Running head: PURSUIT OF QUALITY IN MILITARY HEALTH CARE

Graduate Management Project

The Pursuit of Quality in Military Health Care: Are We Held to a Higher Standard?

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REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.

1. REPORT DATE *(DD-MM-YYYY)*	2. REPORT TYPE	3. DATES COVERED *(From - To)*
20-06-2006	Graduate Management Project	JUL 2005-JUL 2006

4. TITLE AND SUBTITLE

5a. CONTRACT NUMBER

5b. GRANT NUMBER

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

EDUARDO J. ROSA III, CPT, MS

5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

United States Army Medical Materiel Agency, Fort Detrick, MD

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)

US Army Medical Department Center and School
BLDG 2841 MCCS-HFB (Army-Baylor Program in Healthcare Administration
3151 Scott Road, Suite 1411
Fort Sam Houston, TX 78234-6135

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

35-06

12. DISTRIBUTION/AVAILABILITY STATEMENT

Approved for public release; distribution is unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT

The Institute of Medicine (IOM) followed its To Err is Human and Crossing the Quality Chasm reports with a charge to the federal sector healthcare system to lead the way in quality initiatives. The military health system is a major player in federal sector health care serving 9.1 million beneficiaries with full-spectrum healthcare services through 76 military hospitals, over 500 military health clinics, and private sector health care partners. By outlining the ethical underpinnings for IOM's charge to federal sector healthcare, this paper adds validity to the idea that the federal and specifically the military health system has an obligation and duty to lead the way in pursuing quality health care.

15. SUBJECT TERMS

Institute of Medicine (IOM); quality initiatives; military health system; ethical underpinnings.

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			Education Technician
U	U	U	U U	33	19b. TELEPHONE NUMBER *(Include area code)* (210) 221-6443

Abstract

The Institute of Medicine (IOM) followed its *To Err is Human* and *Crossing the Quality Chasm* reports with a charge to the federal sector healthcare system to lead the way in quality initiatives. The military health system is a major player in federal sector health care serving 9.1 million beneficiaries with full-spectrum healthcare services through 76 military hospitals, over 500 military health clinics, and private sector health care partners. By outlining the ethical underpinnings for IOM's charge to federal sector healthcare, this paper adds validity to the idea that the federal and specifically the military health system has an obligation and duty to lead the way in pursuing quality health care.

Table of Contents

Introduction

Conditions that prompted the study

The Institute of Medicine (IOM) followed its *To Err is Human* and *Crossing the Quality Chasm* reports with a charge to the federal sector health care system to lead the way in quality initiatives (Committee on Enhancing, 2003). The military health system is a major player in federal sector health care serving 9.1 million beneficiaries with full-spectrum health care services through 76 military hospitals, over 500 military health clinics, and private sector health care partners (Health Affairs Organization, n.d.). In *Leadership by Example*, the Committee on Enhancing Federal Health Care Quality Programs recommends standardizing performance measures that follow an established conceptual framework, incorporating clinical information systems, enhancing the transparency of quality information across the system and for the public, and evaluating the effectiveness of quality enhancement activities (Committee on Enhancing). The military health system holds a unique position in leading the way on these initiatives; whereas other federal health care delivery systems have varying degrees of control and responsibility for quality, the military is totally responsible for quality within its health system (Committee on Enhancing).

Literature Review

Performance measures. Performance measures are mechanisms for maintaining accountability in health care delivery with the purpose of assessing performance, demonstrating improvement, and controlling performance. Purchasers of health care and payers for health care often demand reporting of performance measures to show that the health care organization is providing "high-quality care at fair prices" (Ransom, Joshi, & Nash, 2005, p. 145). According to the Joint Commission on Accreditation of Health Care Organizations (JCAHO), a performance

measure is defined as, "a quantitative tool (for example, rate, ratio, index, percentage) that provides an indication of an organization's performance in relation to a specified process or outcome" (Joint Commission, 2005a). Further, JCAHO defines effective performance measurement as a process that

- Provides factual evidence of performance
- Promotes ongoing organization, self-evaluation, and improvement
- Illustrates improvement
- Facilitates cost-benefit analysis
- Helps to meet external requirements/demands for performance evaluation
- May facilitate the establishment of long-term relationships with various external stakeholders
- May differentiate the organization from competitors
- May contribute to the awarding of business contracts
- Fosters organizational survival (Ransom, Joshi, & Nash, 2005, p.146).

The cornerstone of any performance improvement project is using appropriate performance measures. Performance measures can be developed internally or selected from external sources (Ransom, Joshi, & Nash, 2005). Clinical performance measures are sometimes referred to as indicators and often include meeting a certain benchmark, or threshold (Committee on Enhancing, 2003).

Several governmental and private agencies have developed performance measures for quality health care delivery. JCAHO has led the way in performance measurement through the ORYX initiative. The ORYX initiative integrates performance measures with the accreditation

process. JCAHO began using a core set of measures in 2002, which makes comparison between health care organizations possible (Joint Commission, 2005b).

Another health care organization accrediting body, the National Committee for Quality Assurance (NCQA), has also developed standards for quality health care delivery and performance measures. NCQA historically accredited health plans, not necessarily health care delivery organizations, and developed what is commonly known as HEDIS®, or the Health Plan Employer Data and Information Set. Any health care organization can use these measures for internal quality improvement; however the main goal of HEDIS is to compare across health plans. Consumers, health plans, and other agencies use HEDIS measures to "track the quality of care delivered by the nation's health plans" (National Committee for Quality Assurance, 2005).

The National Quality Forum was formed in 1999, after recommendations made by the President's Advisory Commission on Consumer Protection and Quality in Health Care Industry for a concerted national effort to improve quality. A private, not-for-profit organization, the National Quality Forum is made up of members from all segments of health care delivery in the United States with the mission of creating "consensus-based national standards for measurement and public reporting of healthcare performance data that provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable, and efficient" (National Quality Forum, 2005).

The Agency for Healthcare Research and Quality (AHRQ) is the lead federal agency for research on health care quality, costs, outcomes, and patient safety (AHRQ, 2005a). AHRQ developed CONQUEST, a Computerized Needs-Oriented Quality Measurement Evaluation System, that gives health care professionals evidence-based measures to assess and improve clinical performance in a variety of health care settings. AHRQ continually assesses the scientific

basis of quality measurement to provide "validated, ready-to-use measures" through their project entitled, Expansion of Quality of Care Measures (Q-SPAN) (AHRQ, 2005b).

AHRQ also sponsors the National Quality Measures Clearinghouse™ (NQMC), a web-based database for evidence-based health care quality measures. The NQMC builds on other AHRQ efforts such as CONQUEST and Q-SPAN to "provide practitioners, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining detailed information on quality measures, and to further their dissemination, implementation, and use in order to inform health care decisions" (NQMC, 2005). NQMC evaluates quality measures for congruence with current scientific evidence. Health care organizations can submit quality measures for consideration by NQMC and posting on the website to promote use across the nation's health care systems.

AHRQ was also instrumental in developing CAHPS®, which presents data on health plans with the intent of helping consumers and purchasers choose a health plan that best meets their health care needs (AHRQ, 2005c). CAHPS provides an evaluation of the quality of a health plan specifically from the consumer perspective.

Another national organization that was formed to address health care quality and performance measures is the National Committee for Quality Healthcare (NCQHC). Membership in NCQHC includes the senior leaders from across the healthcare industry. NCQHC has an Executive Institute, which "provides an opportunity to examine and share best practices in such broad areas as data collection and analysis, performance measurement and outcomes, pay for performance, medical information technology, quality delivery for public health concerns, and dissemination of information." Experts in various aspects of quality in health care sit on task

forces that create guidance for health care executives focused on performance measurement (NCQHC, 2005).

The Centers for Medicare and Medicaid Services (CMS) have several initiatives to establish standardized performance measures in the areas of home health care, hospital-based care, nursing home care, end stage renal disease care, and ambulatory care (CMS, 2005a). Most notable is the Doctors' Office Quality (DOQ) project, which measures quality of care for chronic disease and preventive services provided to Medicare beneficiaries in the ambulatory care setting. The DOQ project seeks to: "(1) to provide information for informed decision making, and (2) to support and stimulate the adoption of quality improvement strategies by practitioners in doctor's offices" (CMS, 2005b). It represents collaboration between national organizations such as the American Medical Association (AMA), National Committee on Quality Assurance (NCQA), National Quality Forum (NQF), Robert Wood Johnson Foundation (RWJ) and others (CMS, 2005a).

The Leapfrog Group approaches performance from purchasing point of view. Made up of members from more than 170 organizations that buy health care, the purpose of the Leapfrog Group is to mobilize "employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded." The Leapfrog Group surveys health care organizations and publishes the scores for consumers and purchasers to evaluate health care quality and safety (The Leapfrog Group, 2005).

The vast numbers of organizations that have developed performance measures for health care quality add to the complexity and confusion in evaluating quality health care delivery. While some organizations claim to be standardizing the various performance measures for nationwide use (i.e., the National Quality Measures Clearinghouse), other organizations are

developing performance measures that are specific to the organizational mission. *Leadership by Example* has charged the Quality Interagency Coordination Task Force (QuIC) with coordinating efforts to standardize performance measures across all governmental health care delivery agencies. The chair of QuIC is the Secretary of Health and Human Services, with representation from six other federal agencies: Departments of Defense, Veterans Affairs, Labor, and Commerce; Office of Personnel Management, Office of Management and Budget, U.S. Coast Guard, Federal Bureau of Prisons, National Highway Transportation and Safety Administration, and the Federal Trade Commission (AHRQ, 2005d).

The DoD has a unique opportunity to use national measures, or create specific performance measures that are at least standardized across DoD organizations, to assure quality health care delivery within the DoD. Currently, the DoD has incorporated performance measures for improved health and health care delivery through its DoD-wide Population Health Improvement (PHI) Plan and Guide (DoD TRICARE Management Activity, 2001). Additionally, military health care facilities must comply with the JCAHO ORYX initiative, and are incorporating HEDIS measures into various report card mechanisms. TRICARE also monitors patient satisfaction with health care services through the Health Care Survey of DoD Beneficiaries, using CAHPS methodology to benchmark with civilian health care providers (Committee on Enhancing, 2003)

Clinical information systems. Quality improvement activities require gathering and assimilation of health care data. Disjointed health care systems and archaic methods of obtaining data on the outcomes of health care delivery make retrieving data difficult. *Leadership by Example* calls for a national health care information technology infrastructure that bridges all systems (Committee on Enhancing, 2003). Accessing and monitoring quality in health care

requires automated clinical information systems and decision support systems (Committee on Quality Health Care in America, 2001).

Since the publication of the IOM reports *To Err is Human* and *Crossing the Quality Chasm*, technological advances have focused on creating information systems that reduce medical errors. The electronic medical record, computerized physician order entry (CPOE), and clinical decision-making systems are several information systems that are being developed and implemented in private and government health care delivery systems. Studies have shown reduced medical errors and health care costs with the use of CPOE and electronic medical records, especially when these systems are tied to a clinical decision support system (Committee on Enhancing, 2003). Studies evaluating the impact of computerized chronic disease and treatment monitoring on health care costs are few. Some evaluations have found cost savings from these types of care delivery systems where reimbursement is based on capitation rather than fee-for-service (Ransom, Joshi, & Nash, 2005). Although it is difficult to determine if the cost savings of such systems are enough to offset the initiation and implementation costs, most experts agree that these systems reduce harm to patients and that is the right thing to do (Committee on Enhancing).

Patients are also interested in accessing their own health care information and interacting with their health care system on line. Many health care organizations are incorporating on line interfaces for their patients and providers. Some of the issues with these information systems include lagging reimbursement policies for health care transactions on line and privacy protection of patient-level health care data under the Health Insurance Portability and Accountability Act (HIPAA) (Committee on Quality, 2001; Ransom, Joshi, & Nash, 2005).

The DoD is in a position to standardize information technology across the system. DoD computerized health care information systems have evolved over the years into the Composite Health Care System II (CHCS II), which is a comprehensive electronic patient record for military health system beneficiaries world-wide. CHCS II "integrates patient data into a central database of individual lifetime records for easy retrieval and clinical analysis, and provides efficient, centralized access to patients' records at the point of care" (Composite Health Care System II, 2005). The military health system has also implemented TRICARE Online, an on line health communications system that allows patients to search information on health topics and pharmaceuticals, find health care providers, schedule appointments with a primary care manager, and access personal health information (TRICARE Online, 2005).

Gathering and monitoring data from the entire military health care delivery system can provide opportunities to compare health care for subgroups of the population in efforts to reduce any disparities in health outcomes, benchmark performance across the system, and collect data on best practices. Also, because the DoD purchases care from the private sector, data collected on care delivered to military beneficiaries can aid in developing policies and regulations to enhance the quality of health care across the nation (Committee on Enhancing, 2003). Unlike the private sector, the technological infrastructure in the military health system and other governmental systems has not received special funding. Economies of scale could be gained from all governmental organizations working together to standardize their information technology infrastructure. A system developed in the federal sector may have the most potential for transfer to the private sector in efforts to standardize information technology across the nation's health care delivery systems (Committee on Enhancing).

Enhancing transparency. Transparency is a term used to describe making data on the quality of health care delivery readily available in a useful format for providers, patients, purchasers, accreditors, and regulators to evaluate and compare health care. The federal government has not been publicly displaying these data. Private sector health care organizations have been on the forefront of publicly releasing comparative data, especially in their efforts to gain market share. The danger in this type of transparency for private sector health care is the potential for increased adverse selection where the sicker, costlier patients choose to enroll in an organization that provides the highest quality disease management. Although data to support this claim is not readily available, the risk is a concern to private organizations and thwarts the "selling" of excellence (Leatherman, et al., 2003). The Committee on Enhancing Federal Healthcare Quality Programs set a target date of fiscal year 2008, for public posting of quality data for governmental health care delivery systems (Committee on Enhancing, 2003). The DoD has posted results of how well DoD meets HEDIS measures and the Health Care Survey of DoD Beneficiaries on the TRICARE website; however, more work is needed to keep these reports updated and user-friendly.

Evaluating the effectiveness of quality enhancement activities. More research is needed to establish a core set of performance measures that can be used to compare quality across most health care delivery organizations. Any evaluation of the effectiveness of these core measures must include the feasibility of collecting the required data, privacy of the data, and ability to publicly present the results. *Leadership by Example* tasked the QuIC to coordinate these efforts. Evaluation of quality enhancement activities can only occur after a robust quality infrastructure is in place—standardized performance measures, information technology designed to collect and analyze the data, and public reporting of quality data (Committee on Enhancing, 2003).

Almost three years after the publication of *Leadership by Example*, the federal government, and more specifically the military health system, still does not have standardized performance measures, lacks a uniform information technology infrastructure, and does not publicly report on health care quality in a timely and user-friendly manner. This review of what has been accomplished by the federal government in meeting the challenge set forth by the Committee on Enhancing Federal Health Care Quality Programs revealed the paucity of standardizing that has been accomplished in both performance measures and information technology support for measuring and reporting on quality.

Statement of the Problem

It appears that the Committee holds the federal government, and more specifically the military health system, to a higher standard of pursuing health care quality than private sector health care systems. As the title, *Leadership by Example* conveys, the federal government can lead the nation to quality health care delivery, and governmental agencies have been working in this direction. Don Berwick, president and chief executive officer of the Institute for Healthcare Improvement (IHI) in Boston, Massachusetts, states that leadership is the key to improving our health care system. Organizations have spent less time developing leaders in the health care arena than reforming aspects of health care such as medical education. Part of developing leaders is sharing information and best practices, "Where should a hospital or group practice turn for support to improve its work?" (Galvin, 2005, p. W5-7). Berwick believes that information on how to improve health care is a public good, and as such, the government should support efforts to improve care. "....[The] government is an extraordinarily important player in the American health care scene, and it has inescapable duties with respect to improvement of care, or we're not going to get improved care" (Galvin, p. W5-6).

Leadership by Example outlines the roles of federal sector health care delivery in purchasing, providing, and regulating health care as reasons for needing to lead the way. However, there are potentially basic ethical principles guiding the Committee's recommendations. The purpose of this paper is to outline the ethical underpinnings of why society holds the military health system to a higher standard of quality health care delivery.

Discussion

Definition of ethics. Ethics is traditionally defined as "a general pattern", "way of life", "a set of rules of conduct and a moral code", or a philosophy about the ways of life and rules of conduct (Abelson & Nielsen, 1967, p. 81). Ethics concerns personal choices and standards of conduct, whether on an individual basis or collectively in an organization. According to Conway and Fernandez (2000), the study of ethics concerns not only right and wrong behavior but what is spoken. Ethics may also be characterized as the study of "value statements which identify the standards of conduct which an individual may acknowledge as constitutive of his person or personality, or which a group or society may acknowledge as constitutive of its character" (Golden, Berquist, & Coleman, 1989, p. 297).

The central question in ethics, which Socrates initiated, is how should one live. Paul and Strbiak (1997) define ethics as "general theories that address Socrates' question of how we ought to live ... what is good and right, an issue of considerable disagreement among philosophers" (p. 151). Some classical philosophers believe one should live a life of reason. As Plato and Aristotle provided some answers to this the reasons inevitably spawned more questions. According to Plato, not understanding, or a lack of reason, is the only cause of evil while Aristotle highlighted the principle of happiness. For Aristotle, happiness is the aim of ethics, and the general welfare.

Aristotle professed that happiness is an end in itself, a final cause of seeking the good in other pursuits (Abelson & Nielsen, 1967).

Immanuel Kant's ideas also have a significant influence on ethics. Kant defined ethics as the philosophical science that "... deals with the laws of free moral action" (Kant, 1964, p. 13). Kant's ethical theories are based on the idea of free will, which he states makes ought a possibility for human beings. Described as existing in a dual world of nature, with immutable laws, and a world of intelligence and reason, the human being is capable of actions reflecting reason as opposed to being hostage to the laws of nature.

Business Ethics. How do ethical standards apply to business? Business has been characterized by the utility or profit-maximizing mantra. Managers must continuously balance the needs of the organization and its stockholders with the needs of other stakeholders. In this thinking, it can be argued that business, being an organization and not an individual, can never be ethical. Despite this tension between competing interests, today's business leaders can model behaviors and create a corporate culture that support ethical business practices even while making their firms more competitive in the marketplace. The core concepts that comprise the business ethics include integrity, dignity, fairness, justice, and respect (Costa, 1998).

Integrity is an important precondition for the smooth functioning of organizations. Each member of the organization must always ask himself, "Am I doing what a person of integrity would do? Have I retained my integrity? Integrity requires a member to observe both the form and the spirit of technical and ethical standards" (Gorlin, 1994, p. 5, quoted in Wilson, 2003, p. 11). An organization with integrity strengthens stakeholder confidence in the organization, reduces external regulation and conflict, and enhances cooperation with stakeholders, while the loss of integrity can have devastating effects. A case in point is the 2001 collapse of Enron. In

opposition to this, welfare, efficiency, and loyalty thrive in organizations where people treat each other with integrity. In a study of the American labor force, it was found that with respect to integrity, there is still room for improvement in the American workplace (KPMG Integrity Management Services, 2000).

Another important concept is dignity. Harcum and Rosen (1993) defined dignity in a single word, "worth" (p. 20). An operationalized dictionary definition of dignity is as follows:

> A person has dignity to the extent that he or she has worth, excellence, value, usefulness, or is held in esteem, as indicated when other persons show such behaviors toward that person as overtly supporting, rewarding, admiring, saving, defending, and/or honoring. Negative dignity is the opposite of dignity. A person has negative dignity to the extent that he or she is unworthy, detrimental, injurious, harmful, and/or is a liability or failure, as indicated when other persons show such behaviors toward that person as overtly opposing, punishing, despising, expending, attacking, and/or discrediting (Harcum & Rosen, 1993, p. 31).

Thus, in subscribing to the highest level of acceptable ethical behavior concerning dignity, business professionals must simply live the adage, do unto others what you want others do unto you.

The third concept is fairness. Although the definition, conception, and perception of fairness vary across individuals, there is a broad consensus that fairness involves a commitment to equality, impartiality (following the law and regulations), flexibility, and consistency (doing it the same way each time). Fair treatment depends on being open, clear, courteous, responsive, timely, and accurate. While the ethical concept of fairness is expressed in different words, the core of fairness is seen in the same way and same results are expected. Business professionals should strive to achieve fairness regardless of age, race, status, gender, religion, socio-economic status, etc. According to Wilson (2003), "While it is not unethical for the business professional to

act in a manner that serves his best interests, the business professional must take caution and ensure that his actions are fair and that his constituents are best served" (p. 12).

Furthermore, business professionals must ensure that their actions are just. Business professionals have ethical obligations, not just to themselves and their immediate families, but also to the good of the community as a whole. The concept of social justice explains such obligations. If business is understood as being committed to providing long term profits to the shareholders, one can see more clearly why business needs to be concerned about ethics. If a business is to survive, it must be committed to its products and its customers; if it is to flourish, however, it needs to conduct itself in accordance with the demands of justice. The business organization and its people must work "to create that society that we would entrust ourselves to if we needed to be cared for" (Costa, 1998, p. 169, quoted in Wilson, 2003, p. 13).

Finally, business professionals must show respect to employees because they are the backbone of the organization therefore value must be placed on the employees. Demonstrating respect takes many forms i.e. recognition for a job well done by giving rewards and benefits, or offering work setting improvements and packages.

In the business world, these values – integrity, dignity, fairness, justice, and respect – may not always be easily reconcilable, and hard choices may have to be made amongst them; given the complexities of moral life, it may sometimes be necessary to forego one moral value in favor of another.

Military ethics. Whereas the core concepts that comprise the business ethics are integrity, dignity, fairness, justice, and respect; the core concepts that comprise the military ethics are honesty, integrity, loyalty, accountability, fairness, caring, respect, promise keeping, responsible citizenship, and pursuit of excellence (DoD Directive 5500.7, Standards of Conduct).

Honesty means being truthful and straightforward. This would imply Department of Defense (DoD) employees are obligated to not deceive or tell lies, even for altruistic reasons. The employee must be also straightforward in telling the truth, otherwise, confusion, misinterpretation, or inaccurate conclusions may result. In terms of integrity, the military personnel must be faithful to their convictions. Integrity can be built and maintained by following principles, performing duties with impartiality, maintaining independent judgment, and acting with honor. Often loyalty is also referred to as fidelity, devotion, allegiance, and faithfulness. In the military, loyalty is not viewed as blind obedience or unquestioning acceptance of the status quo. The display of loyalty should not be on an individual or personal level; it should be on an organizational level (Wilson, 2003).

Another core concept of military ethics is accountability. In this concept the military personnel is required to accept responsibility for his decisions and the resulting consequences. Compassion is also an important conduct in the military. This principle of caring for others is the counterbalance against the temptation to pursue the mission at any cost. In addition, military professionals need to treat people with utmost dignity, to honor their privacy, and to allow for self-determination. If this principle is lacking in practice, a breakdown of loyalty and honesty results, which consequently brings chaos. This principle would obligate military personnel to hold the military organization in the highest possible regard since that organization dictates their official and some non-official actions. They must also show respect to other service members and avoid the dangers of "exploitation and degradation of subordinates" (Brown & Matthews, 1989, p. xv, cited in Wilson, 2003, p. 9).

By oath and contract, military professionals are obligated to keep their promises and commitments. This obligation is necessary for the fostering of trust and cooperation. To mitigate

the dangers associated with unfulfilled promise making, military professionals must only make commitments within their authority and power. Another core concept of military ethics is fairness, which is demonstrated by open-mindedness and impartiality. In the performance of their official duties, the military professional must be committed to justice. The duty of the military professional is to ensure that day-to-day actions seek to improve the quality of the organization and its people. It is the civic duty of every citizen, particularly military professionals, to exercise discretion. They engage personal judgment in the performance of official duties within the limits of their authority so that the will of the people is respected according to democratic principles. Finally, all actions of military professionals must be geared towards excellence; all actions must strive to be beyond mediocrity.

While the scope of these core principles that comprise the military ethics, honesty, integrity, loyalty, accountability, fairness, caring, respect, promise keeping, responsible citizenship, and pursuit of excellence will overlap at times. The overall purpose of each principle is to demonstrate a standard of behavior for the military professional. Like in the business environment, it may sometimes be necessary to sacrifice one moral value in favor of another given the complexities of a moral life.

Clinical ethics. How are professional values defined and applied in the actual practice of modern health care? More specifically, how do physicians move between the realms of ethical theories, on the one hand, and the clinical realities of health practice, on the other? It has been argued that the discipline clinical ethics represents one approach for linking professional and ethical values with practice (Pellegrino, 1993). It is a field that focuses in on the clinical realities of moral choices as they are confronted in daily health and medical care (Siegler, 1978).

In essence, clinical ethics are a practical and applied philosophical discipline that aims to improve patient care and patient outcomes by reaching a right and good decision in individual cases. It also focuses on the doctor-patient relationship and takes account of the ethical and legal issues that patients, doctors, and hospitals must address to reach good decisions for individual patients. In clinical ethics, the need to combine scientific and technical abilities with ethical concerns for the personal values of the patients who seek their help is emphasized (Siegler, 2000).

Important issues in clinical ethics include truth-telling, informed consent, end of life care, palliative care, allocation of clinical resources, and the ethics of medical research. Clinical ethics also includes at its core the study of the doctor-patient relationship, including such issues as honesty, competence, integrity, and respect for persons. Therefore, clinical ethics focuses on the ethos of the professional and on the character and virtues of the physician, whom the public expects to demonstrate these qualities (Siegler, 2000).

Traditionally, ethics in health care has been viewed from the perspective of the patient. Health care for an individual should be provided in a way that meets the four basic ethical principles outlined by Beauchamp and Childress (1994):

- Beneficence, or balancing benefits against the risks or costs
- Justice, or fairly distributing benefits and risks
- Autonomy, or respecting the decision-making capability of an individual
- Nonmaleficence or avoiding harm to the patient.

Ethical and legal considerations. It is of importance to distinguish between ethical considerations and legal considerations. This is because the federal government often misrepresents legal concerns as ethical concerns; ethical problems are viewed through a legal

lens that focuses on new regulation and closing loopholes. Here, the presumption is that all problems are solved through new laws, judicial interpretation, and the development of new lists of "thou shalt nots" (Mackenzie, 2002).

As the term suggests, ethical considerations involve concerns that have moral implications. Thus it is clear that ethical considerations refer to the value of honesty, integrity, loyalty, accountability, fairness, caring, respect, promise keeping, responsible citizenship, and pursuit of excellence. Conversely, legal considerations refer to concerns that are governed by law. Here, there is no concern for questions about the moral dimension of the law; legal considerations do not consider whether a particular disposition is morally deplorable or not. They are only concerned with the conditions under which a legal norm can be thought and be defined as valid. Typically, lawyers study the structure of a particular system and when they question the validity of a judgment, they do not look into morality. Instead, they consult the legal system and the hierarchical order of its norms.

Federal Ethics Regulation. When proposing what later became the Ethics in Government Act of 1978, Jimmy Carter said the law would assure that the American government "is devoted exclusively to the public interest" by creating "far-reaching safeguards against conflicts of interest and abuse of the public trust by Government officials" (Mackenzie, 2002, p.37). In examining the 1978 law and previous regulations governing the conduct of executive branch officials, Mackenzie (2002) concludes that federal ethics policies have failed to realize their stated aspirations. Moreover, despite forty years of steadily increasing regulation, there is little proof that federal government employees are any more ethical than they were before President Kennedy's 1961 executive order established the first new ethics standards since World War I (Mackenzie, 2002). Mackenzie argues that the current approach is both misdirected and

ineffective because the very definition of unethical behavior has changed over time; there is no way to make longitudinal comparisons of the efficacy of any particular set of rules. Moreover, this regulatory process involves significant costs of time and money.

The next paragraphs will discuss the legal basis for providing quality care, referred to as corporate compliance in the business world (Weber, 2001) and quality assurance in the health care arena (Ransom, Joshi, & Nash, 2005).

Corporate Compliance. As heated issues of corporate responsibility fill the headlines, corporate directors are under greater scrutiny. State legislation, the Sarbanes-Oxley Act, agency pronouncements, scholarly writings, and court cases provide a number of regulations, rules, interpretations, and prohibitions in this area.

Although many organizations have well run ethical management and are committed to following all laws and regulations, they are still at risk for compliance violations and punitive penalties. Under the Federal Sentencing Guidelines, an organization may reduce its culpability by having had in place an effective program of compliance with the law. A compliance program is a mitigating factor despite its failure to prevent a criminal offense from occurring because of the recognition that even the most diligent corporate monitor may fail to catch every violation. An effective compliance program must ensure that the organization exercises due diligence in seeking to prevent and detect criminal conduct. The organization's actions must demonstrate that the organization is not indifferent to the law, and has adopted a proactive plan for compliance (Groskaufmanis, 1994).

The Guidelines enumerate seven components of an effective qualifying program. First, an organization must establish compliance standards and procedures that can reduce the prospect of criminal conduct. Second, the organization must assign high-level personnel to oversee the

compliance effort. Third, the organization must use "due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in illegal activities." Fourth, an organization must effectively communicate the standards and procedures of the program to all employees. Fifth, an organization must enforce its compliance program; monitoring and auditing systems may be used to ensure adherence to the program. Sixth, an organization must enforce the standards through appropriate disciplinary mechanisms. The seventh component is the response and prevention.

Lack of a corporate compliance program exposes the organization to an avoidable risk of damage from non-compliance. Moreover, an effective program can contribute to the efficient operation of the organization and be a key piece of its corporate culture. The Guidelines provide strong incentives for organizations to establish compliance programs, but they guarantee no immunity from prosecution. On the minus side, such programs carry inherent risks, such as the disclosure of offenses that would otherwise have gone undetected or the possible waiver of confidential communications (Gruner, 1994).

Corporate directors indeed are under greater scrutiny as they have important responsibilities that need to be met relating to corporate compliance requirements. The fiduciary duties of corporate directors reflect the expectation of corporate stakeholders regarding oversight of corporate affairs. A basic understanding of the director's fiduciary obligations and how the duty of care may be exercised in overseeing the company's compliance systems has become essential. Of all the principal fiduciary obligations owed by directors to their corporations, the one duty specifically implicated by corporate compliance programs is the duty of care (U.S.

Department of Health and Human Services and the American Health Lawyer's Association, 2003).

The duty of care means the obligation of corporate directors to exercise the proper amount of care in their decision-making process. In most states, duty of care involves determining whether corporate directors acted in "good faith," with that level of care that an ordinarily prudent person would exercise in like circumstances, and in a manner that they reasonably believe is in the best interest of the corporation (U.S. Department of Health and Human Services and the American Health Lawyer's Association, 2003)..

To expound, the good faith analysis usually focuses upon whether the matter or transaction at hand involves any improper financial benefit to an individual, and/or whether any intent exists to take advantage of the corporation. Furthermore, the reasonable inquiry test asks whether these directors conducted the appropriate level of due diligence to allow them to make an informed decision. Lastly, corporate directors are obligated to act in a manner that they reasonably believe to be in the best interests of the corporation (U.S. Department of Health and Human Services and the American Health Lawyer's Association, 2003).

Quality Assurance. Many were shocked, stunned, and outraged by the Institute of Medicine's (IOM) report, *To Err Is Human*, which cited human error in medicine as the cause of death for tens of thousands of individuals who sought the curative powers of hospitalized care (Kohn, Corrigan, & Donaldson, 1999). The report estimated that between 44,000 and 98,000 Americans die each year due to preventable medical errors. Under these figures, more Americans die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516). It must be highlighted that the figures in the IOM report were of deaths; including statistics of error-related injuries would increase the numbers

considerably. Although it has not been assessed, there is no reason to doubt that harm related to errors also occurs in outpatient care, which increases the magnitude of the problem even more. The problem would be even greater if, in addition to serious injuries and death, the number of patients who require additional treatment because of adverse outcomes from error were included.

Total national costs (lost income, lost household production, disability, and health care costs) of medical errors that result in injury are estimated to be between $17 billion and $29 billion, of which health care costs represent over one-half. The increased hospital costs of preventable medication-related errors to patients alone are estimated to be about $2 billion for the nation as a whole. Health care error is a problem, a problem with profound financial and social implications for the nation at large as well as ramifications for the people directly involved.

According to William C. Richardson, chairman of the panel that conducted the IOM study, "These stunningly high rates of medical errors resulting in deaths, permanent disability and unnecessary suffering are simply unacceptable in a medical system that promises first to 'do no harm'" (Pear, 1999, p. A1). The IOM contends that most medical errors are not caused by the carelessness of individual physicians, nurses, or other hospital personnel; rather, they are the result of the cumulative opportunities for human error that inevitably arise in today's complex medical system. One area that clearly shows the systemic root of medical error involves medication errors. One example of this is the pharmacist's difficulty deciphering the illegible handwriting of doctors who prescribe drugs. Also, there are many new drugs that have similar names, causing confusion for doctors, nurses, and patients. Approximately 7,000 hospital patients died in 1993 due to medication-related errors alone, more than the number of Americans who die from workplace injuries in an average year (Pear, 1999).

The IOM report also found the following: the costs of medical adverse events are recorded as being higher than the direct and indirect costs of caring for people with HIV and AIDS; among medication-related outpatient deaths, there was nearly 8.5% increase in frequency between 1983 and 1993; amongst medication-related deaths occurring in hospitals, the rate increased 2.57% over the same time period; 70% of the adverse events that occur in American hospitals are preventable. The most common types of these preventable errors include technical errors (44%), improper diagnosis (17%), and mistakes in the use of a drug (10%); and in hospitals, high error rates with serious consequences are most likely in intensive care units, operating rooms and emergency departments. The complexity and technology largely contributes to human errors as evidenced by the higher rates of errors that occur in the more technical surgical specialties of vascular surgery, cardiac surgery, and neurosurgery.

The IOM report condemns current systems of dealing with medical mistakes, which include a combination of peer reviews, various state and federal regulations and sanctions, evaluations by private accrediting bodies, and, lastly, malpractice lawsuits. To address the problem of medical error, the IOM report recommended a mandatory adverse event reporting program that requires health care providers, particularly physicians, to report their errors for the purpose of accountability. That recommendation reflects the assumption about the nature of error expressed in the title of the IOM report, an attitude that is pervasive throughout society, that humans, including health care providers, are innately error-prone. Such an attitude is very powerful because it determines the focus of efforts to reduce the likelihood of error. If the focus is accurate, then efforts to address error are effective; however, if the focus is inappropriate, then efforts to address error are misdirected and the problem persists. To address adverse outcomes through appropriately directed efforts, it is necessary to understand human error.

One body dedicated to improving health quality is the National Committee for Quality Assurance (NCQA). A private, not-for-profit organization, NCQA is active in quality oversight and improvement initiatives at all levels of the health care system, from evaluating entire systems of care to recognizing individual providers who demonstrate excellence. In the 2004 report by the NCQA, *The State of Health Care Quality*, it is found that the health care system remains plagued by enormous quality gaps, and the majority of Americans still receive less than optimal care. The quality gap refers to the disparity on a given clinical measure between national performance and the performance of the top 10 percent of health plans. According to the report, the combination of increasing costs, declining access and varying performance and quality is entirely unacceptable. This only suggests that there should be a move from quality assurance to quality improvement. Focusing on a minimum standard of quality is perhaps too narrow of a focus for health care, and has not assured the public that health care is safe.

Health Care in the Military. Compared with the business world, the military may have more of a duty or obligation to provide quality health care than private health care organizations. This is because of the ethical standards in the military such as duty and selfless service that encompass accountability, fiduciary responsibility, trusteeship, public scrutiny, private versus public goods, and service to community (Wilson, 2003; Committee on Enhancing, 2003; Weber 2001).

To the military professional, duty involves commitment and "implies not only the obligation to do one's job conscientiously, but also to do so within ethically acceptable norms" (Brown, 1989, p. 108, quoted in Wilson, 2003, p. 6). In the military, individuals have a responsibility to learn the basic ethical standards of the organization and apply them to everyday actions. The ethical standard of selfless service also makes the military more responsible in

providing quality health care than private health care organizations. Basically, selfless service refers to military professional placing individual goals and desires subordinate to the goals and desires of the organization. According to Widnall and Fogleman (2001), "Military service is not just another job. It's an uncommon profession that calls for people of uncommon dedication. Every military member realizes from day one that his or her individual needs will be subordinated to the needs of the nation. The Air Force requires a high level of professional skill, a 24-hour-a-day commitment, and a willingness to make personal sacrifices." (p. 81, quoted in Wilson, 2003, pp. 8-9). Moreover, under this context, the military may also have a greater duty to provide high quality health care because active duty service members are not allowed to sue the federal government for any medical wrong-doing.

Conclusions and Recommendations

It appears that society holds the federal government, and more specifically the military health system, to a higher standard of pursuing health care quality than private sector health care systems. *Leadership by Example* suggests the federal government can and should lead the nation to quality health care delivery. The federal government already has the corporate culture to allocate the time and resources to develop these health care leaders. The government is an extremely vital player in American health care, and it has obvious duties with respect to development of health care, or we're not going to get better care (Galvin, 2005).

Leadership by Example outlined the roles of federal sector health care delivery in purchasing, providing, and regulating health care as reasons for needing to lead the way. The purpose of this project was to outline the ethical underpinnings of why society holds the military health system to a higher standard of quality health care delivery.

We are all vulnerable to the devastation that these systemic and human errors can create. A high rate of health care errors in this country poses serious health threats that have significant impact to the general well-being of our society. The federal government must lead the nation from quality assurance to quality health care delivery, and governmental agencies must achieve this in the soonest possible time.

Our society has the tools to improve health care quality but has been unable to institute a national change to the overall quality of our national health care system. By outlining the ethical underpinnings for IOM's charge to federal sector health care, this paper adds validity to the idea that the federal and specifically the military health system has an obligation and duty to lead the way in pursuing quality health care.

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