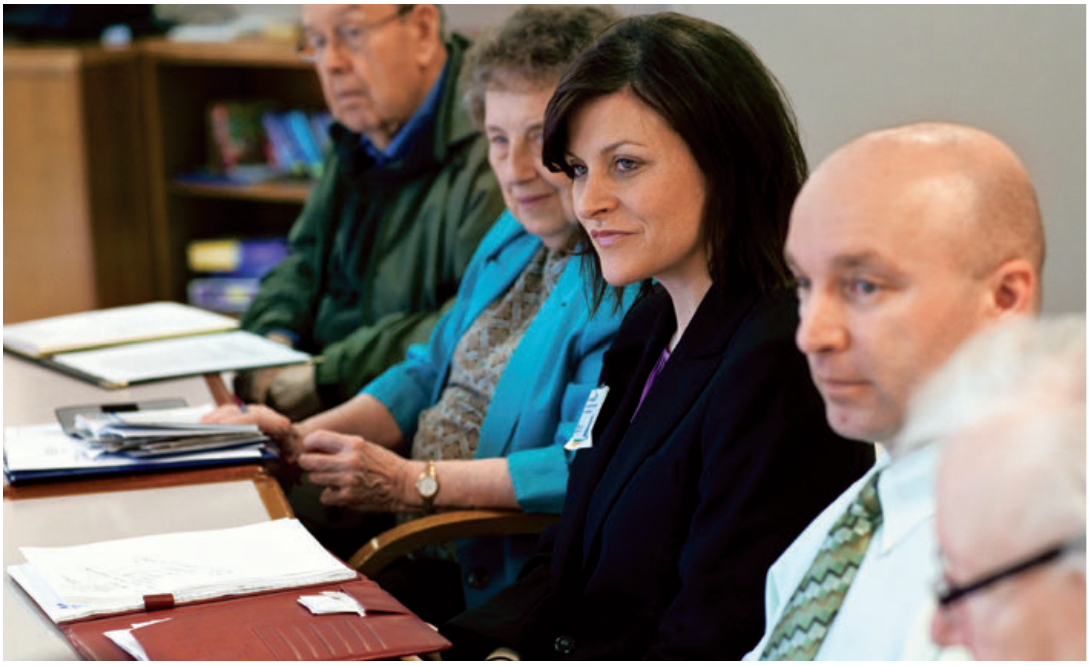
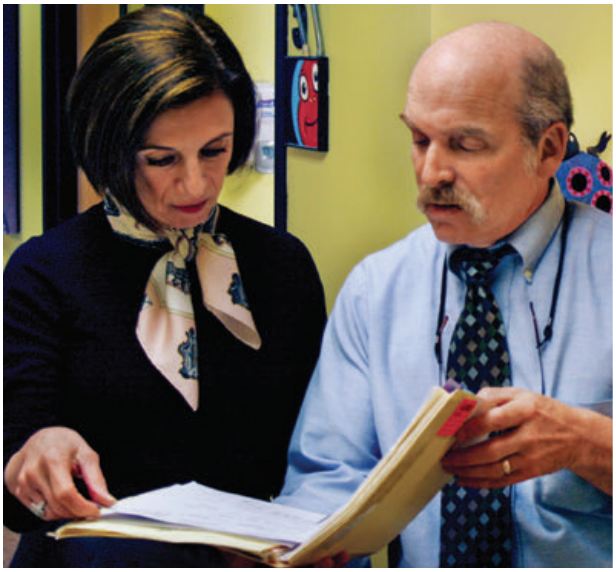


STRIVING FOR EXCELLENCE IN ETHICS

A RESOURCE FOR THE CATHOLIC HEALTH MINISTRY



CHA
Catholic Health Association of the United States

ASCENSION HEALTH

CONTENTS

** The Assessment Tool may be downloaded at **www.chausa.org/excellenceinethics***
CHA member access is required.

PREFACE

THE PAST SEVERAL YEARS HAVE SEEN MAJOR INITIATIVES IN SECULAR BIOETHICS AIMED AT STRENGTHENING THE QUALITY OF ETHICS CONSULTATION AND ETHICS COMMITTEES. The American Society for Bioethics and Humanities' (ASBH) revised *Core Competencies for Health Care Ethics Consultation* and the VA's National Center for Ethics in Health Care's *IntegratedEthics* are excellent examples of this.

Both of these initiatives sparked a conversation at a meeting of CHA's Theology and Ethics Committee (TEC) in October of 2009 about what might be done to strengthen ethics in Catholic health care organizations. One member of TEC suggested that CHA develop a "Catholic version" of the ASBH document. A small advisory group of ministry ethicists was subsequently assembled to discuss the feasibility of such a project. During a conference call in February of 2010, the group unanimously supported the project though they also broadened its scope beyond a Catholic version of the ASBH's *Core Competencies*.

Instead, the group recommended that the project focus on identifying core components of a robust ethics service and, for each component, suggesting "standards" that, if implemented, would enhance that particular component. Together, the components and standards could provide a roadmap for achieving excellence in ethics in our Catholic health care organizations. That was the birth of this resource—"striving for excellence in ethics." The ad hoc advisory group subsequently became the work group for the project.

In mid-2010, CHA learned that Ascension Health was in the beginning phases of a similar project and a decision was made to collaborate rather than duplicate efforts. This resource is the result of that collaboration. Several groups have contributed to the resource *(listed in Appendix C: Contributors)*—CHA's Theologian and Ethicist Committee and the project work group, along with Ascension Health's Ethics Advisory Group and participants in the annual mission leaders meeting *(May, 2011)*.

There are two parts to the resource—a printed booklet and a website. The booklet includes an introduction, recommended standards for eight core components of a robust ethics service, and a tool for assessing a particular organization's performance with regard to each component as well as each of its standards *(see Appendix A: Assessment Tool)*. Completing the assessment tool will assist an organization in determining its strengths as well as identifying gaps in services and opportunities for improvement. It can provide an agenda for near- and long-term strategic planning toward achieving excellence in ethics.

The website portion of the resource *(www.chausa.org/excellenceinethics)* includes tools from several Catholic health care systems, the VA's *IntegratedEthics*, and the ASBH's *Core Competencies*. These tools may be downloaded and will assist in implementing many of the standards. They are listed in Appendix B: Index of Tools and correspond to the various components. The website portion of this resource is intended to be dynamic to accommodate additional tools over time as appropriate, along with other resources that may contribute to enhancing ethics services in our organizations.

With so many challenges to the identity and integrity of Catholic health care today, we hope that this resource—intended primarily for ministry ethicists, ethics committees, and mission leaders who have responsibility for ethics—will help to underscore the importance of ethics for our organizations, provide an approach for achieving excellence in our ethics services, and contribute to shaping a vibrant ethical culture within all of our organizations.

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Why "Striving for Excellence in Ethics"?

WHY "STRIVING FOR EXCELLENCE IN ETHICS"?

"Catholic health care is a response to the challenge of Jesus to go and do likewise...to be Christ's healing compassion in the world,"[1] "not only by providing care for the physically ill, but also by working to restore health and wholeness in all facets of the human person and the human community."[2] This is the purpose and the mission of Catholic health care—why Catholic health care exists.

In carrying out this mission, Catholic health care encounters human beings facing some of the most challenging of human experiences—illness with its limitations, pain and suffering; questions about the meaning of life, suffering, dying and death; the finitude of injury, illness, disability, physical and mental decline, aging, and dying.

Since human beings in need of healing are at the center of Catholic health care, carrying out the healing mission of Jesus is a fundamentally ethical endeavor. It deals with how we respond to the inherent dignity of those we encounter in their situations of vulnerability and how the care we provide "assists those in need to experience their own dignity and value."[3]

Whenever and wherever we are dealing with human dignity and human well-being, theologian John Glaser reminds us, we are dealing with ethics. "There are," he says, "virtually no ethics free zones...."[4] Hence, the everyday activities of health care delivery are profoundly ethical—caring for patients, staff interactions, working with employees, budgeting, strategic planning, business development, entering into partnerships, vendor and community relations, health policy, and the like. Ethics is an ever present challenge in our health care organizations—in the clinical issues involved with patient care, in the activities of the organization as employer, provider, insurer and citizen,[5] and in how the organization responds to social issues such as health policy and the financing of health care.[6]

Helping to ensure that Catholic health care organizations remain focused on carrying out the healing mission of Jesus to those in need of healing is its commitment to several biblically-grounded core values—respect for human dignity, promotion of the common good, care for the poor and vulnerable, stewardship of resources, and acting on behalf of justice. In addition, each of our organizations has its own particular mission and values that echo the mission and values of Catholic health care generally. And all of Catholic health care is guided by the *Ethical and Religious Directives for Catholic Health Care Services* that underscore and promote respect for human dignity in various aspects of health care delivery.

> Remaining true to its mission is an ever-increasing challenge for Catholic health care, as it finds itself in the health care marketplace with all the pressures to compete, to "grow the business," to "secure market share," and to "meet the bottom line."

In order to survive in the marketplace, Catholic health care must play in the marketplace and, when it does, there is always the possibility that marketplace values begin to overshadow, in practice, the core values to which Catholic health care is committed. How do we ensure that the Catholic health care ministry does not lose its very self as particular systems and facilities face ever-changing issues—for example, merging with other-than-Catholic organizations, employing physicians some of whom perform procedures inconsistent with Catholic moral teaching, initiating new service lines to increase market share, forming ACOs, or dealing with the strains of charity care, layoffs, union issues, difficult pregnancies, women whose health requires that they have no more children, or new technologies or therapies that are morally problematic—issues that affect their identity and integrity in important ways. What is at stake for Catholic health care is its remaining true to who it is and claims to be, and ensuring that who it is and what it does are closely aligned.

Attention to the ethical dimensions of everyday activities and decisions by everyone within an organization can strengthen the organization's identity and integrity. The reverse is also true as has been amply illustrated by the many scandals in and out of health care in recent years—Enron, Arthur Andersen, WorldCom, Lehman Brothers, HCA, Tenet, and Allegheny among them. Given this possibility, it makes sense to make every effort to ensure a high level of excellence in ethics—in outcomes and in the various mechanisms that can help foster, support, and further those outcomes. Anything less threatens to weaken the identity and integrity of the organization. Hence, this resource—"striving for excellence in ethics."

In addition to strengthening the identity and integrity of an organization and of individuals within the organization, a range of strong ethics services can reap other benefits as well. On the one hand, there are likely to be fewer ethical and legal violations that could lead to scandals and even litigation.[7] On the other hand, studies have shown that a strong ethical culture enhances employee morale which, in turn, leads to greater productivity, increased loyalty to the organization, a greater personal investment in contributing to the organization's mission and success, and better performance toward all those served by the organization which contributes to more satisfied customers, whoever they happen to be.[8]

PURPOSES OF THE RESOURCE

The purpose of this resource is fourfold: first, to underscore the importance of ethics in our organizations; second, to identify the range of ethics services that can promote and support the identity and integrity of an organization and those within it; third, to recommend standards for promoting the highest quality performance in each mode of ethics service; and, fourth, to provide tools that will assist in the pursuit of ever greater excellence in the ethics services provided. This resource deliberately depicts the ideal, recognizing that in pursuing excellence in ethics, the present reality will likely be made better.

> *Striving* for excellence in ethics is what is important, because ethics itself is so important. Any gains in the quality of ethics services will most probably become embodied in the organization's culture that will, in turn, likely affect its identity and integrity.

And what might an ethical culture look like? According to the authors of *IntegratedEthics*, a resource published by the National Center for Ethics in Health Care of the Veterans' Health Administration, it means fostering an environment where people do the right thing for the right reasons (i.e., consistent with the value commitments of the organization). Such an environment is one where virtually everyone appreciates that ethics is important, recognizes and discusses ethical concerns, seeks consultation on ethical concerns as appropriate, works to resolve ethics issues on a systems level, sees ethics as part of quality, understands what is expected of them with regard to ethical practice, feels empowered to behave ethically, and views organizational decisions as ethical.[9]

Creating such an ethical culture and achieving excellence in ethics, while everyone's responsibility, are greatly facilitated by the example and support of leadership, both senior leadership and middle managers. That example and support may consist of making it clear that ethics is a priority for the organization, setting clear expectations for right behavior, modeling ethical decision making, and actively supporting the range of ethics services within the organization. The latter can occur by leadership's participation in ethics-related activities, encouraging staff participation and publicly valuing such participation (e.g., on the ethics committee or in educational programs), providing resources (financial and otherwise), making use of various ethics services, and holding the ethics program accountable.[10]

USING THIS RESOURCE

As noted earlier, this resource identifies components of a robust ethics service and makes recommendations for striving for excellence with regard to each component. Ideally, a robust ethics service will consist of each of these components. While such a program may not be the present reality in most organizations, the goal is to have as many of these elements present as possible and to continuously strive to improve the quality of each.

The resource can serve initially as an assessment tool, assisting those responsible for ethics in their organizations to identify which elements are present in their organizations, and to what extent and degree. What exists and what does not? Where are the opportunities for improvement? This assessment, in turn, can lead to the development of a plan for improving or strengthening the organization's ethics services. The "tools," which correlate with many aspects of each of the elements, should be helpful in moving the organization forward in the direction of excellence in ethics.

Excellence in ethics is not an end in itself. It is rather an attempt to ensure that all those who serve in our organizations are faithful to the mission of Catholic health care and that our organizations increasingly strengthen their identity and integrity so that they can ever more effectively carry on the healing mission of Jesus and, in the words of the *Ethical and Religious Directives*, be "a sign of that final healing that will one day bring about the new creation."[11]

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[3] Ibid., p. 11.

[4] John Glaser, "Hospital Ethics Committees: One of Many Centers of Responsibility," *Theoretical Medicine* 10 (1989): 278.

[5] This categorization of the health care organization's roles is employed by Leonard Weber in his book, *Business Ethics in Healthcare*, Indianapolis, IN: Indiana University Press, 2001.

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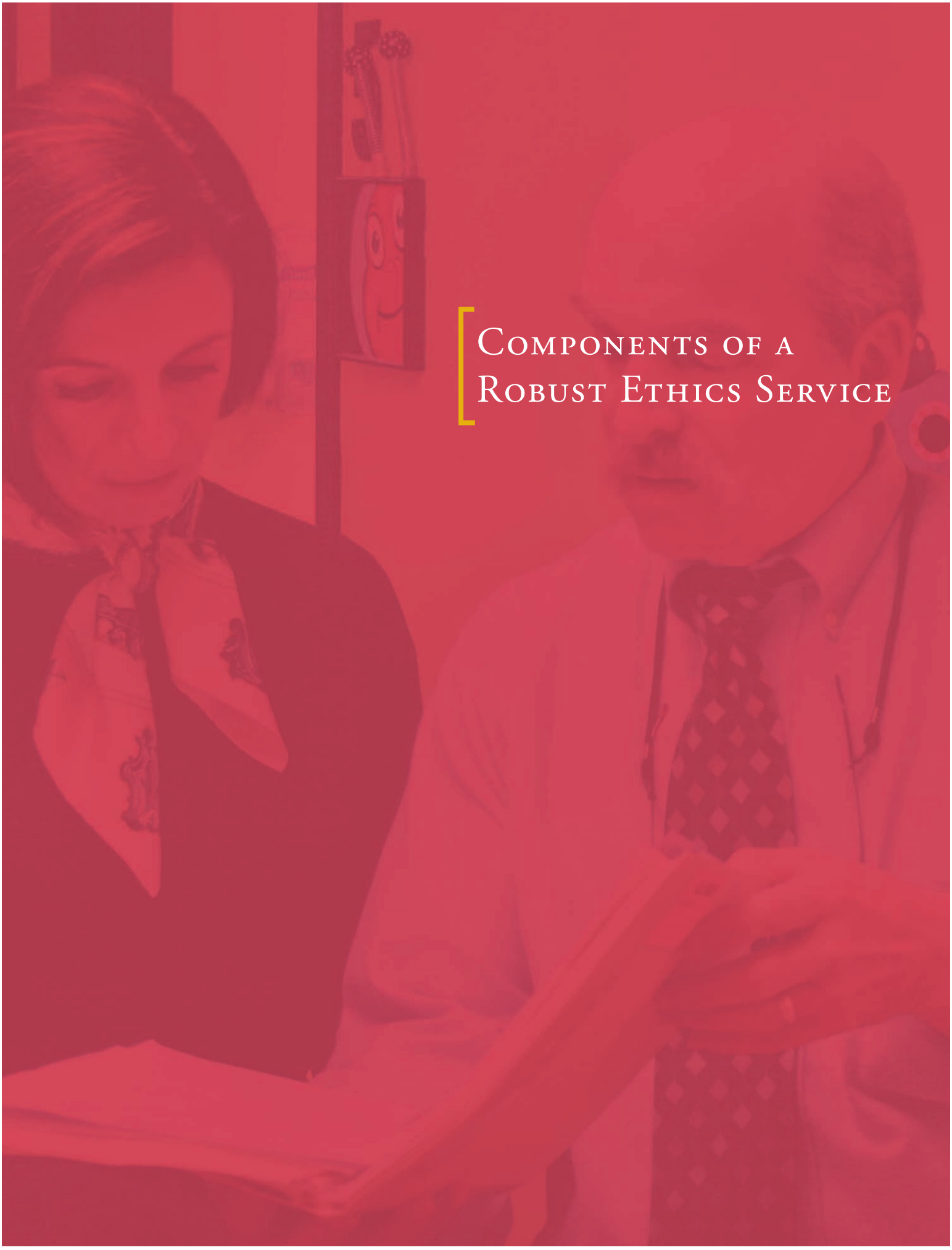
[10] Ibid., pp. 22-39.

[11] *The Ethical and Religious Directives for Catholic Health Care Services*, p. 33.



Components of a Robust Ethics Service

COMPONENTS OF A ROBUST ETHICS SERVICE

OPEN PAGE
TO VIEW SUMMARY OF STANDARDS

STRIVING FOR EXCELLENCE IN ETHICS

1 ETHICS EXPERTISE	2 ETHICS COMMITTEES	3 CONSULTATION & ADVISEMENT	4 EDUCATION & FORMATION
1.a. Multi-facility systems have a Ph.D.-trained ethicist 1.b. Smaller systems have a designated individual with at least an M.A. in ethics 1.c. Facilities 1.d. Mentoring is provided	2.a. Structure • Policy & by-laws • Functions • Reporting relationship • Membership • Committee appointment • Committee leadership • Term of membership • Frequency and length of meetings • Attendance at meetings • Subcommittees • Institutional support • Meeting agenda • Records • Committee authority 2.b. Competencies • Member competencies • Chairperson competencies • Core curriculum 2.c. Procedures • Customer needs assessment • Self-evaluation and development plan • Annual goal setting and review • Individual member self-evaluation • Committee self-education • Awareness and access to the committee • Resources	3.a. Consultation/advisement • Advisement • Prospective consultation • Retrospective case analysis • Proactive/preventive ethics 3.b. Defined mechanism for consultation 3.c. Access to ethics consultation 3.d. Guidelines for ethics consultation • Structure and organization • Scope and authority • Desired characteristics of consultants • Methodology for ethics consultation • Documentation of processes and standards • Evaluation of the consultation • Identifying systematic issues • Defined processes for follow-up 3.e. Composition • Appropriate competencies • Appropriate specialties and expertise • Consultation experience • Appropriate cultural competencies 3.f. Basic competencies • ERD knowledge • Moral reasoning • Ability to evaluate • Mediation skills 3.g. Education 3.h. Evaluation and quality improvement 3.i. Information management 3.j. Preventive ethics	4.a. Infrastructure • Identify audiences • Needs assessment • Program development • Program implementation • Program evaluation • Integration of ethics education 4.b. Resources • Administration – provided resources • Subscriptions, books, other media • Ethics resource center • Availability of time, room, equipment 4.c. Integration of institutional practices and ethics education 4.d. Instrumental support • Needs assessment • Evaluation tools • Curriculum templates • Competency development forms • Program management database

RECOMMENDED STANDARDS

5 POLICY REVIEW & DEVELOPMENT

5.a. Develops and reviews institutional policies and processes
5.b. Support review and development in functional areas of:
- Care of the poor
- Charity care
- Compliance
- Community benefit
- Finance
- Fundraising/ development
- Human resources
- Legal
- Mission
- Quality
- Safety

5.c. Support review and development regarding:
- Care at beginning of life
- Care at end of life
- Provider-patient relationship
- Partnerships
- Wages, promotions, etc.
- Other topics

6 COMMUNITY OUTREACH

6.a. Support Church relations
- Regularly meet with bishop
- Ad hoc meetings with bishop
- Support State Catholic Conferences and diocesan entities
- Support parish programs and education

6.b. Support health policy collaboration with government agencies regarding:
- Persons living in poverty and other vulnerable populations
- Public health

6.c. Support collaboration with educational institutions
- Teaching arrangements with local academic institutions
- Conferences and colloquia
- Internships and externships
- Student volunteers and volunteer programs
- Interfaith relationship initiatives and events

7 INSTITUTIONAL INTEGRATION

7.a. Active presence on or link to key institutional committees
- Charity care
- Compliance
- Formation
- Human resources
- IRB
- Medical exec. board
- Mission
- Mortality/morbidity
- Organizational development
- Quality
- Safety
- Patient relations
- Public relations
- Nursing forum
- Operations
- Facilities
- Strategy

7.b. Use decision-making tools
- Leaders are trained in using tools
- Maintain trained facilitator

7.c. Relationship building
- Education events
- Inter-departmental meetings, discussions, etc.
- Ad hoc initiatives

7.d. Coordinating council to develop and oversee ethics services within multi-facility system
7.e. Establishing process for evaluating integration of ethics services

8 LEADERSHIP SUPPORT

8.a. Leadership demonstrates that ethics is a priority
8.b. Leadership fosters ethical environment and culture
8.c. Leadership supports range of services by participating in activities, encouraging staff participation, providing resources, use of services, holding ethics program accountable
8.d. There is a champion for ethics within leadership
8.e. Leadership ensures mentoring is provided

Recommended Standards

RECOMMENDED STANDARDS

1. ETHICS EXPERTISE*

While ethics is ultimately everyone's responsibility, given the importance of ethics in and to the organization, it is critical for every Catholic health care organization, whether facility or system, to have a designated individual within the organization with expertise in ethics or, at minimum, easy access to someone outside the organization with expertise in ethics. Depending on the nature of the organization, that individual may be a professional ethicist (i.e., a Ph.D.-trained ethicist) or someone who is not a professional ethicist but who has training in ethics appropriate to his or her role and responsibilities.

1.a.	Multi-facility systems have a Ph.D.-trained ethicist who meets the CHA-recommended qualifications and competencies for system ethicists.
1.b.	Smaller systems have a designated individual with at least an M.A. in ethics and who meets most of the CHA-recommended qualifications and competencies for system ethicists.
1.c.	Facilities have a designated individual who may be a Ph.D.-trained ethicist or some other individual with training in ethics suitable to the size and needs of the facility, along with ready access to a Ph.D.-trained ethicist. The CHA-recommended qualifications and competencies for those doing ethics in facilities guide the selection and training of this individual. At minimum, the facility has ready access to the services of a Ph.D.-trained ethicist. This individual may be from the Catholic Health Association, a system or facility within Catholic health care, a health care ethics center, or a local university.
1.d.	Mentoring is provided to the individual with ethics expertise when that individual is 1) new to health care, 2) new to Catholic health care, 3) new to the role.

* ***See Appendix B: Index of Tools related to Ethics Expertise***

2. ETHICS COMMITTEES*

Much of the formal ethics that is done in Catholic health care organizations is done by ethics committees. And yet it is well-known that the quality, competency, and effectiveness of ethics committees are very uneven. Some committees are highly effective, dynamic entities whose members are well-prepared to competently address ethical issues and to help foster ethical cultures within their organizations. However, this is not true of all or perhaps even of most. Many ethics committees struggle to survive, to function well, to be effective, and to make a difference in their organizations. Even when ethics committees seem to be succeeding, it is often unclear whether their efforts are valued by administrators, clinicians, and patients and whether they affect clinical outcomes and/or organizational decisions and practice.

Surveys of ethics committees over the past ten years, including a survey of committees in Catholic hospitals, support the abundant anecdotal evidence that there is no shortage of opportunities for improvement in the organization, competency, functioning, and effectiveness of many if not most committees.[1] This should be of considerable concern to all, especially to the leadership of Catholic health care organizations given that ethics is critical to promoting and supporting organizational identity and integrity, and the ethics committee is a key mechanism for addressing ethical issues and fostering an ethical culture.

Recommendations follow for improving the quality of ethics committees. Not all recommendations will be applicable to every committee. Areas of strength and opportunities for improvement will vary from committee to committee. The recommendations can actually be employed to perform a self-assessment and to identify areas for improvement. The accompanying tools will be useful in implementing some of the recommended standards.

The recommended standards are divided into three major categories—structure, competencies and processes. Under each of these general headings are subheadings with specific recommended standards.

2.a. Structure

2.a.i. **Policy and Bylaws.** Committees have an institutional policy as well as bylaws that spell out such things as the purpose of the committee (its mission), its functions, authority of the committee, to whom it reports and how it is held accountable, membership (number, selection process, representation, term, qualifications and expectations, meeting attendance), officers, frequency and length of meetings, orientation for new members, ongoing education, aspects of the consultation service (how consultations will be provided and by whom, the process of consultation, documenting and tracking consultations), meeting minutes, access to the committee, subcommittees, goal-setting, and evaluation.

2.a.ii. **Functions.** Traditionally, the ethics committee has three primary functions—education, consultation, policy review and development. In order to help foster robust ethics services within the organization, the ethics committee is encouraged to broaden its responsibilities beyond education, consultation, policy review and development to include:

- Quality improvement in both the clinical and organizational arenas (see 3.a.iv and 3.j below);
- Organizational integration (see #7 below);
- Community outreach (see #6 below)

2.a.iii. **Reporting Relationship.** The ethics committee reports to either the administration, the medical staff or the board of trustees. Each reporting relationship has its own advantages and disadvantages. That reporting relationship is best which facilitates the committee's work, visibility and support. To whom the committee reports will likely affect the scope of its work. Having the right institutional sponsor can help the committee gain recognition, needed support and champions. It is recommended that the committee not report to a particular division or department.

2.a.iv. **Membership.** Members of the ethics committee reflect a variety of disciplines. There is representation from administration, the medical staff, nursing, pastoral care, social work, palliative care and hospice, the board of trustees, and ethics. This does not preclude representation from other disciplines and areas such as pharmacy, dietary, physical therapy, home health, rehab, outpatient clinics, risk or legal, the community, the diocese, and the like. From the medical staff, consideration is given to representatives from obstetrics, emergency medicine, pulmonology, psychiatry, surgery, oncology, cardiology, primary care, geriatrics, a hospitalist and an intensivist, graduate medical education and residents, depending on the patient population, the primary clinical services of the facility, and the focus of most ethical issues. From among administration, consideration is given to the CEO, the COO, the CMO, and the vice-presidents for mission, patient services, and human resources, depending on the role(s) of the ethics committee. Many committees have a mixture of ex officio and appointed members.

2.a.v. **Appointment to the Committee.** The committee has a process for selecting and appointing members to the committee. In selecting members, consideration is given not only to prospective members' discipline, interest in health care ethics, and willingness to serve, but also to their knowledge of health care ethics, their willingness to learn, and several other desired competencies.

2.a.vi. **Committee Leadership.** The chair of the committee possesses leadership skills in addition to respect from colleagues, integration into the organization, and an ability to facilitate. A vice-chair is recommended to step in when the chair is not available and eventually to step into the role of chair. Generally, the chair should not be the ethicist. The leadership of the committee is critical to its success. The chair is able to commit time and energy to support the work of the committee over time. One way of demonstrating its commitment to ethics is for the administration to provide a certain percentage of time to the chair of the committee to carry out the responsibilities of the chair. Chairing the committee becomes part of the individual's job responsibilities and annual performance review.

2.a.vii. **Term of Membership.** The ethics committee has some mechanism in place to provide for turnover of members while maintaining continuity. It is important to keep the committee fresh with new blood to allow for increased interest, energy and new perspectives, while also maintaining institutional memory. Terms help prevent staleness and allow for broader participation in the work of the committee by facility staff. For members, a term of three years with two renewals (for a total of nine years) and, for the chair, a term of two years with one renewal (for a total of four years) is recommended. This does not apply to ex officio members.

2.a.viii. **Frequency and Length of Meetings.** Meetings of the ethics committee are held monthly for at least one hour to the degree that this is feasible. The recommended monthly meetings facilitate the committee's work, provide opportunities for ethical reflection and ongoing self-education, and strengthen working relationships among members of the committee.

2.a.ix. **Attendance at Meetings.** Members of the ethics committee are expected to attend at least 75% of meetings annually.

2.a.x. **Subcommittees.** The ethics committee makes use of subcommittees in order to advance its work and involve other staff who are not currently members of the ethics committee. Subcommittees are of at least two types. One type consists of members of the ethics committee and is established around one of the committee's roles or functions. Establishing such subcommittees allows for sharing the work load and keeping the committee's work moving. Another type of subcommittee is the ad hoc committee. This type of committee can be established to accomplish a particular discrete task (e.g., developing a policy on family presence at resuscitations). Ad hoc committees usually benefit from including members from facility staff who are not ethics committee members. This allows for broader participation of staff in the work of the ethics committee adding expertise that may not be on the committee and, in some cases, obtaining greater buy-in by individuals who are not part of the committee.

2.a.xi. **Support.** The ethics committee receives *financial* and *secretarial* support, as well as support from relevant departments within the organization (e.g., IT, marketing and communications, mission). Reasonable financial support is needed for committee member education, programming, projects and other varied expenses. Secretarial support relieves some work for the chair of the committee (and chairs of subcommittees if there are any), who are typically volunteers. Support from relevant departments assists the committee in completing its work.

2.a.xii. **Meeting Agenda.** While meeting agendas will vary from meeting to meeting and will vary depending on the nature of the committee and particular circumstances, the following elements are considered: 1) case consultation review for the purpose of quality improvement and addressing systemic issues; 2) ethics education (e.g., discussion of an article, a presentation); 3) ethics updates (i.e., what is going on in the world of health care ethics); 4) open forum (i.e., members are free to raise ethical issues/concerns for discussion); 5) reports from subcommittees and discussion of the reports as appropriate; 6) monitoring of annual goals.

2.a.xiii. **Records.** The committee keeps accurate and sufficiently detailed minutes of its meetings. Records of committee and subcommittee meetings are subject to the norms of professional confidentiality. Generally, anonymity of persons should be maintained.

2.a.xiv. **Authority of the Committee.** Committee recommendations are intended to identify ethical dimensions of a situation and ethically acceptable ways to address it. At times, however, the committee or a subcommittee may need to establish ethical boundaries (i.e., identify what is and is not ethically justifiable, especially in light of the *Ethical and Religious Directives* and Church teaching) and even affirm certain options as not morally permissible.

2.b. Competencies

2.b.i. **Ethics Committee Member Competencies.** Members of the committee have basic knowledge in several core areas: the nature, role and function of ethics committees (clinical and organizational); the basics of ethical theories; a moral framework for decision making that is appropriate for a Catholic health care organization; and an understanding of the *Ethical and Religious Directives* and the theological tradition that informs them.

Members may obtain this knowledge by moving through a core curriculum that consists of appropriate literature, online modules, and/or workshops. Ethics committee chairs are encouraged to administer a pre-test and post-test to members who need to score at least 80% on the post-test. Members keep track of their on going education.

2.b.ii. **Ethics Committee Chair Competencies.** The chair of the ethics committee possesses the competencies delineated above. In addition, the chair has knowledge of key issues in *patient care and organizational ethics* as well as meeting facilitation skills.

As with ethics committee members, the committee chair obtains this knowledge by moving through a core curriculum that consists of appropriate literature, online modules, and/or workshops. Ideally, the chair of the committee is administered a pre- and post-test by whomever has immediate responsibility for or oversight of the committee and should also score at least 80%.

2.b.iii. **Core Curriculum.** The committee establishes a core curriculum, develops or makes available the resources necessary for implementing the curriculum, and develops a set of expectations for committee members, the committee chair, and the members of the ethics consultation team. In addition, the committee establishes a plan for ongoing self-education.

2.c. Procedures

2.c.i. **Customer Needs Assessment.** The ethics committee conducts a yearly needs assessment of those it serves within the organization. This can occur through a survey, data obtained from ethics consultations, feedback from educational programs, and other mechanisms. Based on this needs assessment, the committee sets goals for the coming year.

2.c.ii. **Self-Evaluation and Development Plan.** The ethics committee evaluates itself annually and formulates a plan for self-development in light of the results of the evaluation. Consideration might also be given to a periodic evaluation (e.g., every three years) by an individual or individuals from outside the facility. An accountability mechanism is in place. Results of the self-evaluation and development plan are shared with the individual who has oversight of ethics and the ethics committee.

2.c.iii. **Annual Goal-Setting and Review.** The committee sets annual goals to guide its initiatives within and outside of the organization and assesses the degree of success in achieving those goals. Setting these goals is done with attention to broader organizational goals, needs of the organization, the customer needs assessment, and the self-evaluation. Data inform this goal-setting process. An accountability mechanism is in place. Annual goals and progress toward those goals are shared with the individual who has oversight of ethics and the ethics committee.

2.c.iv. **Individual Member Self-Evaluation.** Each member of the ethics committee annually assesses the level of his/her knowledge and develops a personal plan for addressing knowledge gaps.

2.c.v. **Committee Self-Education.** The ethics committee establishes a curriculum for self-education in order to achieve knowledge competencies within the committee. It is essential that ethics committee members achieve an adequate level of competency in health care ethics. Taking an inventory of the knowledge and skills of members of the committee can assist the committee in developing such a curriculum. Members' self-education also occurs through personal reading and study, online modules, webinars, audioconferences, conferences and workshops.

2.c.vi. **Awareness of and Access to the Committee.** The ethics committee takes measures to ensure that its existence is known and that staff know how to access it. This is crucial to the committee's being an effective and influential presence in the organization. A survey regarding awareness and access can be helpful to establish a benchmark, followed by surveys every two or three years. There are many ways to publicize the existence of the committee, what it offers the organization, and how it can be accessed. Examples include a brochure, screen savers, educational programs, newsletters for clinical and non-clinical staff, an "ethics week," and the like. The organization's marketing and communications departments can provide considerable assistance.

2.c.vii. **Resources.** The committee provides ethics resources for the entire organization. This can take many forms such as a section on the organization's website, an electronic resource reserve, or a special section in the library.

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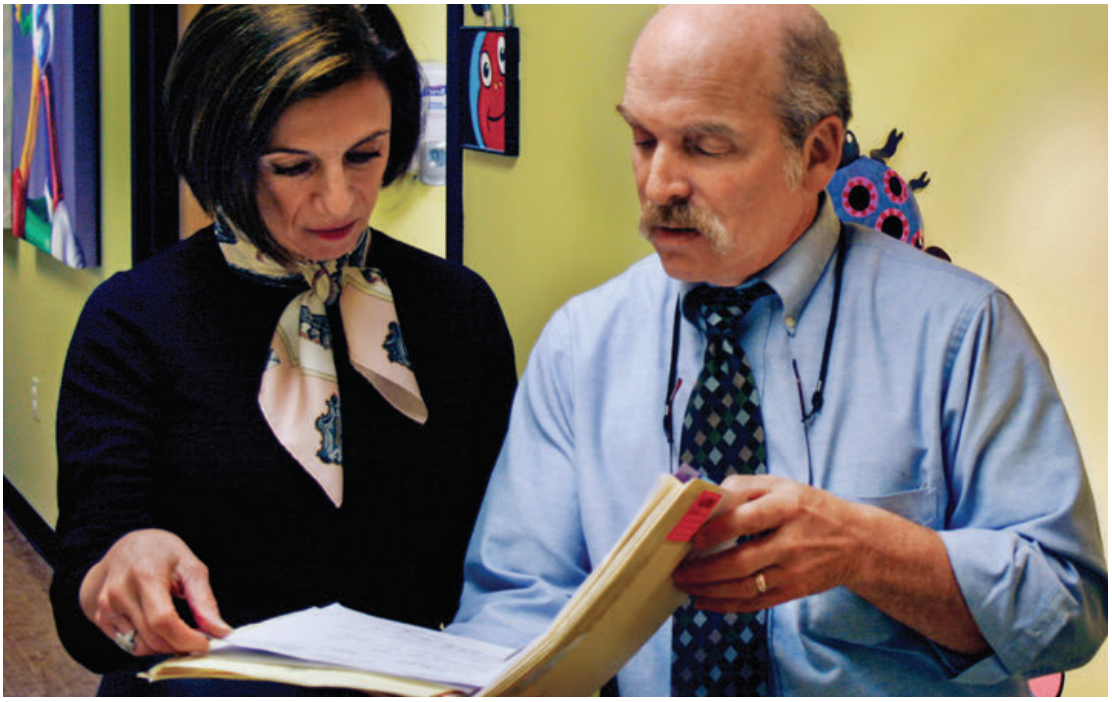
* ***See Appendix B: Index of Tools related to Ethics Committees***

3. CONSULTATION/ADVISEMENT*



An "excellent" ethics program includes a robust consultation/advisement service. Consultation services are defined as "a set of services provided by an individual or a group to help patients, families, surrogates, health care providers, or other involved parties address uncertainty or conflict regarding value-laden concerns that emerge in health care."[2] The consultation/advisement service can also be viewed as *proactively identifying* practices, structures, and policies that could be altered in order to improve patient care, avoid ethical conflicts, or better promote the mission and values of the organization. The following are the elements of a robust consultation/advisement service.

3.a. **Consultation/Advisement.** The ethics consultation service, which may be whole or part of the ethics committee, provides at minimum the following:

3.a.i. *Advisement* – Offering an opinion or recommendation on some ethical matter, e.g., appropriate interpretation of Church teaching or hospital policy.

3.a.ii. *Prospective consultation* – Resulting in a recommendation to be included in the patient's record.

3.a.iii. *Retrospective case analysis* – Providing for education, process improvement, and systemic quality improvement purposes.

3.a.iv. *Proactive-Preventive Ethics* – Identifying practices, policies, or structures that do or might contribute to ethical conflicts, or that might not promote the organization's mission and values, or that might not lead to the best patient care. Also, instituting practices, such as rounding, that either help prevent issues from arising or proactively recommending measures to improve patient care or some dimension of organizational life.

3.b. **A Defined Mechanism for an Ethics Consultation Service.** The organization has a defined mechanism for conducting ethics consultations—by a single consultant, a subcommittee, or the entire ethics committee—while maintaining the flexibility to adapt to particular circumstances.

3.c. **Access to Ethics Consultation/Advisement Services.** The clinical ethics consultation service is accessible to patients, family members and surrogates, direct care givers and anyone in a supportive role. Information about how to access the ethics consultation service is marketed and made publicly available throughout the organization.

3.d. **Guidelines for Ethics Consultation.** The ethics consultation service operates according to established committee guidelines regarding:

3.d.i. Structure and organization of the ethics consultation service, including disciplines to be represented.

3.d.ii. Scope and authority of the ethics consultation service (e.g., clinical and organizational ethics, discernment and staff support).

3.d.iii. Desired characteristics of consultants.

3.d.iv. Methodology for ethics consultation.

3.d.v. Documentation processes and standards.

3.d.vi. Evaluation of the consultation.

3.d.vii. Identifying systemic issues that gave rise to the consultation.

3.d.viii. Defined process for follow-up.

3.e. **Composition of an Ethics Consultation Team.** If the organization makes use of an ethics consultation team, the team, for any given consult, consists of individuals who possess:

3.e.i. Competencies needed to address the issue in question.

3.e.ii. Specialties and expertise relevant to the particular ethical issue.

3.e.iii. Varied levels of consultation experience.

3.e.iv. Appropriate cultural competencies.

3.f. **Basic Competencies of the Ethics Consultation Service Consultant or Members.** The ethics consultation service, whether an individual, a team, or the full ethics committee, has proficiency or has ready access to an expert in the following areas of competency. Not every member of the consultation team needs to be proficient in every area, but the team is comprised of individuals who collectively bring proficiency in each area.

3.f.i. Knowledge of the *Ethical and Religious Directives for Catholic Health Care Services* and the theological tradition that informs them.

3.f.ii. Moral reasoning, ethical theory and key ethical principles.

3.f.iii. Ability to evaluate and weigh competing moral claims and values.

3.f.iv. Mediation skills.

3.f.v. Pastoral and facilitation skills.

3.g. **Education of the Ethics Consultation Service.** The ethics consultation service, whatever form it takes, has a set of core competencies necessary for providing the service and a defined curriculum for ongoing self-education. Ethics consultation service education includes both clinical and organizational ethics. Consultation team members should complete a pre-test and post-test and score at least 80% on the post-test. Consultation team members keep track of their ongoing education.

3.h. **Evaluation and Quality Improvement of the Service.** The ethics consultation service has an established process for evaluating and assessing effectiveness of structures, processes and quality of outcomes, identifying systemic factors that may have contributed to the ethical issue, and reporting back to the ethics committee for follow-up.

3.i. **Information Management.** The ethics consultation service has an established method for keeping track of consultations and analyzing aggregated data quantitatively and qualitatively.

3.j. **Quality Improvement/Proactive Ethics.** The ethics consultation service and the ethics committee have an established process for addressing quality improvement issues and systemic change based on individual ethics consultations and aggregated data from a range of consultations.

**** See Appendix B: Index of Tools related to Consultation/Advisement.***

4. EDUCATION/FORMATION*

Striving for excellence in ethics and fostering and strengthening an ethical culture require a robust, intentional, and well-designed ethics education program. The program is multi-faceted and addresses a variety of audiences in a variety of ways. Successful educational initiatives over time change the culture of the organization as well as practices within the organization. They seek to impart information and increase knowledge as well as transform the character of individuals and of the organization by changing hearts, heightening sensibilities, and promoting growth in virtue (formation). It is virtually impossible to achieve excellence in ethics or to foster and sustain a strong ethical culture without a vibrant ethics education program.

Excellence in ethics education is the habit of building and strengthening the competency of various audiences within the organization to recognize and address ethical issues successfully and to carry out their responsibilities in an ethical manner. In addition, it entails the ongoing development of ethical competencies to deliver ethics services.

Excellence in ethics education encompasses both clinical and organizational ethics.

4.a. **Infrastructure for Ethics Education.** The individual or group responsible for ethics education:

4.a.i. *Identifies audiences* (e.g., clinical staff, residents, medical students, specific clinical units, administration, senior leadership, particular departments, non-clinical staff, area clergy, the community).

4.a.ii. Conducts a *needs assessment* in order to determine *priorities* and possible integration and *collaboration* (See Appendix B: Index of Tools). When feasible and appropriate, collaborate with existing educational structures and activities such as continuing medical education and/or medical grand rounds, continuing education for nurses and other health professionals, manager orientation and training, mission formation, and the like.

4.a.iii. Develops a program, series of programs or a curriculum based on the use as assessment—whatever is needed and appropriate to the audience and the particular situation. Developing an educational program or programs includes: identifying *learning outcomes* and appropriate *content*, the most effective *modalities* for delivering the content (i.e., a lecture, a lecture series, a workshop, a discussion/reading group, a retreat, monthly or bi-monthly "ethics for lunch," a newsletter, rounding, case discussions, issue debriefing with units or departments, online modules, webinars, audioconferences), the most effective way for *communicating the content, presenter(s), and a marketing plan*. Effective ethics education programs address both minds and hearts. They are both educational and formative in their approaches.

4.a.iv. *Implements* the program.

4.a.v. *Evaluates* the program and makes changes, if necessary, for future programs.

4.a.vi. *Integrates* ethics education into existing programs, especially formation programs, that deal with the mission and values of the organization (e.g., Foundations of Catholic Health Care).

4.b. **Resources.** Providing resources for educational activities is an investment in the culture of the organization and in ethical practice throughout the organization.

4.b.i. Administration provides *adequate resources* for educational initiatives across the organization, including *financial resources*.

4.b.ii. Resources are available for journal subscriptions, books, and other media related to health care ethics.

4.b.iii. A designated area is established (perhaps in the library) as a health care ethics resource center/area.

4.b.iv. Availability of time, room, and equipment necessary to advertise and deliver high-quality programs and modules.

4.c. **Integration.** Institutional practices support ethics education. For example, there is an expectation of and support for continuing professional development and continuing education. Credits are available when appropriate. Ethics education is linked to performance goals and reviews when appropriate. In addition, ethics-related material is included in mission formation opportunities and orientation programs.

4.d. **Instrumental Support.** In developing and sustaining a strong ethics education program, the ethics committee or person or persons responsible for ethics education make use of the following:

4.d.i. Needs assessment tools

- Surveys
- Consult patterns (derived from an ethics consultation database)
- Focus groups
- Chart audits

4.d.ii. Evaluation tools

- Participant/audience evaluation of the educational opportunity
- Joint evaluation form for ethics committee meetings and mini-modules within meetings

4.d.iii. Curriculum templates

- Curricular templates that map out themes and topics, including schedules, faculty, and learning objectives for individual modules or opportunities
- Program or module templates

4.d.iv. Competency development tracking form(s) for ethics committee members, consultants, and team members

4.d.v. Program management database for several activities:

- Registration
- Evaluations
- Curriculum mapping
- Other

* ***See Appendix B: Index of Tools related to Education/Formation***

5. POLICY REVIEW AND DEVELOPMENT

An excellent ethics program actively reviews and updates applicable institutional policies and provides input as appropriate to individuals with responsibilities for reviewing and updating institutional policies.

Policy review and development attend carefully to 1) accurate and adequate ethical rationales, 2) linkages to the *Ethical and Religious Directives* and the theological tradition that informs them, and 3) linkages to the organization's mission and values.

5.a. The individual with responsibility for ethics and/or the ethics committee develops and *reviews* institutional policies and processes in key ethics areas such as informed consent, confidentiality, maternal-fetal conflict, forgoing life-sustaining treatment, DNR, determination of brain death, procurement of organs for transplantation, conscientious objection and the like.

5.b. Ethics committee members engage in policy review and development in the functional areas of:

- 5.b.i. Care of the poor
- 5.b.ii. Charity care
- 5.b.iii. Compliance
- 5.b.iv. Community benefit
- 5.b.v. Finance
- 5.b.vi. Fundraising/development
- 5.b.vii. Human resources
- 5.b.viii. Legal
- 5.b.ix. Mission
- 5.b.x. Quality
- 5.b.xi. Research
- 5.b.xii. Safety

5.c. Ethics committee members engage in policy review and development regarding:

- 5.c.i. Care at the beginning of life
- 5.c.ii. Care at the end of life
- 5.c.iii. Provider-patient relationship issues
- 5.c.iv. Partnerships, joint ventures and vendor relations
- 5.c.v. Wages, promotions, etc.
- 5.c.vi. Other topics aligned with the functional areas

6. COMMUNITY OUTREACH

An excellent ethics program supports individuals with responsibility for maintaining the organization's presence in the community through outreach initiatives with key stakeholders and strengthens relations with the institutional Church.

6.a. The individual with responsibility for ethics, in collaboration with the mission leader, supports the CEO in fulfilling his or her responsibility for Church relations through activities such as:

- 6.a.i. Regular meetings with the local bishop or his representative.

6.a.ii. Ad hoc meetings with the local bishop or his representative to address issues of concern.

6.a.iii. Participation in and support of State Catholic Conferences and diocesan entities dealing with health care.

6.a.iv. Support of parish outreach programs or parish education initiatives.

6.b. The individual with responsibility for ethics provides assistance as appropriate to individuals within the organization in collaborating with state and local government agencies regarding health policy such as:

6.b.i. Directly or indirectly participating in or supporting local and state initiatives for expanding access for persons living in poverty and other vulnerable populations.

6.b.ii. Directly or indirectly participating in or supporting local and state government initiatives in the area of public health.

6.c. The individual with responsibility for ethics supports individuals in collaborating with secondary and post-secondary education institutions such as:

6.c.i. Directly or indirectly supporting joint or cooperative teaching arrangements with local academic institutions.

6.c.ii. Directly or indirectly supporting academic conferences and colloquia, particularly regarding Catholic moral theology, moral philosophy, medical ethics, and research ethics.

6.c.iii. Directly or indirectly supporting internships and externships with key academic departments in local higher learning institutions.

6.c.iv. Recruiting, training, and organizing student volunteers and volunteer programs.

6.c.v. Directly or indirectly supporting academic interfaith relationship initiatives and events.

7. ORGANIZATIONAL INTEGRATION*

An excellent ethics program is operationally integrated so as to have a visible impact for the good of the organization and those it serves. The ethics program is integrated into the organization's functional dynamics such that it is a vital and valued presence within the health ministry.

7.a. Ethics committee members maintain an active presence or connection with key committees throughout the organization, including:

- 7.a.i. Charity care
- 7.a.ii. Compliance
- 7.a.iii. Formation
- 7.a.iv. Human resources
- 7.a.v. IRB
- 7.a.vi. Medical executive board
- 7.a.vii. Mission
- 7.a.viii. Mortality and morbidity
- 7.a.vix. Organizational development
- 7.a.x. Quality
- 7.a.xi. Safety
- 7.a.xii. Patient relations
- 7.a.xiii. Public relations
- 7.a.xiv. Nursing forum
- 7.a.xv. Operations
- 7.a.xvi. Facilities
- 7.a.xvii. Strategy

7.b. The health care organization makes regular use of decision-making tools, especially an Organizational Ethics Discernment Process or other Values-Based Decision-Making Process:

- 7.b.i. Executive leaders, department leaders and other appropriate staff are trained in using such tools.
- 7.b.ii. The health ministry maintains someone as a trained facilitator in the use of such tools.

7.c. The individual responsible for ethics maintains a vibrant in-house networking program that is focused on relationship building through:

7.c.i. Education events.

7.c.ii. Periodic inter-departmental meetings, discussions, or needs-sharing sessions.

7.c.iii. Ad hoc collaborative initiatives.

7.d.	Where appropriate, the individual responsible for ethics maintains a coordinating council with responsibility for developing and overseeing ethics services across facilities within a multi-facility system.

7.e.	The individual responsible for ethics has an established process for evaluating and assessing systemic ethics integration, including ethics committee member participation in operational and clinical committees and staff and administrative utilization of the ethics services.

* ***See Appendix B: Index of Tools related to Organizational Integration***

8. LEADERSHIP SUPPORT*

Achieving excellence in ethics is greatly facilitated by the visible and active support of the organization's leadership, both senior leadership and middle managers. In the words of the authors of the Veteran's Health Administration's *IntegratedEthics* program, leaders "play a critical role in creating, sustaining, and changing their organization's culture, through their own behavior and through the programs and activities they support and praise or neglect and criticize."[3] Their underscoring the importance of ethics in and to the organization as well as the importance of individual ethics services can go a long way in promoting efforts toward greater excellence in ethics. In addition, leaders have a responsibility "to foster an environment and culture that supports ethical practices throughout the organization."[4] What does this mean? According to the authors of *IntegratedEthics*, it means fostering an environment where people do the right thing for the right reasons (i.e. consistent with the value commitments of the organization). Such an environment is one where virtually everyone appreciates that ethics is important, recognizes and discusses ethical concerns, seeks consultation on ethical concerns when needed, works to resolve ethics issues on a systems level, understands what is expected of them with regard to ethical practices, feels empowered to act ethically, and views organizational decisions as ethical.[5]

8.a.	Leadership demonstrates that ethics is a priority in and for the organization as evidenced by drawing attention to the ethical dimensions of issues, insisting on ethical behavior, promoting the use of an ethical discernment process, being involved in ethics education and the like.

8.b.	Leadership actively fosters an ethical environment and culture, in part, by setting clear expectations for ethical behavior, and in modeling and encouraging ethical decision-making.[6]
8.c.	Leadership actively supports the range of ethics services within the organization by participating in activities, encouraging staff participation and publicly valuing such participation, providing resources, making use of various ethics services, and holding the ethics program accountable.[7]
8.d.	Leadership's active fostering of ethical behavior, culture and active support for ethics services are part of the organization's performance management system.
8.e.	The organization has an ethics champion from amongst leadership. This individual is someone who represents to leadership and leadership committees the interests, concerns and input from the ethicist, the individual with expertise in ethics, and/or the ethics committee.
8.f.	Leadership ensures that mentoring is provided to the individual with ethics expertise when that individual is 1) new to health care, 2) new to Catholic health care, or 3) new to the role.

**** See Appendix B: Index of Tools related to Support from Leadership***

REFERENCES

[1] See for example, Ellen Fox, Sarah Myers, and Robert Pearlman, "Ethics Consultation in the United States: A National Survey," *The American Journal of Bioethics* 7, no. 2 (February 2007): 13-25; Carol Bayley, "Ethics Committee DX: Failure to Thrive," *HEC Forum* 18, no. 4 (2006): 357-67; Francis Bernt, Peter Clark, Josita Starrs, Patricia Talone, "Ethics Committees in Catholic Hospitals," *Health Progress* 87, no. 2 (March-April 2006): 18-25; D. Milmore, "Hospital Ethics Committees: A Survey in Upstate New York," *HEC Forum* 18, no. 3 (September 2006): 222-44; Kathleen Berchelmann and Barbara Blechner, "Searching for Effectiveness: The Functioning of Connecticut Clinical Ethics Committees," *The Journal of Clinical Ethics* 13, no. 2 (Summer 2002): 131-145; Glenn McGee, et al., "Successes and Failures of Hospital Ethics Committees: A National Survey of Ethics Committee Chairs," *Cambridge Quarterly of Healthcare Ethics* 11 (2002): 87-93; Glenn McGee et al., "A National Study of Ethics Committees," *American Journal of Bioethics* 1, no. 4 (Fall 2001): 60-64.

[2] See, ASBH, "Core Competencies for Health Care Ethics Consultation," draft revision, November 2009, Part II, 1.1 Defining Ethics Consultation, p. 4.

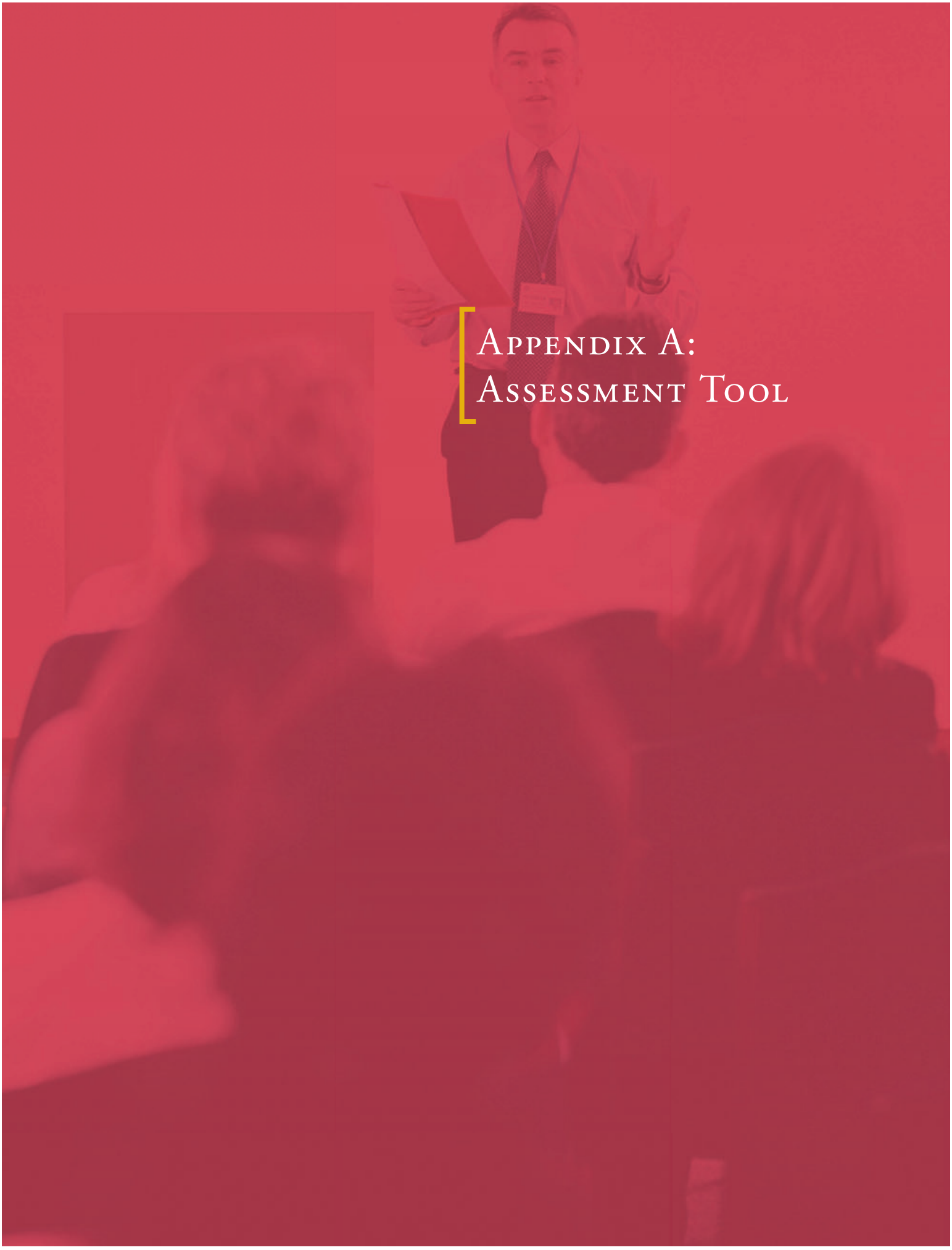
[3] National Center for Ethics in Health Care, *IntegratedEthics: Ethical Leadership*, Washington, D.C.: National Center for Ethics in Health Care, 2008, p. ii. At www.ethics.va.gov/integratedethics.

[4] Ibid.

[5] Ibid., pp. 14-16.

[6] Ibid., pp. 22-37.

[7] Ibid., pp. 37-39.



Appendix A: Assessment Tool

ASSESSMENT TOOL

Note: This assessment tool can serve a dual purpose—assessing strengths and opportunities for improvement with regard to the components themselves (by considering the composite scores of each component) as well as within each component (by considering the subtotal scores within each component). Because the standards are summarized in the assessment tool, it may be necessary to refer back to the full statement of the standards. After completing the assessment, prioritization of opportunities for improvement and development of a work plan would be helpful. For your convenience, the assessment tool may also be downloaded at www.chausa.org/excellenceinethics. *CHA member access is required.*

		STRONGLY DISAGREE					STRONGLY AGREE
1. ETHICS EXPERTISE							
1.a.	Multi-facility systems have a Ph.D.-trained ethicist who meets the CHA-recommended qualifications and competencies for system ethicists.	1	2	3	4	5	N/A
1.b.	Smaller systems have a designated individual with at least an M.A. in ethics and who meets most of the CHA-recommended qualifications and competencies for system ethicists.	1	2	3	4	5	N/A
1.c.	Facilities have a designated individual who may be a Ph.D.-trained ethicist or some other individual with training in ethics suitable to the size and needs of the facility, along with ready access to a Ph.D.-trained ethicist from outside the organization.	1	2	3	4	5	N/A
1.d.	Mentoring is provided to the individual with ethics expertise when that individual is 1) new to health care, 2) new to Catholic health care, 3) new to the role.	1	2	3	4	5	N/A
1. ETHICS EXPERTISE TOTAL (20 possible) =							

			STRONGLY DISAGREE					STRONGLY AGREE
2.	**ETHICS COMMITTEES**							
2.a.	**Structure**							
	2.a.i.	**Policy and Bylaws.** Committees have an institutional policy as well as bylaws that spell out the purpose as well as the overall function and operation of the committee.	1	2	3	4	5	N/A
	2.a.ii.	**Functions.** The ethics committee is encouraged to broaden its responsibilities beyond education consultation, policy review and development to include:						
		• Quality improvement in both the clinical and organizational arenas (see 3.a.iv and 3.j below)	1	2	3	4	5	N/A
		• Institutional integration (see #7 below)	1	2	3	4	5	N/A
		• Community outreach (see #6 below)	1	2	3	4	5	N/A
	2.a.iii.	**Reporting Relationship.** The ethics committee reports to either the administration, the medical staff or the board of trustees.	1	2	3	4	5	N/A
	2.a.iv.	**Membership.** Members of the ethics committee reflect a variety of disciplines.	1	2	3	4	5	N/A
	2.a.v.	**Appointment to the Committee.** The committee has a process for selecting and appointing members to the committee.	1	2	3	4	5	N/A
	2.a.vi.	**Committee Leadership.** The chair of the committee possesses leadership skills in addition to respect from colleagues, integration in the organization and an ability to facilitate.	1	2	3	4	5	N/A
	2.a.vii.	**Term of Membership.** The ethics committee has some mechanism in place to provide for turnover of members while maintaining continuity.	1	2	3	4	5	N/A
	2.a.viii.	**Frequency and Length of Meetings.** Meetings of the ethics committee are held monthly for at least one hour to the degree that this is feasible.	1	2	3	4	5	N/A
	2.a.ix.	**Attendance at Meetings.** Members of the ethics committee are expected to attend at least 75% of meetings annually.	1	2	3	4	5	N/A
	2.a.x.	**Subcommittees.** The ethics committee makes use of subcommittees to accomplish its work and to include other staff in its work	1	2	3	4	5	N/A

			STRONGLY DISAGREE					STRONGLY AGREE
	2.a.xi.	**Support.** The ethics committee receives *financial* and *secretarial* support, as well as support from relevant departments within the organization.	1	2	3	4	5	N/A
	2.a.xii.	**Meeting Agenda.** While meeting agendas will vary, the following elements are considered: 1) case consultation review; 2) ethics education; 3) ethics updates; 4) open forum; 5) reports from subcommittees; and 6) monitoring of annual goals.	1	2	3	4	5	N/A
	2.a.xiii.	**Records.** The committee keeps accurate and sufficiently detailed minutes of its meetings.	1	2	3	4	5	N/A
	2.a.xiv.	**Authority of the Committee.** Committee recommendations are intended to identify ethical dimensions of a situation and ethically acceptable ways to address it.	1	2	3	4	5	N/A
2.a.	**SUBSTRUCTURE SUBTOTAL** (80 possible) **=**							
2.b.	**Competencies**							
	2.b.i.	**Ethics Committee *Member* Competencies.** Members of the committee have basic knowledge in several core areas: the nature, role and function of ethics committees (clinical and organizational); the basics of ethical theories; a moral framework for decision making that is appropriate for a Catholic health care organization; and an understanding of the *Ethical and Religious Directives* and the theological tradition that informs them.	1	2	3	4	5	N/A
	2.b.ii.	**Ethics Committee *Chair* Competencies.** The chair of the ethics committee possesses the competencies delineated above and, in addition, has a knowledge of key issues in patient care and key issues in organizational ethics as well as meeting facilitation skills.	1	2	3	4	5	N/A

			STRONGLY DISAGREE					STRONGLY AGREE
	2.b.iii.	**Core Curriculum.** The committee establishes a core curriculum, develops or makes available the resources necessary for implementing the curriculum, and develops a set of expectations, including ongoing self-education for all committee members.	1	2	3	4	5	N/A
2.b.	**COMPETENCIES SUBTOTAL** (15 possible) **=**							
2.c.	**Procedures**							
	2.c.i.	**Customer Needs Assessment.** The ethics committee conducts a yearly needs assessment of those it serves.	1	2	3	4	5	N/A
	2.c.ii.	**Self-Evaluation and Development Plan.** The ethics committee evaluates itself annually and formulates a plan for self-development in light of the results of the evaluation.	1	2	3	4	5	N/A
	2.c.iii.	**Annual Goal Setting and Review.** The committee sets annual goals to guide its initiatives within and outside of the organization and assesses the degree of success in achieving those goals.	1	2	3	4	5	N/A
	2.c.iv.	**Individual Member Self-Evaluation.** Each member of the ethics committee annually assesses the level of his/her knowledge and develops a personal plan for addressing knowledge gaps.	1	2	3	4	5	N/A
	2.c.v.	**Committee Self-Education.** The ethics committee establishes a curriculum for self-education in order to achieve knowledge competencies within the committee	1	2	3	4	5	N/A

		STRONGLY DISAGREE					STRONGLY AGREE
2.c.vi.	**Awareness of and Access to the Committee.** The ethics committee takes measures to ensure that its existence is known and that staff know how to access it.	1	2	3	4	5	N/A
2.c.vii.	**Resources.** The committee provides ethics resources for the entire organization.	1	2	3	4	5	N/A
2.c.	**PROCEDURES SUBTOTAL** (35 possible) **=**						
2.	**ETHICS COMMITTEES TOTAL** (130 possible) **=**						

3. CONSULTATION/ADVISEMENT

3.a.	**Consultation/Advisement.** The ethics consultation service provides, at minimum, the following:						
3.a.i.	*Advisement* – Offering an opinion or recommendation on some ethical matter.	1	2	3	4	5	N/A
3.a.ii.	*Prospective consultation* – Resulting in a recommendation to be included in the patient's record.	1	2	3	4	5	N/A
3.a.iii.	*Retrospective case analysis* – Providing for education, process improvement, and systemic quality improvement purposes.	1	2	3	4	5	N/A
3.a.iv.	*Proactive-Preventive Ethics* – Identifying areas that might not lead to the best patient care.	1	2	3	4	5	N/A
3.b.	**A Defined Mechanism for an Ethics Consultation Service.** The organization has a defined mechanism for conducting ethics consultations while maintaining the flexibility to adapt to particular circumstances.	1	2	3	4	5	N/A
3.c.	**Access to Ethics Consultation/Advisement Services.** The clinical ethics consultation service is accessible to patients, family members and surrogates, and direct care givers.	1	2	3	4	5	N/A
3.d.	**Guidelines for Ethics Consultation.** The ethics consultation service operates according to established committee guidelines regarding:						
3.d.i.	Structure and organization of the ethics consultation service, including disciplines to be represented.	1	2	3	4	5	N/A

		STRONGLY DISAGREE				STRONGLY AGREE	
3.d.ii.	Scope and authority of the ethics consultation service.	1	2	3	4	5	N/A
3.d.iii.	Desired characteristics of consultants.	1	2	3	4	5	N/A
3.d.iv.	Methodology for ethics consultation.	1	2	3	4	5	N/A
3.d.v.	Documentation processes and standards.	1	2	3	4	5	N/A
3.d.vi.	Evaluation of the consultation.	1	2	3	4	5	N/A
3.d.vii.	Identifying systemic issues that gave rise to the consultation.	1	2	3	4	5	N/A
3.d.viii.	Defined process for follow-up.	1	2	3	4	5	N/A
3.e.	**Composition of an Ethics Consultation Team.** If the organization makes use of an ethics consultation team, the team, for any given consult, consists of individuals who:						
3.e.i.	Possess the competencies needed to address the issue in question.	1	2	3	4	5	N/A
3.e.ii.	Have specialties and expertise relevant to the particular ethical issue.	1	2	3	4	5	N/A
3.e.iii.	Represent varied levels of consultation experience.	1	2	3	4	5	N/A
3.e.iv.	Possess appropriate cultural competencies.	1	2	3	4	5	N/A
3.f.	**Basic Competencies of the Ethics Consultation Service Consultant or Members.** The ethics consultation service, whether an individual, a team, or the full ethics committee, has proficiency or has ready access to an expert in the following areas of competency:						
3.f.i.	Knowledge of the *Ethical and Religious Directives for Catholic Health Care Services* and the theological tradition that informs them.	1	2	3	4	5	N/A
3.f.ii.	Moral reasoning, ethical theory and key ethical principles.	1	2	3	4	5	N/A
3.f.iii.	Ability to evaluate and weigh competing moral claims and values.	1	2	3	4	5	N/A
3.f.iv.	Mediation skills; pastoral and facilitation skills.	1	2	3	4	5	N/A
3.g.	**Education of the Ethics Consultation Service.** The ethics consultation service has set core competencies necessary to be part of the service and a defined curriculum for ongoing self-education.	1	2	3	4	5	N/A

		STRONGLY DISAGREE					STRONGLY AGREE
3.h.	**Evaluation and Quality Improvement of the Service.** The ethics consultation service has an established process for evaluating and assessing effectiveness of structures, processes and quality of outcomes, and for identifying systemic factors that may have contributed to the ethical issue and for reporting such back to the ethics committee for follow-up.	1	2	3	4	5	N/A
3.i.	**Information Management.** The ethics consultation service has an established method for keeping track of consultations and analyzing aggregated data quantitatively and qualitatively.	1	2	3	4	5	N/A
3.j.	**Quality Improvement/Preventive Ethics.** The ethics consultation service and the ethics committee have an established process for addressing quality improvement issues and systemic change based on individual ethics consultations and aggregated data from a range of consultations.	1	2	3	4	5	N/A

3. CONSULTATION/ADVISEMENT TOTAL (130 possible) =

4. EDUCATION/FORMATION

4.a.	**Infrastructure for Ethics Education.** The individual or group responsible for ethics education:							
	4.a.i.	*Identifies audiences*.	1	2	3	4	5	N/A
	4.a.ii.	Conducts a *needs assessment* in order to determine *priorities* and possible integration and *collaboration*.	1	2	3	4	5	N/A
	4.a.iii.	Develops *a program*, a series of programs, or a curriculum based on the needs assessment.	1	2	3	4	5	N/A
	4.a.iv.	*Implements* the program.	1	2	3	4	5	N/A
	4.a.v.	*Evaluates* the program and makes changes, if necessary, for future programs.	1	2	3	4	5	N/A
	4.a.vi.	*Integrates* ethics education into existing programs that deal with the mission and values of the organization.	1	2	3	4	5	N/A
4.b.	**Resources.** Providing resources for educational activities is an investment in the culture of the organization and in ethical practice. This requires:							
	4.b.i.	*Adequate resources* are provided for educational initiatives across the organization, including *financial resources*.	1	2	3	4	5	N/A

			STRONGLY DISAGREE					STRONGLY AGREE
	4.b.ii.	Resources are available for journal subscriptions, books, and other media related to health care ethics.	1	2	3	4	5	N/A
	4.b.iii.	A designated area is established (perhaps in the library) as a health care ethics resource center/area.	1	2	3	4	5	N/A
	4.b.iv.	Availability of time, room, and equipment necessary to advertise and deliver high-quality programs and modules.	1	2	3	4	5	N/A
4.c.		**Integration.** Institutional practices support ethics education.	1	2	3	4	5	N/A
4.d.		**Instrumental Support.** In developing and sustaining a strong ethics education program, the ethics committee or person(s) responsible for ethics education make use of the following:						
	4.d.i.	Needs assessment tools.	1	2	3	4	5	N/A
	4.d.ii.	Evaluation tools.	1	2	3	4	5	N/A
	4.d.iii.	Curriculum templates.	1	2	3	4	5	N/A
	4.d.iv.	Competency development tracking form(s) for ethics committee members, consultants, and team members.	1	2	3	4	5	N/A
	4.d.v.	Program management database for several activities i.e., registration, evaluations, curriculum mapping, etc.	1	2	3	4	5	N/A

4. EDUCATION/FORMATION TOTAL (80 possible) =

5. POLICY REVIEW AND DEVELOPMENT

5.a.		The individual with responsibility for ethics *develops and reviews* institutional policies and processes in key ethics areas.	1	2	3	4	5	N/A
5.b.		Ethics committee members *support* policy review and development in the functional areas of:						
	5.b.i.	Care of the poor	1	2	3	4	5	N/A
	5.b.ii.	Charity care	1	2	3	4	5	N/A
	5.b.iii.	Compliance	1	2	3	4	5	N/A
	5.b.iv.	Community benefit	1	2	3	4	5	N/A
	5.b.v.	Finance	1	2	3	4	5	N/A
	5.b.vi.	Fundraising/development	1	2	3	4	5	N/A
	5.b.vii.	Human resources	1	2	3	4	5	N/A
	5.b.viii.	Legal	1	2	3	4	5	N/A

		STRONGLY DISAGREE					STRONGLY AGREE
5.b.ix.	Mission	1	2	3	4	5	N/A
5.b.x.	Quality	1	2	3	4	5	N/A
5.b.xi.	Safety	1	2	3	4	5	N/A
5.c.	Ethics Committee members *support* policy review and development regarding:						
5.c.i.	Care at the beginning of life	1	2	3	4	5	N/A
5.c.ii.	Care at the end of life	1	2	3	4	5	N/A
5.c.iii.	Provider-patient relationship issues	1	2	3	4	5	N/A
5.c.iv.	Partnerships, joint ventures and vendor relations	1	2	3	4	5	N/A
5.c.v.	Wages, promotions, etc.	1	2	3	4	5	N/A
5.c.vi.	Other topics that are aligned with the functional areas.	1	2	3	4	5	N/A

5. POLICY REVIEW AND DEVELOPMENT TOTAL (90 possible) **=**

6. COMMUNITY OUTREACH

6.a.	The individual with responsibility for ethics supports the CEO in fulfilling his or her responsibility for Church relations through:						
6.a.i.	Regular meetings with the local bishop or his representative.	1	2	3	4	5	N/A
6.a.ii.	Ad hoc meetings with the local bishop or his representative to address issues of concern.	1	2	3	4	5	N/A
6.a.iii.	Participation in and support of State Catholic Conferences and diocesan entities dealing with health care.	1	2	3	4	5	N/A
6.a.iv.	Support of parish outreach programs or parish education initiatives.	1	2	3	4	5	N/A
6.b.	The individual with responsibility for ethics, supports individuals within the organization in collaborating with state and local government agencies regarding health policy by:						
6.b.i.	Directly or indirectly participating in or supporting local and state initiatives for expanding access for persons living in poverty and other vulnerable populations.	1	2	3	4	5	N/A
6.b.ii.	Directly or indirectly participating in or supporting local and state government initiatives in the area of public health.	1	2	3	4	5	N/A
6.c.	The individual with responsibility for ethics supports individuals in collaborating with secondary and post-secondary education institutions through:						

			STRONGLY DISAGREE					STRONGLY AGREE
	6.c.i.	Directly or indirectly supporting joint or cooperative teaching arrangements with local academic institutions.	1	2	3	4	5	N/A
	6.c.ii.	Directly or indirectly supporting academic conferences and colloquia, particularly regarding Catholic moral theology, moral philosophy, medical ethics, and research ethics.	1	2	3	4	5	N/A
	6.c.iii.	Directly or indirectly supporting internships and externships with key academic departments in local higher learning institutions.	1	2	3	4	5	N/A
	6.c.iv.	Recruiting, training, and organizing student volunteers and volunteer programs.	1	2	3	4	5	N/A
	6.c.v.	Directly or indirectly supporting academic interfaith relationship initiatives and events.	1	2	3	4	5	N/A

6. COMMUNITY OUTREACH TOTAL (55 possible) **=**

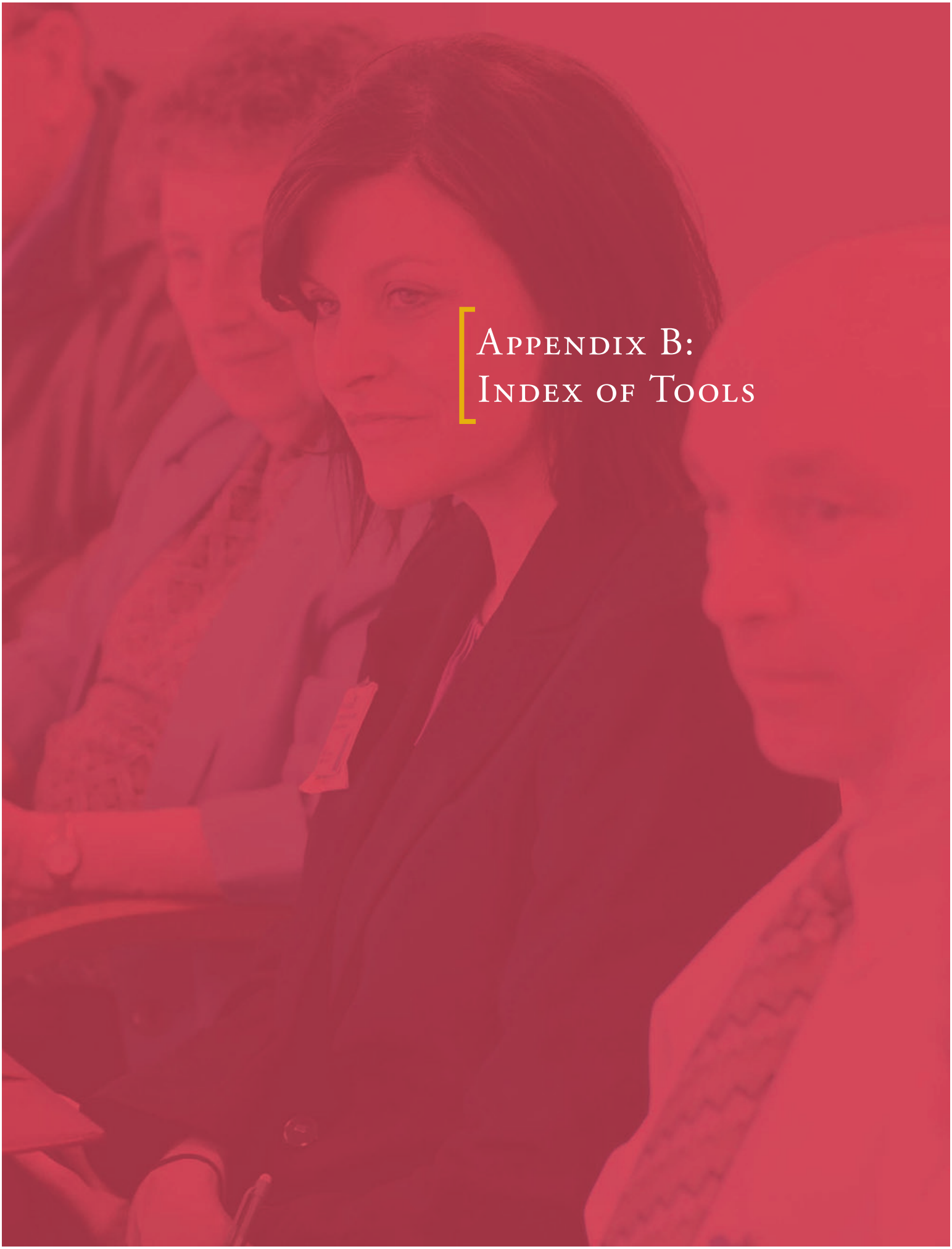
7. INSTITUTIONAL INTEGRATION

7.a.	Ethics committee members maintain an active presence on, or link with, key committees throughout the institution, including:							
	7.a.i.	Charity care	1	2	3	4	5	N/A
	7.a.ii.	Compliance	1	2	3	4	5	N/A
	7.a.iii.	Formation	1	2	3	4	5	N/A
	7.a.iv.	Human resources	1	2	3	4	5	N/A
	7.a.v.	IRB	1	2	3	4	5	N/A
	7.a.vi.	Medical executive board	1	2	3	4	5	N/A
	7.a.vii.	Mission	1	2	3	4	5	N/A
	7.a.viii.	Mortality and morbidity	1	2	3	4	5	N/A
	7.a.vix.	Organizational development	1	2	3	4	5	N/A
	7.a.x.	Quality	1	2	3	4	5	N/A
	7.a.xi.	Safety	1	2	3	4	5	N/A
	7.a.xii.	Patient relations	1	2	3	4	5	N/A
	7.a.xiii.	Public relations	1	2	3	4	5	N/A
	7.a.xiv.	Nursing forum	1	2	3	4	5	N/A
	7.a.xv.	Operations	1	2	3	4	5	N/A
	7.a.xvi.	Facilities	1	2	3	4	5	N/A

		STRONGLY DISAGREE					STRONGLY AGREE
	7.a.xvii. Strategy	1	2	3	4	5	N/A
7.b.	The health care organization makes regular use of decision-making tools, especially an Organizational Ethics Discernment Process or other Values-Based Decision-Making Process:						
	7.b.i. Executive leaders, department leaders and other appropriate staff are trained in using such tools.	1	2	3	4	5	N/A
	7.b.ii. The health ministry maintains someone as a trained facilitator in the use of such tools.	1	2	3	4	5	N/A
7.c.	The individual responsible for ethics maintains a vibrant in-house networking program that is focused on relationship building through:						
	7.c.i. Educational events.	1	2	3	4	5	N/A
	7.c.ii. Periodic inter-departmental meetings, discussions, or needs-sharing sessions.	1	2	3	4	5	N/A
	7.c.iii. Ad hoc collaborative initiatives.	1	2	3	4	5	N/A
7.d.	Where appropriate, the individual responsible for ethics maintains a coordinating council with facilities within a multi-facility system.	1	2	3	4	5	N/A
7.e.	The individual responsible for ethics has an established process for evaluating and assessing systemic ethics integration.	1	2	3	4	5	N/A
7.	**INSTITUTIONAL INTEGRATION TOTAL** (120 possible) **=**						

8. SUPPORT FROM LEADERSHIP

8.a.	Leadership demonstrates that ethics is a priority in and for the organization.	1	2	3	4	5	N/A
8.b.	Leadership actively fosters an ethical environment and culture.	1	2	3	4	5	N/A
8.c.	Leadership actively supports the range of ethics services within the organization.	1	2	3	4	5	N/A
8.d.	There is a champion for ethics within leadership.	1	2	3	4	5	N/A
8.e.	Leadership ensures that mentoring is provided to the individual with ethics expertise when that individual is 1) new to health care, 2) new to Catholic health care, or 3) new to the role	1	2	3	4	5	N/A
8.	**SUPPORT FROM LEADERSHIP TOTAL** (25 possible) **=**						



Appendix B: Index of Tools

INDEX OF TOOLS

For your convenience, the tools listed below may also be accessed at *www.chausa.org/excellenceinethics*. Tools appearing in this publication represent those that were available when this brochure was printed. Additional tools will be posted on CHA's website as they become available. We invite you to visit the website often as it will contain the most current and complete listing of tools as time goes on.

1. ETHICS EXPERTISE

- Recommended Qualifications for Facility Ethicists—CHA
- Recommended Qualifications for System Ethicists—CHA

2. ETHICS COMMITTEES

Fundamentals/Policy

- Policy—SSM
- Functions and Structure Policy—AH
- Guidelines—SSM
- Standards—CHP
- Role and Function Presentation—AH
- Promotion Presentation—SSM

Competencies

- Competencies for EC Members, Presentation—AH

Orientation/Education

- Health Care Ethics: An Orientation for EC Members—SSM
- Core Curriculum for EC Members—SSM

Evaluation

- Member Self-Evaluation—SSM
- Self-Assessment Tool—AH
- Self-Evaluation—CHE
- Evaluation—SSM
- Ethics Strategic Plan—CHE

Surveys

- Customer Feedback Form—SSM
- Staff Survey—VA, *IntegratedEthics*

Preventive Ethics

- Intro to Preventive Ethics/ISSUES Approach—VA, *IntegratedEthics*
- ISSUES Pocket Card—VA, *IntegratedEthics*
- Sample ISSUES Log—VA, *IntegratedEthics*
- ISSUES Log Form—VA, *IntegratedEthics*
- Sample Summary of ISSUES Cycle—VA, *IntegratedEthics*
- Summary of ISSUES Cycle—VA, *IntegratedEthics*

3. CONSULTATION/ADVISEMENT

Policy

- Process Standards for HCEC—ASBH
- Ethics Consultation Service Policy—CHRISTUS
- Institutional Policy for Ethics Consultation—VA, *IntegratedEthics*
- Ethics Consultation Sample Brochure—CHE

Competencies/Education

- Core Skills for Ethics Consultation—ASBH
- Core Knowledge for Ethics Consultation—ASBH
- Attributes, Attitudes, and Behaviors of Ethics Consultants—ASBH
- Ethics Consultant Proficiency Assessment Tool—VA, *IntegratedEthics*
- Ethics Consultation Educational Modules—CHRISTUS

Consultation Protocols and Forms

- Clinical Ethics Consultation Tool—AH
- Ethics Consultation Protocol—SSM
- Ethics Consultation Pocket Card—OSF
- Bioethics Consultation Form—CHE
- CASES Approach to Ethics Consultation—VA, *IntegratedEthics*
- CASES Pocket Card—VA, *IntegratedEthics*
- Data Elements of Consultation Form—Providence
- Ethics Case Consultation Summary Template—VA, *IntegratedEthics*
- Sample Ethics Case Consultation Summary—VA, *IntegratedEthics*

Meeting Protocols

- Care Conference Facilitator Checklist—SSM
- Care Conference Facilitator Preparation Guide—SSM
- Family Meetings Pocket Card—OSF
- Ethics Case Consultation Pre-Conference Checklist—CHRISTUS
- Ethics Case Consultation Meeting Format—CHRISTUS
- Decisional Capacity/Informed Consent Pocket Card—OSF

Evaluation

- Consultation Satisfaction Survey—AH
- Consultation Satisfaction Survey—CHE
- Consultation Audit Tool—CHE
- Ethics Consultation Feedback Tool—ASBH
- Evaluation of the Ethics Consultation Structure—ASBH
- Evaluation of the Ethics Consultation Process—ASBH
- Evaluation of Ethics Consultation Outcomes—ASBH
- Evaluation of Access to Ethics Consultation Services—ASBH
- Evaluation of the Efficiency of Ethics Consultation Services—ASBH

4. EDUCATION/FORMATION

- Employee and Physician Ethics Education Survey—SSM

5. POLICY REVIEW AND DEVELOPMENT

- Sampling of Topics for Institutional Health Care Ethics Policies—ASBH

6. COMMUNITY OUTREACH

Tools pending at time of publication.

7. ORGANIZATIONAL INTEGRATION

Decision Making Processes

- Organizational Ethics Discernment Process—AH
- Proactive Ethics Integration Matrix—AH
- Ethical Decision-Making Process—Bon Secours
- Process for Ethical Decision-Making—CHW
- Mission-Based Decision Making Toolkit—CHP
- Values in Decision Making—Covenant
- Values-based Decision Model—CHE
- Ethical Discernment—PeaceHealth

Preventive Ethics

- See Preventive Ethics under "Ethics Committees"

Other

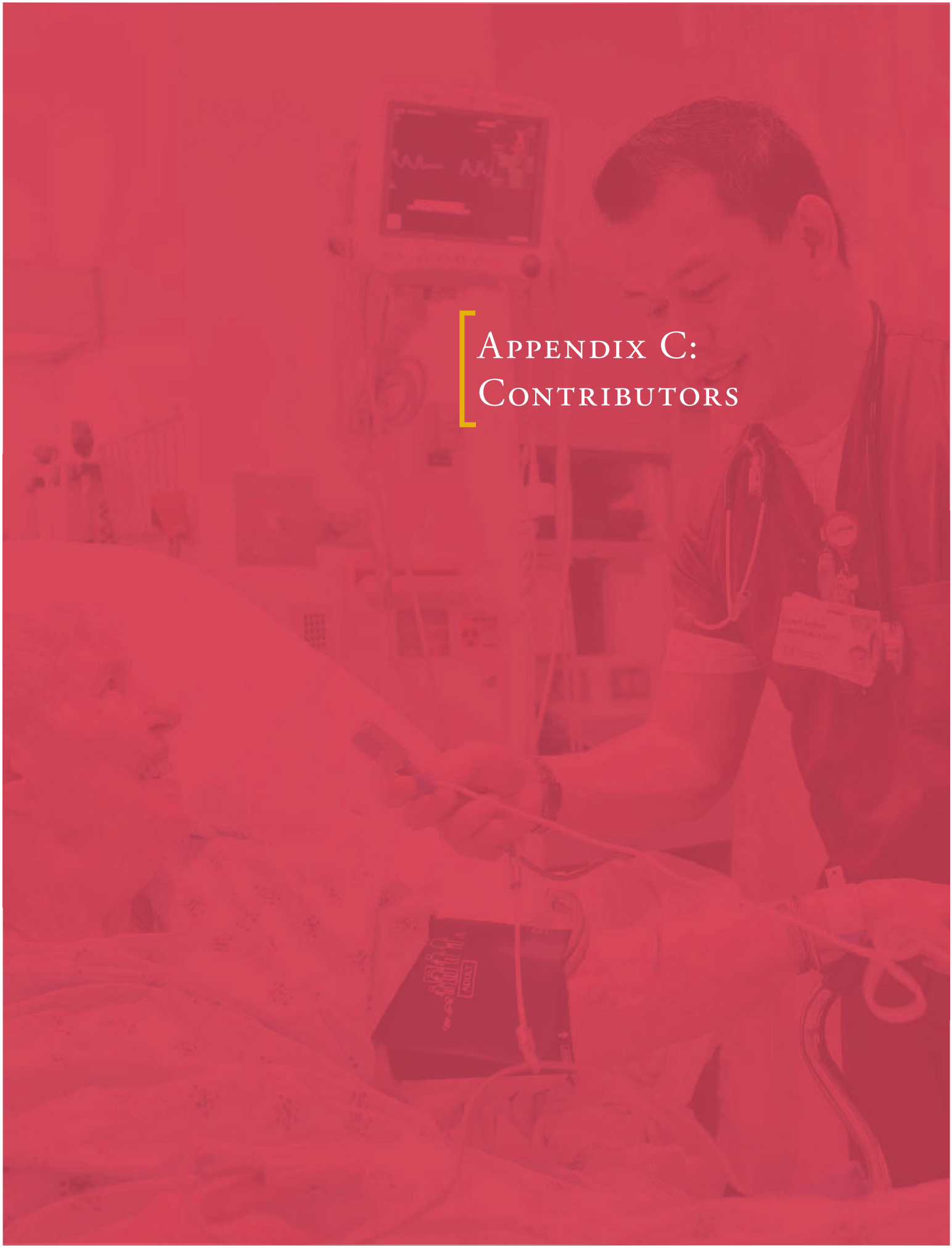
- Organizational Ethics Coordinating Council Charter—CHRISTUS

8. SUPPORT FROM LEADERSHIP

- Ethical Leadership Fostering an Ethical Environment & Culture—VA, *IntegratedEthics*
- Ethical Leadership Self-Assessment Tool—VA, *IntegratedEthics*
- Ethical Leadership Self-Assessment Tool—CHP

ABBREVIATIONS

ASBH	American Society for Bioethics and Humanities, Core Competencies for Health Care Ethics Consultation
AH	Ascension Health, St. Louis
CHA	Catholic Health Association, St. Louis
CHE	Catholic Health East, Newtown Square, PA
CHP	Catholic Healthcare Partners, Cincinnati
CHW	Catholic Health West, San Francisco
OSF	OSF Saint Francis Medical Center & Children's Hospital of Illinois (Peoria)
SSM	SSM Health Care, St. Louis
VA	Veteran's Administration, *IntegratedEthics*



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Participants In Ascension Health's Annual Mission Leader Meeting (May 2011)

A special word of thanks to Linda Raney, CHA administrative assistant, and Elliott Bedford, Ascension Health fellow, for their extensive work on portions of this resource.

A Passionate Voice for Compassionate Care

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