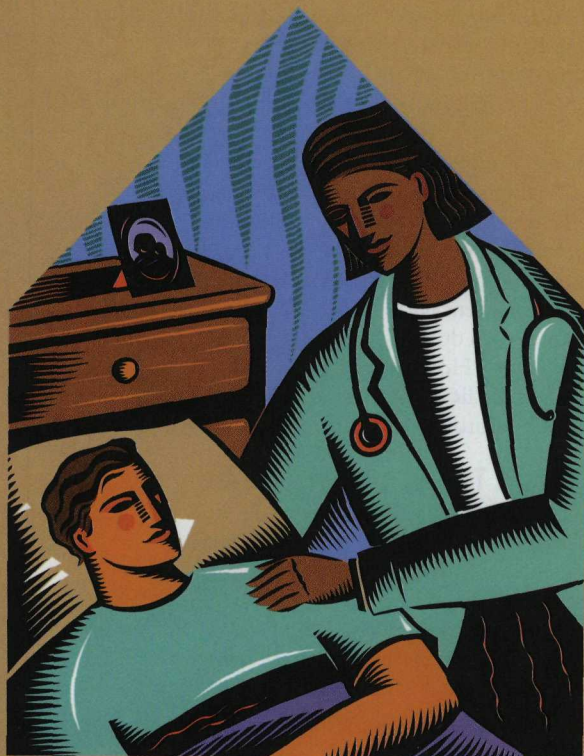


THE PRIVILEGE OF CONTINUING HIS WORK



Some Thoughts on Quality, Safety, and the Mission of Catholic Health Care



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We who serve Catholic health care believe that our mission flows from the ministry of Jesus. We agree that anything less than the highest quality is a betrayal of that mission. We believe it is a privilege and a sacred obligation to serve the injured and suffering members of Christ's body.

But saying this raises a question. Since our commitment to high quality and safety flows from our commitment to mission, why doesn't our performance exceed that of every other health care provider in the country? Although some Catholic hospitals are among the nation's top performers in quality and safety, we have to admit that, in many instances, we still have a long way to go. (For that matter, U.S. health care in general is still at the beginning of its journey toward safety and high quality.)

In considering the issue of quality, we might get some help from an unusual source, namely, the *Catechism of the Catholic Church*. According to the catechism, a virtue is an habitual and firm disposition to do good. It's a firm attitude, a stable disposition, a quality of intellect and will. Everyday examples are truth-telling, kindness, patience, and courage. How is virtue acquired? It is acquired through practice, through forming the habit of speaking the truth, acting with kindness, and so forth.

Here's where the analogy to quality comes in. Both the pursuit of virtue and the pursuit of quality involve cultivating the habit of doing the right thing, so that doing the opposite becomes uncomfortable and unthinkable. For example, once I form the habit of always double-checking the label on a drug, of always washing my hands before entering a patient's room, of always asking the patient to mark the site for surgery—and of documenting these actions—then I am less likely to fail in my patient care.

Over the last 10 years, health care's approach to quality has become more and more methodologically sophisticated. Data gathering, targets, benchmarks, and statistical analysis are now everyday tools. How often was the correct drug administered in the right dosage at the right time? How many patient falls were there per so many days of care? How many patients would definitely recommend this hospital to their friends? How do these numbers compare with national benchmarks and evidence-based protocols? These are all questions that health care organizations now routinely ask themselves.

This attention paid to data gathering reminds me of another comparison to virtue formation, one that women religious can easily relate to.

Many years ago, when some of us sisters were trained in the ways of convent life, we were given chains of beads to wear. Each time you performed the specific good act you were trying to cultivate, or failed in a way you were trying to avoid, you moved one of the beads. At day's end, you added up the day's results and recorded the total for a future conference with your director. We didn't know it at the time, but we were preparing for future quality-improvement efforts.

Assuming that examen beads and catechism quotes aren't going to move our quality, safety, and service excellence scores, how do we instill the attention to meticulous detail that enables superior performance? How do we move from individual virtue to organizational virtue? How do we create a culture of excellence? Let me suggest four resources for cultural development that are unique to our Catholic mission (and require no capital investment or technology upgrades): legacy, vision, values, and leadership. For readers who like acronyms, that's LVVL.

THE LEGACY OF OUR FOUNDERS

The tales of the pioneer religious have often been recounted. We know that they established the first hospitals in our Eastern cities and on the expanding frontier; that they served on the battlefields of the Civil War and the Spanish American War; and that they nursed victims of typhoid, cholera, yellow fever, smallpox, and other diseases without regard for their own safety.

In 1823 Mother Elizabeth Seton's newly founded Sisters of Charity were invited by physicians at the University of Maryland to staff a 50-bed infirmary in Baltimore. In 1841 the congregation's Mother Mary Xavier Clark wrote a wonderful instructional manual for nurses that describes their early approach to quality. The guiding principle in the manual's section on preparing and distributing medicines was to establish a routine. "Order promotes peace of conscience and makes us happy," Mother Clark wrote, "but disorder generally creates unhappiness, troubles the conscience, offends God, and grieves those around us."¹

Mother Clark's instructions on mixing drugs properly and purchasing medicines specified that the ingredients were to be the best available: "Never get indifferent things because they are cheap; nor even when given free of cost," she wrote.² Mother Clark understood what promoted patient satisfaction as well. The nursing sister, she wrote, should "foresee the wants of poor sick and never wait till her patient asks for a drink, or to be changed, or to have the bed and pillows fixed, etc.

She sees all that without being asked. . . . There are some patients who are afraid to give trouble, or sometimes think it more perfect or agreeable to God not to ask for what they need. . . . Oh! Give it, and wait not till it is asked."³

Although we don't find the word "quality" used in these annals in the sense we use it today, we do find ample evidence of the passion for service that underlay the pioneer efforts.

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With the outbreak of the Civil War, for example, the Sisters of Providence in Terre Haute, IN, took charge of the military hospital in Indianapolis. The congregational superior, on making her first visit to the facility, was shocked by the "miserable state of filth and disorder and the sick in a wretched condition."⁴ Before long, the sisters had rolled up their sleeves and transformed the place, gratefully acknowledging that the Lord was permitting them the happiness of serving him in the person of the sick.

In the summer of 1868, two Sisters of Mercy took charge of San Francisco's pesthouse during a smallpox epidemic. One of the sisters wrote back to her community in Ireland: "Proud men cannot but feel themselves objects of disgust to their fellow-creatures, and even to themselves. They are abandoned by their nearest and dearest, shunned as objects of terror. Therefore, when they see us joyfully attend them, they are astonished and thankful, particularly as they know we receive no money for it."⁵

These anecdotes, and countless others like them, are not stories of unhappy women and men who came to their work grudgingly or tried to cut corners in the service of the sick. They are tales of persons passionate about serving the sick, especially the poorest among them, because they saw the face of the Lord Jesus in those they served.

OUR VISION

This brings us to the second resource we have for developing a culture of quality and safety, namely, a vision of health care that embraces care for the whole person, body and spirit, in the context of family and community.

Eliminating pressure ulcers, reducing mortality rates, promoting professional behavior, and improving diabetes detection and care in the community—these are as much a part of our mission as anointing the dying. Whenever we allow someone to reduce our mission to the funds allotted to charity care, we are allowing them to diminish this holistic vision.

Our commitment to holistic quality means that spiritual care is integral to the care plan and that chaplains are part of the care team. We strive for excellence in spiritual care at the same time, and with as much intensity, as we strive to improve clinical outcomes. Our vision of holistic care means that no aspect is exempt from the mandate to continuously improve.

VALUES THAT TRANSCEND MEASUREMENT

Although measurement and data gathering are important, the deepest meaning of how we live our mission is best conveyed through images and stories. In a hospital or nursing home, we witness birth and death, daily dramas of suffering, hope, care, sensitivity, and generosity. This facility is fertile ground for what many health systems have come to call “sacred stories,” illustrations of their mission and values in action. We all know from personal experience how easy it is to find examples of creativity and generosity among our fellow workers and patients, and how wonderful it is to share those stories. The culture is formed by that which we celebrate and honor and even mourn together.

Let me illustrate the point by mentioning three of the values, especially prized by Catholic health care, that transcend measurement.

Human Dignity We honor the dignity of each individual as a person created and loved by God and as an inherently valuable member of the community. This inherent value requires us to respect each person independently of any personal

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Respect for human dignity means that every visitor to the emergency department—even the “frequent flyer”—is treated with respect in each and every encounter. It means that courtesy prevails in the operating room and in the labor and delivery suite, that rudeness and intimidation are not tolerated. It means that concern for patient privacy is more than compliance with Hospital Insurance Portability and Accountability Act regulations; it is a safeguard of the patient's dignity. It means that people of diverse ethnic, racial, and religious backgrounds are made to feel that their uniqueness is a special gift to the community. The value of respect for human dignity is foundational to all the other values.

Mercy Another value, mercy or compassion—meaning sensitivity to the spiritual, physical, psychological, and emotional needs of another person—flows from a commitment to respect the other. Only when I recognize the dignity of another person, our shared humanity, can I begin to feel with him or her, to stand in the other's place and experience his or her need. How can one create a metric for that sensitivity? It has to become part of the organization's DNA. One of our spiritual care coordinators tells each recently bereaved person, “Your grief is different from everyone else's. It is uniquely yours.” I was impressed by the wisdom revealed in that comment. Who could define the spiritual, psychological, and emotional pain another feels at the loss of a spouse or parent or child? Similarly, who can calculate another's physical pain? Our measures are crude at best. But the value of compassion prompts one to stand with the other in his or her suffering and to offer a word of comfort and hope.

Because compassion is a value for us, achieving a benchmark of 93 percent and top decile performances on some care protocol won't make us complacent, because we will picture the 7 percent of patients whose care was less than optimal.

Service This value commits us to give of ourselves in order that we might respond appropriately to others' needs. This is a value that, at one level, admits of hundreds of metrics. Numbers of patients served, numbers of procedures performed, numbers of illnesses correctly diagnosed and treated—these are measures for service. But note that the value is described as “giving of ourselves.” I don't think productivity metrics get at what is meant by that phrase.

The service that is a gift of self comes from another

er place, the same place from which emanate respect and compassion. These are *soul* measures. And unless Catholic health care is engaged at *that* level, it will be only a public service—a needed one, perhaps a successful one (as banks, bondholders, and regulatory agencies measure success)—but something less than a ministry of the church, something less than a continuation of the ministry of the countless women and men who have gone before us.

LEADERSHIP

Finally, continuous cultural improvement rests on the shoulders of our fourth resource: committed and capable leaders. We need women and men who can tell the stories in fresh and compelling ways, who can inspire personal choices for the good through the way they demonstrate it in their lives, who are transparent in their own accountability for the mission entrusted to them. They are people who recognize the obstacles to organizational virtue—human frailty, conflicting priorities, disincentives—because they have confronted them in their own lives. They remind us that new stories are being written by each associate, within each department, facility, and region.

Recruiting and supporting leaders—whether at the sponsor, board, or management level—must be Catholic health care's greatest priority in the years to come. If that fails, our quality and safety improvement efforts, indeed our mission itself, will be lost.

After Jesus had given the Sermon on the Mount, he came down from the mountain followed by large crowds. They watched as a leper approached and did him homage. They heard the leper say, "Lord, if you wish, you can make me clean." Jesus stretched out his hand, touched him, and said, "I will do it. Be made clean." The leprosy was cleansed immediately (Mt. 8:1-3).

This story and others like it are told countless times in the New Testament. To see Jesus, crowds jostled one another and climbed onto roofs and into trees. People strained to get a glimpse of the Healer, or even to touch his garment. Jesus' heart was moved by their need. He understood that, by healing physical ills, he was also responding to people's spiritual pain, their doubt, anxiety, and fear. He willed that they be made whole so that they could participate joyfully in the Kingdom he had come to proclaim.

What a privilege it is to carry on his work. ■

NOTES

1. Christopher J. Kauffman, *Ministry & Meaning: A Religious History of Catholic Health Care in the United States*, Crossroad Publishing, New York City, 1995, p. 37.
2. Kauffman, p. 38.
3. Kauffman.
4. Kauffman, p. 90.
5. Kauffman, p. 124.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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