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The Pre-conditions for "Building Capacity" in an Ethics Program

Ann E. Mills · Mary V. Rorty

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Abstract Most organizations and/or their sub-units like ethics programs want to acquire the knowledge, skills and other resources needed to achieve their goals efficiently and effectively. Thus, they want to acquire or develop needed "capacity." But there are pre-conditions to building capacity that are often overlooked or forgotten, but which nevertheless, must be in place before capacity can be developed. This essay identifies these pre-conditions and discusses why they are necessary before attempts are made to enhance the capacity of any ethics program. The essay closes by offering a series of questions that ethics program leaders/and or members can asked themselves to assess whether or not these pre-conditions exist.

Keywords Ethics programs · Mental models · Ethical climate · Culture · Relationships

Over the decades in which ethics programs have been making important contributions to the healthcare organizations in which they function, healthcare in the United States has undergone, and continues to undergo, change. Institutionalization of clinical ethics is an important resource for attention to ethical issues in

A. E. Mills (✉)
Program in Ethics and Policy, Center for Biomedical Ethics, University of Virginia, Box 800858, Charlottesville, VA 22908, USA
e-mail: Amh2r@virginia.edu

M. V. Rorty
Member Ethics Consultation Service, Lucile Packard Children's Hospital, Stanford University Medical Center, Stanford, CA 94305, USA
e-mail: mvr2j@stanford.edu

healthcare. But in a changing environment, there is little opportunity to rest on our laurels. Ethics services need to adapt and change in order to maintain their usefulness in their organizations. Business and management literature speaks of this dynamic need of even well-established structures as a need to "build capacity."

The term "building capacity" can mean different things to different people and is used in a wide variety of contexts. It can mean the formation of partnerships, or strategy, or the acquisition of infrastructure, as for instance, when an organization acquires new buildings or new technology. We can speak of building capacity in an international context (Condell and Begley 2007), an organizational context (McKinsey & Co 2001), or an individual context (Azar and Read 2009). It can refer to an organization acquiring or developing intellectual talent, for instance, when an organization trains its members to use new technology. It can be used in public health, in a for-profit or nonprofit context, in education, engineering or medicine. This variety of application reflects its utility in describing what organizations and their sub-units generally want to do: acquire or further develop the knowledge, skills, attitudes, and other resources needed to be effective and efficient in achieving their goals.

But building capacity requires something more fundamental than the ability to acquire or develop appropriate knowledge and skills. This foundation, which we call the pre-conditions for building capacity, is often forgotten in the day-to-day rush to "get things done." The pre-conditions for building capacity depend on the kinds of relationships that are generated within an organization or its sub-units. And these relationships affect and are affected by organizational culture and shared mental models of individuals in the organization or its sub-units. Since building capacity is or should be one of the goals of leaders, it important to periodically assess the relationships, the shared culture and the mental models of people in an organization or its sub-units in order to ensure that this foundation is strong so that appropriate capacity can be acquired or developed.

In what follows, we direct our attention to what we consider preconditions for building capacity. Although our discussion is relevant for any organization or program interested in setting the stage for building capacity, our focus is on ethics programs. We focus on ethics programs for two reasons. First, ethics programs typically have few resources, little power to make decisions, and are often unsure and sometimes fearful about expanding their activities. Success in institutional life without resources, the ability and authority to make decisions, and the confidence to expand their activities, is problematic at best. But one thing people on ethics programs can do is ensure that they themselves do not contribute to the failure of their programs. One way of doing this is ensuring that the foundation on which the program rests is strong. Second, as mentioned above, changes in emphasis in our healthcare system make it increasingly important that ethics programs prepare for possible changes in their role in their institutions. If ethics programs are asked to change their role, essentially they are being asked to build capacity, which they will not be able to do without a strong foundation.

We define culture and mental models. We discuss what we mean by positive relationships. We describe the lively interplay and interdependence among culture, mental models and relationships, and to illustrate, we embed vignettes in each

section. While it is difficult, if not impossible, to delimit the boundaries between culture, mental models and relationships because they are interdependent, our focus in the vignettes highlights the specific idea we are describing. We offer comments on the vignettes correlating the vignette to our ideas. We argue that capacity building in ethics programs depends upon positive relationships among the people involved, which in turn means, that the culture of the program, and the mental models of those in the program, should also be positive. We close by offering a set of questions that that leaders can ask themselves and/or their program members in order to assess whether or not culture, mental models, and relationships are such that they will support or hinder capacity building.

Culture

Organizational development and management literature offer a variety of definitions for "organizational culture." The controversial Elliott Jaques defines culture as the "[t]he customary or traditional ways of thinking and doing things, which are shared to a greater or lesser extent by all members of the organization and which new members of the organization must learn and at least partially accept in order to be accepted into the service of the firm" (Jaques 1951, p. 251). Fifty years later, Hill and Jones define culture as "…the specific collection of values and norms that are shared by people and groups in an organization and that control the way they interact with each other and with stakeholders outside the organization" (Hill and Jones 2008, p. 413). Common mores, values, and norms inform the behavior of internal constituencies and the expectations of external ones.

We can look at culture at the macro level (the organization) or at the more micro level (sub-units of the organization.) For instance, we can study and compare one organization's culture with another organization's culture (Collins and Porras 1994). But in large and complex organizations like hospitals, culture can vary across sub-units because it may be that even if people working in a hospital share the same values and norms, they might prioritize them differently. And this might produce quite different patterns of behavior among the various sub-units of a hospital. Thus micro-cultures may vary, depending upon the various roles the functional units in the organization are assigned as their primary responsibility.

But whether we are looking at culture at the macro or micro level, from our perspective, these two definitions capture three important dimensions of culture. First, both definitions capture the idea that culture is something shared, whether it is articulated as the "customary ways of thinking and doing" or as "values and norms." Second, culture must be learned by newcomers in order for them to be at least partially accepted, either in the organization or sub-unit. Third, culture is a mechanism that at least partially controls how people in an organization interact with each other and with others outside the organization. As such, culture affects the behavior of those in the organization or sub-unit. And if culture promotes a common vision, the integration of newcomers, and influences behavior, it can help the organization or sub-unit become more efficient and effective by promoting and reinforcing the way in which the business of the organization or sub-unit is conducted.

Vignette

An eager new recruit to the clinical ethics consultation service in a small hospital was puzzled by remarks made by the chair as he summarized a recent case. She started to interrupt the chair but the person sitting next to her looked at her, frowned slightly, and shook her head. The new recruit fell silent. Later, when the chair had finished his remarks, he threw the discussion open to the other five members of the service, and all of them, including the new recruit, had comments and questions about the case.

The healthcare organizations within which ethics programs function are as diverse as their individual members. Each individual program member has specific experience, professional training and personal values which, while overlapping, may not (and ideally should not) be identical. At the same time, ethics programs have a role in the organization, and their members share interests and commitments that lead them to serve on these programs. Similarly, the organizations in which the ethics programs function have different histories, may serve different populations, may play different roles in their communities, and through their resource allocation decisions may have different capacities and priorities. An ethics program in a small rural community hospital has a different sense of its strengths, weaknesses and priorities than that of an urban academic medical center. We can think of these differences as differences in organizational culture—the analogue on an organizational level of personality on the level of the individual. A sub-culture, such as our example of an ethics program, has a mutually understood way of "conducting its business", of carrying out its role in its organization.

Comment

In this service, the case is first presented by the chair, after which committee members explore its ramifications and raise possibly relevant issues. Thus, other consultation service members are silent while the case is summarized by the chair. Later, when the chair is finished, the case is discussed by the members. We do not know why this is the way it is done. It may be that members believe this is most efficient way of communicating about a case. It may be that members believe doing it this way shows respect to whoever was involved in a case. But the new recruit is learning the processes of her sub-unit, how things are done on the consultation service. And by falling silent, she is accepting that this is the way things are done, at least in this specific instance.

Since the new recruit is eager to be part of the service, we can reasonably assume that she will observe and learn further how service members interact with each other and those outside the service. It is possible that an initial orientation/education session for new members would have made the stages of the process clearer to her, saving her this initial embarrassment.

As a functional sub-unit of the larger organization, the ethics service has a specific role to play. Most hospitals in the United States are required to have an ethics service in order to be eligible for federal funding, and case consultation remains one of the most visible and valued ethical functions. An excellent ethics

service arranges how best to meet the expectations of the larger organization, and most hospitals value reliability and expertise. This is a value of the larger institution and if taken seriously, will govern behavior in the hospital. This value reflects the larger institution's commitment to their patients and is consistent with the other goals of the hospital and with social norms for how a hospital should prioritize its mission and how its professionals and other members should behave.

Mental Models

In an organization or sub-unit, insofar as culture is something that is shared, it depends on its members having a similar understanding of the organization or sub-unit. Thus, it relies on shared mental models; on its members having a similar understanding of the organization's purpose and how it should conduct its business.

> Our views of the world, of ourselves, of our culture and traditions and even our values orientation are constructions—all experiences are framed, ordered and organized from particular points of view. These points of view or mental models are socially learned, they are incomplete, sometimes distorted, narrow, single-framed. Since they are learned, they are changeable, revisable, etc. But all experience is modeled. Whatever our experiences are about—their content—cannot be separated from the ways we frame that content (Werhane 2008).

"Mental model" is a term developed by cognitive scientists to explain how we as individuals understand and interpret the world around us. Peter Senge defined mental models as "…deeply ingrained assumptions, generalizations, or even pictures and images that influence how we understand the world and how we take action" (Senge 1990, p. 8). We derive our mental models on knowledge and experience gained in the past. We use them to understand the present which allows us to make decisions and take action (Rouse and Morris 1986). And, indeed, we cannot understand the present except through the lens of our mental models.

Vignette

The ethics consult service in this small hospital is made up of six members including the chair. To date, the clinical ethics service has been able to accommodate any requests for consultation by rotating people who are "on-call" in case a consultation is needed. Members plan their personal time, including their vacations, around the schedule so that someone is always available if needed for a consultation.

One of the service members is in a car accident and, while he is expected to fully recover, the schedule must be rearranged to compensate for his absence. All team members are inconvenienced but agree to the revised schedule.

Understanding that experience is modeled and framed allows us to be alert to the advantages and disadvantages of socialization to common or shared models. Shared mental models allow for greater efficiency because the need for communication is

lessened. But shared mental models may prevent us from factoring in (or factoring out) a relevant aspect of any given situation.

Mental models are shaped and sustained by the culture of an organization or sub-unit. But mental models can also affect culture, because the assumptions or generalizations on which mental models are built, can change. It may be that we have figured out a new more efficient way of doing something; and the customary way of doing something seems to us now inefficient or sloppy. It may be that we realize those to whom we deliver a service or product have changed, that they require something different than what we have been providing. Doctors changed their mental models as they began to realize and accept the importance of patient autonomy. As a result, even though their obligations to patients may not have changed, as doctors accepted that patients should have more of a say in their care, their interactions with patients changed.

Because ethics programs are well-established in hospitals, it may be easy to assume that their role or the expectations of them has remained constant over the time they have been functioning. But it may be important to re-visit program preparation and range of responsibility at regular intervals, as membership or environment continues to change. In the 30 years in which ethics programs have been important functional units in healthcare organizations, the tacit assumptions on which the ethics services operate have changed, are being changed, and will change by the changing social context.

Comment

The expectation of the hospital and the program is that someone will always be available if needed for a clinical ethics consultation. This value reflects the larger institution's commitment to their patients and is consistent with the other goals of the hospital and with social norms for how the hospital should prioritize its mission and how its professionals and other members should behave. This expectation is embedded in the mental models of those on the service and reflected in its culture. Members of the ethics consultation service are willing to be inconvenienced, if needed, in order to meet it.

Mental models and culture interact with each other, leading to a change in both—or they can support and reinforce each other. If the people associated with a functional unit have a similar perspective, are operating with similar assumptions about their role, they share mental models that reinforce and magnify their common effort within the micro-culture of their unit. And insofar as the sub-unit's expectations and behaviors are in line with those of the larger organization, mental models contribute to a positive organizational culture. We also would expect that the mental models that interact with positive culture are also positive. For instance, people will know their performance is evaluated with criteria that align with the organization or sub-unit's mission. Attention to the match between the needs of the larger organization and the expectations of the sub-units can minimize disappointment or demoralization.

Relationships

Stacey observes that every human organization is a network of people interacting with one another and with individuals in other organizations that constitute its environment (Stacey 1996, p. 23). This perspective on organizations points to a fundamental truth: that at heart, any functioning social unit consists of individuals interacting in relation to each other, affected to some degree by the formal and informal rules that govern the particular activity in which they are engaged. The institutional roles and the mutual expectations are at best vehicles for those interactions, and the activities resulting from these roles and expectations can be derailed by failures of the relationships of the individuals involved.

The purposes of these relationships distinguish the organization from others and allow it to function. In an organizational sub-unit like an ethics program, the role-demands of participation need to be, and typically are, well understood by the individuals involved in the programs. If Dr. Jones is acting as consultant on an ethics case, her presentation and expectations may well be different than if she is called as a consultant by a colleague for a case in her medical specialty.

Vignette

The young recruit is in the middle of a contentious consultation which has been going on for hours. She glances at the clock near the door and notes that it is near noon. She gets the parties involved to agree to "time out" so that everyone can get some lunch. She will use the time to get some advice from the chair, and if the chair is unavailable she will call other members of the service for their advice. She knows they will be happy to help.

Because program members are all committed to the service and to the benefits it can provide, their shared goals lead them to accommodate and support each other in the work the program does. Their shared understanding of the common enterprise may or may not include the kind of affection more commonly understood as "relationships"—but is no less important. Establishing the kind of working relationships an excellent program needs depends crucially on clear articulation of the purposes and processes of the enterprise.

If culture acts as a control on the interactions of persons in an organization or sub-unit, if it acts as a roadmap in terms of how the business of the program gets done, and if it relies on mental models to be sustainable, then the relationships formed by these interactions are affected by culture and the shared mental models of people in the organization or sub-unit. Relationships and the interactions among the people that make them up can reinforce or disrupt the organization's or sub-unit's culture. Culture, mental models, and the relationships of people in organization or its sub-units are interdependent and interact dynamically, each affected by and affecting the other.

Comment

We do not know the problems associated with the specific consult, but we do know that the new recruit has been made to feel that she can call on the chair as well as

other members of the consultation service for advice. She knows that program members are committed to the goals of the service and that they would want her to call on them if she needs help. She has positive relationships with the other members and these positive relationships will be reinforced by the mentoring she is receiving.

Relationships too can be positive or negative. Positive relationships will reflect and support (and be supported) by a positive culture. Positive relationships reflect clarity of expectations and goals that guide behavior, they are consistent with the mission of the organization or sub-unit, and they reflect appropriate social norms. It is, of course, true, that an organization or a sub-unit can function with negative relationships; not everyone is required to be personally fond of everyone they work with. But negative relationships, more often than not, are *not sustainable*. If there are too many diverse expectations in members, or if what is required is not clear, if the relationships formed are not consistent with the actual goals and mission of the organization or sub-unit, or if they are not based on appropriate social norms, there will probably be some kind of friction in the relationships. And because culture, mental models, and relationships are all dynamically linked, we can expect that negative relationships reflect negative mental models and a negative culture.

Even without overt friction, a negative culture will at some point attract outside interest because organizations and their sub-units are often judged on their cultures. If the role of the program is unclear, if its interventions seem unwelcome or ineffective, if its members are not respected in the wider community or are perceived as incapable of working together, the program will lose respect in the institution. So at some point, these relationships will probably dissolve or be dissolved by either internal or external pressure. People will, in the long term, either leave, try to leave, be fired, become demoralized and/or unproductive, or in the extreme case, the organization or sub-unit might collapse. All of which makes it difficult or impossible to build capacity.

Building Capacity in an Ethics Program

Ethics programs often lack even the minimal budget which could allow them to acquire needed knowledge and skills by attending specialized conferences, or hiring people with specialized skills. But changing social conditions and alterations in the expectations of ethics services in healthcare organizations may require alterations or revisions in what ethics programs are expected to do, and what they expect of themselves. So people in these programs need to explore ways in which they can develop for themselves the knowledge and skills they need. Some programs have established internal libraries of articles relevant to issues that frequently arise in consultations, and circulate among members articles relevant to particular cases. There are plenty of essays, books, and other resources available that give advice and articulate the knowledge, and skills believed to be needed for program effectiveness. There are web-based resources (American Medical Association Journal of Ethics) and specialty-group listserves that allow for collaboration with colleagues in other institutions (Bioethics Discussion Blog). The American Society for Bioethics and Humanities has compiled both educational resources and “core competencies” recommendations, available through its website (American Society for Bioethics and

Humanities 2009) and the Department of Veterans Affairs has made readily available some of the resources developed through their Integrated Ethics program (EC Web).

But it is a mistake to think of capacity building merely in terms of individualized or impersonal information, training, building skills or acquiring other resources. The relationships between the individuals within an ethics program, their ability to collaborate effectively, understand and support each other in their common enterprise, are as important to the growth and effectiveness of an ethics program as any article or conference.

Pre-conditions to building capacity mean that effective leaders must ensure that program members share appropriate culture, mental models, and develop sustainable relationships based on communication, common understandings, and trust. If the relationships among program members, and the relationship of the program with the rest of the institution, are not positive, program members will most likely leave, thereby depriving the ethics program of knowledge and skills that have already been acquired and leaving a gap in the ability of the program to achieve its goals or respond to events. This is especially true in regard to ethics programs, whose members are often volunteers and generally not required in their job descriptions to undertake ethics activities. At best, it will make it necessary for that person to be replaced with a newcomer who has to acquire the requisite knowledge and skills. At worst, program members might simply remain and become unproductive, destroying the effectiveness of the ethics program.

We are not implying that membership (or leadership, for that matter) in any sub-unit should remain static. Environmental changes, changes in expectations on the part of people the sub-unit is serving, regulatory and legal changes, make it imperative that the ethics program periodically assess what it is achieving and what it should be achieving and, if necessary, recruit other individuals who have the knowledge and skills to fill missing gaps. We are arguing that without sustainable relationships, the program's effectiveness will, at least in the long-term, diminish. And because sustainable relationships are dynamically linked and interdependent with culture and mental models, leaders and members of ethics programs should periodically assess their culture, mental models, and relationships.

Below, we offer a series of questions, adapted from a tool developed by McKinsey & Co. (2001) to build capacity in non-profit organizations. Ethics programs can use these questions as a basis on which to build their own assessment tool. Our focus is on culture, mental models and relationships as a precondition for building capacity. Later, when ethics program leaders are satisfied that their programs help develop and sustain positive cultures, mental models, and relationships, they can perform needs assessments to identify inadequate or missing resources, compare performance measures, and develop strategies intended to get their programs where they want to go.

Culture/Mental Models

Mission

- Does the ethics program have written mission statement which explains why the program exists? Is it clear? Is it shared among program members? Does the

mission statement demonstrate how and why the program serves the organization?

Values

- Is there a written statement on the values that the ethics program should reflect? Is the statement clear? Is it shared among program members?

Vision—Clarity

- How much shared understanding do the ethics program members have about what the ethics program aspires to become or achieve beyond the stated mission? How much understanding do ethics program members have of how their vision aligns with organization's goals and priorities?

Relationships

Commitment

- How much energy and commitment do ethics program members display towards the program's mission, values and vision? Are ethics program members articulate about achieving their vision and articulate about how to achieve it?

Personal and Interpersonal Effectiveness

- Do ethics program members earn the respect of others? Are they sought out by others? Do they take time to build relationships? Are they able to build support using a variety of communication styles? Do they value learning? Do they seek out new learning and personal development opportunities?

Dependence on Others

- How reliant are program members on the leader of the ethics program? Can a smooth transition to a new leader be expected? Would operations continue without major problems in the event the program leader is not available? Can ethics program members fill in during transition? Can one or several ethics program members potentially take on leadership role?

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