Next Generation Model of Ethics One Ministry's Experience

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EDITOR'S NOTE

This is a follow-up to Gerry Heeley's article "A System's Transition to Next Generation Model of Ethics," published in the Fall 2007 issue of *Health Care Ethics USA.*

In January 2003, Trinity Health chose to adopt the Next Generation Model of Ethics because its foundational principles appeared to address many of the deficiencies that the ethics leaders experienced in the traditional ethics committee. The foundational principles shaping the implementation of the Next Generation approach can be stated briefly as:

- Organizationally integrated
- Strategically proactive
- Outcomes focused
- Mission and values oriented

One ministry organization in Trinity Health, Saint Mary's Health Care, Grand Rapids, Mich., experienced a clinical issue early in the transition to the Next Generation Model that served as an opportunity to expedite the adoption of the model's foundational principles. Saint Mary's Health Care, as an early adopter of the model, faced particular challenges, but also achieved successful outcomes. Saint Mary's became one of our leading ministry organizations in the Next Generation Model. This article shares their initial experience and learning.

Saint Mary's Clinical Ethics Committees: Before Next Generation Ethics

Similar to most of the ethics committees across the Trinity Health system, Saint Mary's ethics committee met monthly with agendas primarily focused around policy review and development, staff education, and retrospective review of formal case consultations. The latter actually became the greatest time consumer of the meeting agenda, with extensive reiteration of the entire ethics situation. However, the reviews missed the system or process causes of the specific situations. Ethics committee meetings adjourned with an experience of lively conversation, but few concrete solutions. Functioning as an "isolated" group without significant impact on day-to-day patient care left committee members with feelings of dissatisfaction and questions about the purpose of the committee.

Additionally, members of the committee assigned to the ethics consultation function heard from the physicians and other care providers that their consultations were not helpful, especially for situations that involved medical futility. Two reasons accounted for this "customer" dissatisfaction: 1) physicians perceived the organization's medical futility policy and procedure as largely irrelevant to the situations they encountered; 2) the ethics consultation resources were being called for weeks into the clinical course where opposing positions seemed to be cast in stone. Not only were the direct care providers frustrated, but also unresolved conflict resulted in families leaving the hospital with less than a positive view of their care experience. Physicians and other caregivers began to question how the healing mission of Saint Mary's was actually being experienced by our patients and their families.

Saint Mary's Health Care Ethics Committee: Following Introduction of the Next Generation Model

As Saint Mary's ethics committee was struggling with these issues, Trinity Health introduced the Next Generation Model of Ethics. Several committee members quickly embraced this new integrated approach to ethics and initiated a series of subcommittee meetings that focused on quality improvement related to medical futility decisions, with special focus on critical care patients. This small group included our palliative care medical director, the medical director for Saint Mary's critical care services, and two members of the ethics committee. After several discussions regarding the

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ineffectiveness of the futile treatment policy and practices, the group determined that the essence of the problems encountered by clinical staff rested with ineffective communication. Physicians, patients and families experienced communication challenges and gaps, which also frequently involved the extended care team, including other treating physicians. All too frequently, the messages given were specific to a physician's specialty, inconsistent with messages given by other treating clinicians, dependent upon the personality and communication style of the clinician and confusing for the care team, patient and family.

Once the subcommittee recognized the heart of the conflicts, members brought the following recommendation to the full ethics committee: *Rather than developing a revised medical futility policy, concentrate on developing more effective communication methodology.* Seeing the wisdom in this recommendation, the ethics committee supported continuation of the subcommittee with its primary focus being the *integration* of the palliative care services with the critical care units and ethics. Such an integrated approach was considered essential for an effective *proactive* approach to medical futility.

Consequently, the subcommittee has continued to meet one hour each week. Now known as the integrated palliative care/ICU/ethics group, membership has expanded to include additional professionals, such as critical care nurses, nursing case managers, social work and pastoral care. Invited guests frequently include medical residents, nursing students and caregivers directly involved in a medical situation. The group typically numbers 12-15 individuals; the palliative care medical director or her designee facilitates the group's discussion. Beyond the critical care patient situations, this group often addresses complex patient care cases that surface in other hospital service areas.

In the weekly meetings, the palliative care/ICU/ethics subcommittee reviews the diagnosis, prognosis, and involvement of palliative care in the treatment of critical care patients. Each discipline provides helpful input for a holistic approach to the most appropriate medical treatment. Focus is always on the communication elements associated with the particular situation. The group finds this *integrated* way of managing patient care mutually supportive and authentic to Saint Mary's mission and values.

The Next Generation approach has resulted in ethics being more *organizationally integrated* and, hence, more *proactive* in the care of patients. Meeting weekly allows for an early focus on identifying potential problems and their ethical implications. It allows the team to thoroughly assess the current and future issues for patients with coordinated, timely interventions. Since ethics is an integral part of the clinical conversation, formal ethics consultations have significantly decreased. When they are requested, the results are more favorable to the direct care providers because there is a clearer understanding of the total patient situation.

Significant Outcomes

A significant outcome of this approach to organizationally integrate ethics is a stronger organizational recognition of the ethics committee as a primary resource to physicians and other care providers. Beyond this outcome, both the integrated palliative care/ICU/ethics subcommittee and the full clinical ethics committee have introduced *measurable outcomes* for their work. In addition to a 70 percent decrease in formal ethics consultations in the ICU between 2005-2007, the subcommittee has been focusing on appropriate levels of treatment/care beyond the ICU and the implications for cost avoidance. From January to November 2007, the estimated cost savings were as follows:

- Transfer from critical care units to less costly unit of service—$455,000
- From critical care units to direct discharge—$132,000

Impact on the Full Ethics Committee

Lessons from the weekly subcommittee meetings are integrated into the agenda and discussion focus of the monthly ethics committee meeting. Agenda items are intentionally selected and presented with direct correlation to the four Next Generation Model of Ethics foundational principles. Committee education is included in every agenda with focus on basic bio-medical ethics and Catholic identity, mission and values. The committee spent one year studying the *Ethical and Religious Directives for Catholic Health Care Services* and its implications for clinical ethics decision making and case consultation services. Ethics policy development now includes intentional language that references and applies our Catholic values to the specific content of policies. Instead of a brief statement at the beginning of a policy, value implications are woven throughout the policy and procedure. The committee views this as critical education for themselves and

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other internal audiences. Committee members used this approach in the development and revision of several policies, with our donation after cardiac death (DCD) policy as the most recent example.

Our approach to reviewing current and past ethics case consultations is quite different now. Rather than reiterating all the elements of the case consultation process, the committee reviews them from a quality improvement, learning perspective. This approach has led the committee to address specific patient care situations within the context of organizational systems and processes. A recent example of this approach related to a several-month intensive care stay for an undocumented immigrant from Guatemala. Very serious difficulties in finding an appropriate discharge plan for this individual led the ethics committee to review communication processes among care providers, family members and government agencies for learning purposes and for identifying where necessary improvement needed to occur. Follow-up to this discussion will lead to the development of organizational guidelines to assist in decision making for future patient care situations.

Measurement of outcomes has become a standard approach to Saint Mary's ethics initiatives. Ethics improvement efforts are now more often linked to the organization's strategic plan and key initiatives—both to Trinity Health's and to Saint Mary's. Currently, those improvement opportunities focus on addressing the injustice of disparities and inequities in the delivery of our health care services throughout Saint Mary's community benefit health centers. Eliminating disparities and inequities in the treatment and management of diabetes and heart disease is the major focus of our initiatives. System clinical targets are used as baselines for our particular projects.

Summary

The Next Generation philosophy and model has not been a quick fix for our challenges, or an immediate culture change reality. Our key learning is that Next Generation principles and approaches advance when direct care providers, especially physicians and nurses, can recognize the improved effectiveness in patient care that results from this approach. Saint Mary's clinical ethics committee is on an important journey that makes patient-centered quality of care—at every level of the care process—central to everything we are about.

Share your knowledge

If you have any ethics-related policies, innovative programs, leading practices or cases with commentary that you would like to share with colleagues throughout Catholic health care, please contact **Scott McConnaha** at smcconnaha@chausa.org.

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