Toward a "Total Organizational Ethic" in Health Care Ethics

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A RECENT EDITION of the *American Journal of Bioethics* contained an article by Ellen Fox and colleagues that has quickly become a must read for those interested in learning about the present state of affairs with ethics consultation in American hospitals.[1] The study is intended to provide baseline data to facilitate quality improvement efforts related to clinical ethics consultation. The authors sought to answer the following questions:

1. What is the prevalence of ethics consultation services (ECSs) in U.S. hospitals?
2. Who performs ethics consultation and what are the backgrounds and training of these individuals?
3. How do ECSs function?
4. Are ownership, teaching role, and a hospital's bed size related to the characteristics of its ECS?[2]

Without delving into too much detail, here are some of the more revealing findings from the study:

- Five percent of clinical ethics consultation providers had completed a fellowship or graduate degree program in bioethics.
- Forty-one percent of clinical ethics consultation providers learned to provide clinical ethics consultation through "formal, direct supervision by an experienced member of an ECS."[3]
- Forty-five percent of clinical ethics consultation providers learned to provide clinical ethics consultation "independently, without formal, direct supervision by an experienced member of an ECS."[4]
- Ninety percent of clinical ethics consultation providers are Caucasion.
- Ninety-five percent of hospitals have or are developing an ECS.
- Three is the median number of clinical ethics consultations performed by ECSs during the year prior to the study (range 0-300).
- Twenty-two percent of the ECSs performed no clinical ethics consultations in the previous year.
- Ninety percent performed fewer than 25 clinical ethics consultations in the previous year.
- 290,000 individuals spent more than 314,000 hours performing more than 36,000 clinical ethics consultations.

From these findings, Fox and her colleagues report that ECSs are: (1) a routine part of patient care; (2) a significant beneficiary of resources; (3) a service performed mostly by clinicians; and (4) a service lacking any kind of formal training standards and quality control procedures.[5] Any way one slices it, these results reveal a number of concerns with ECSs. Though I have always been in favor of making clinical ethics consultation services better, I would not want to do this at the expense of other important initiatives in organizational ethics in health care.

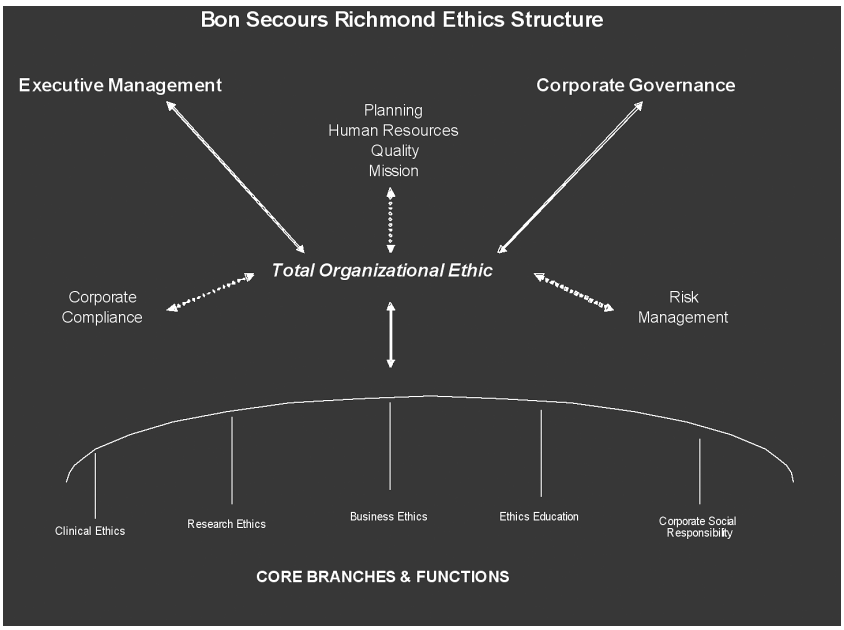
To be sure, there are many reasons for the current state of affairs with clinical ethics consultation.[6] Also, given the resources we have put toward clinical ethics consultation, as well as the long-term experience of it within clinical medicine, it should be in a better place than it currently appears to be. It is not my intention to go into detail here about the appropriate plan of action for repairing these deficiencies.[7] Each ECS will have to assess itself to see where it wants to go in a number of important areas in order to redress the apparent insufficiencies.[8]

I simply wish to suggest that this study ought to lead us, once again, to rethink the overall ethics strategy within our health care organizations. My comments about this study are less about what to do with clinical ethics consultation and more about how clinical ethics consultation fits within the larger organizational context. In this respect, I am writing from the perspective of somebody working within a health system environment assigned with the explicit task of developing a "total organizational ethic." Presumably, this is a perspective that is somewhat different

from the needs and desires of those working within an academic medical center.

I believe these findings offer implicit empirical support for the view that ethics discourse in health care organizations is seriously flawed and misunderstood precisely because it has been almost exclusively confined to clinical issues, dependent on so called "ethics experts," overly concerned with dramatic issues, and is performed infrequently.[9] This does not mean that clinical ethics consultation should be pushed aside; it remains a necessary element in an overall ethics strategy for health care organizations. Rather, it simply means that clinical ethics consultation should be put in its proper place. For too long, it has been asked to carry the weight in health care ethics—a weight it cannot bear given the narrowly circumscribed nature of the practice itself and the evolving nature of organizational ethics in health care.

Within Bon Secours Richmond Health System, we have been considering an "alternative" ethics strategy that attempts to permeate the entire organization, not simply the clinical realm. This ethics strategy might best be understood as a "total organizational ethic." The name attempts to convey at least two meanings: (1) an ethics mechanism that can be responsive to the entire organization; and (2) an ethics mechanism that can take a leading role in a broader effort toward the formation of an authentic organizational culture. I would not pretend to suggest that we are breaking new ground or making radical changes. Our strategy accepts that there is an evolving understanding of the structure, purpose, and function of a total organizational ethic in health care. This is simply our attempt to incorporate this evolution into our vision for ethics within Bon Secours Richmond Health System.



Goals of a total organizational ethic within Bon Secours Richmond Health System

1. To integrate ethical discourse into organizational decision making, practices, and processes
2. To educate for ethical recognition and ethical capacity building, especially among leaders
3. To provide accessible services in a timely fashion
4. To assess empirically the ethical environment of the organization
5. To participate in ethics-related quality improvement projects in clinical and non-clinical areas
6. To partner meaningfully with diverse persons and departments within the organization

These goals cannot be achieved by a single, isolated ethicist or department of ethics. For this approach to work, engagement and overlap with other core functions of the organization must take place. For example, Catholic health care has seen a rather strong division of labor between ethics and corporate responsibility. The same can be said between ethics and risk-management, ethics and quality improvement, as well as between ethics and leadership development. In fact, the same can be said for numerous other departments and functions within our health systems. The same kind of division of labor has most likely contributed something to the current state of clinical ethics consultation. Is this necessary? Is it wise? It seems that by casting the ethics net as wide as possible, so that it touches other "centers of ethical responsibility,"[10] we move toward a broader organizational ethics construct. The diagram here provides a

skeletal glimpse of this emerging ethics strategy within Bon Secours Richmond Health System.

At the end of the day, this is only a structure. In reality, what counts is how this structure is put into practice. To date, clinical ethics has received a disproportionate share of the resources within a flawed ethics infrastructure. The fundamental goal in the approach sketched above, both structurally and practically, is to demonstrate that health care organizational ethics is more than clinical ethics—irrespective of how well or poorly the clinical ethics mechanism is performing.

If it is true that there are many centers of ethical responsibility within a particular health care organization, it seems that we should not be shy about considering alternative approaches to how we organize our ethics structure within the Catholic health care ministry. ■

NOTES

1. Ellen Fox, Sarah Myers, and Robert A. Pearlman, "Ethics Consultation in United States Hospitals: A National Survey," *American Journal of Bioethics* 7 (February 2007): 13-25. It should be noted that data reported in this study is now more than six years old. There appears, however, to be no compelling evidence to suggest the findings of this study are inconsistent with the current reality.
2. Ibid., 13.
3. Ibid., 17.
4. Ibid.
5. Ibid., 19-20.
6. I encourage you to examine the short articles that accompany the study. In particular, and on this point, see Nancy Neveloff Dubler and Jeffrey Blustein, "Credentialing Ethics Consultants: An Invitation to Collaboration," *American Journal of Bioethics* 7 (February 2007): 35-36. See also Denise Dudzinski, "Education to Dispel the Myth," *American Journal of Bioethics* 7 (February 2007): 39-40.
7. For example, see Autumn Fiester, "The Failure of the Consult Model: Why 'Mediation' should Replace 'Consultation'," *American Journal of Bioethics* 7 (February 2007): 31-32. See also Kayhan Parsi and Mark G. Kuczewski, "Failure to Thrive: Can Education Save the Life of Ethics Consultation?" *American Journal of Bioethics* 7 (February 2007): 37-39.
8. For a helpful resource see Mark P. Aulisio and Robert M. Arnold, eds., *Ethics Consultation: From Theory to Practice* (Baltimore: Johns Hopkins University Press, 2003).
9. John W. Glaser, "Hospital Ethics Committees: One of Many Centers of Responsibility," *Theoretical Medicine* 10 (1989): 275.
10. For the best description of the meaning of "centers of ethical responsibility," see Glaser, "Hospital Ethics Committees," esp. 278-82.