FEATURE ARTICLE

The Next Generation of Ethics Mechanisms: Developing Ethics Mechanisms that Add Demonstrable Value

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Health care ethics committees have spent the majority of their existence rightly addressing the clinical ethical dilemmas that cause moral distress for patients, families and staff members. Relatively less time has been spent on addressing the processes used by ethics committees. In 2003, ethics colleagues across Catholic Health East (CHE) drafted a strategic plan for ethics mechanisms, focusing principally on the deficiencies of, and ways to improve the processes that address ethical issues. If imitation is the highest form a flattery, CHE began to replicate processes that were well underway at St. Joseph of Orange Health System,[1] the Veterans Health Administration[2] and Trinity Health.[3] These systems were already actively engaged in imagining and implementing the so called "Next Generation" of ethics mechanisms.

The ethics strategic planning group, working from system-wide semi-structured interviews that audited ethics functions, drew several conclusions about the state of ethics mechanisms across CHE. First, there were obvious wide variations in accountability and effective processes. Second, ethics consultation teams had remarkable variations in clinical bioethics knowledge and facilitation skills. Third, ethics committees spent too much time on high visibility cases like that of Terri Schiavo. Finally, ethics committee activities were not well woven into quality improvement within the institution. In sum—and this was remarkably similar to the national experience of ethics committees[4]—a number of committees were less than effective.

Before the ethics strategic planning group addressed the details, it considered a range of questions.

- What would count as good outcomes for ethics mechanisms?
- How would we assess the performance of existing ethics mechanisms?
- How do we hold ethics mechanisms accountable?
- How do ethics mechanisms improve quality?
- How do we insure the ethics committees promote systemic change?
- How would we know our efforts were successful?

With these questions in mind, the group drafted a mission, philosophy and guiding principles against which to evaluate any plan. The group stated:

> Ethics mechanisms within CHE aim to create a community of moral concern that is reflective about all motivation, choices and behavior that promote the institution's mission to be a healing, transforming presence in the communities we serve. This reflection will be integrated into the operations of CHE to bring value to the patients and communities we serve. To foster this end, each institution will establish a function (i.e., Ethics Resource Service (ERS)) that facilitates difficult clinical and organizational cases and educates patients and staff on ethical issues. In addition, each institution will establish a mechanism that takes information gathered from the difficult clinical and organizational cases and develops strategies to address the cases by integrating the responses into operations (e.g., senior management team).

In addition to this mission, the group articulated the following guiding principles that should stand as a measure of success:

- **Integrated:** ethical reflection will be integrated in all operations across CHE and not isolated to the work of the ethics committees.
- **Transformational:** ethics mechanisms within CHE will contribute to organizational transformation by investigating and analyzing the root causes of moral problems, and by integrating responses into operations that demonstrate value to patients and the institution.
- **Transparent:** significant clinical or organizational decisions should be accompanied by explicit, transparent evidence of the questions explored, the persons affected, the values

considered and the alternatives investigated, and how the decision supports the institution's mission and values.
- **Proactive:** ethics mechanisms will move beyond the current reactive stance and aim to create structures that will proactively address and prevent ethical shortfalls.
- **Quality:** ethics mechanisms will be evaluated on measurable value through improved quality in patient care, employee satisfaction and the promotion of institutional values.

The working group relied on the best practices from the American Society of Bioethics and Humanities (ASBH), (i.e., competencies for ethics consultation)[5] and on the large health care systems that were already integrating ethics into quality outcomes. Consequently, ethics committees across CHE have voluntarily committed to requiring those on ERS teams to demonstrate adequate knowledge in eight areas of bioethics as well as competency in facilitation skills. A member of an ERS must demonstrate a competent understanding in informed consent, capacity determination, advance directives, termination of life-sustaining treatment, confidentiality, truth telling, *Ethical and Religious Directives for Catholic Health Care Services* and a values-based decision-making process. The local ministries have dedicated themselves to acquiring consultation competencies because they realize that ERS acts in the name of the institution, and if they provide faulty information or poor facilitation on difficult cases, they can make a bad situation worse.

Perhaps the biggest advance for the Next Generation ethics mechanisms is identifying ethical issues that, if properly addressed, can bring demonstrable value to the institution. There have been several experiments across CHE. In one instance, a trending study on advance directives was conducted on patients who had died. In cases where advance directives were "followed," the trend report uncovered that in only 6 percent of cases was the documentation required by state law followed by physicians. The trending report resulted in physician education on documentation that the patient was incapacitated to make health care decisions. In another instance of bringing value to the institution, a cancer center became concerned about off-label use of high-cost cancer drugs. The ethical issues identified were stewardship of scarce resources for drugs with minimal reimbursement as well as fairly and transparently allocating the drugs. As a result, an ad hoc group developed ethical and clinical criteria for allocation and use of off-label, scarce cancer drugs that was transparent to patients and physicians, and simultaneously managed the unreimbursed costs. In both instances, there was an ethics problem (e.g., complying with advance directives law, and fairly allocating scarce drugs) that had quality problems. These issues were not addressed by the traditional ethics committee but by ad hoc groups of hospital operations colleagues with expertise in the specific areas. Ad hoc groups were established because operations colleagues know how to improve quality, track advances and hold people accountable for follow-through.

There is no one agreed-upon CHE way to integrate ethics system wide into operations; however, there is a shared vision. Each ministry is clear that the link between the ERS and integration into operations started with a critical link—the mission executive who was the common link between the ERS facilitation team and the mechanisms that are responsible for integrating this information into operations. Each ministry was left to determine the best practice for reporting accountabilities. This might include, but is not limited to:
- A standing item on senior management team agenda.
- ERS sending analysis and recommendations to the senior management team or other committees as needed.
- ERS reporting on annual and strategic goals of the ERS.
- Any report from the ERS should contain a value statement that includes the intended goal and the demonstrable value that will accrue to the organization for accomplishing the integration.

The clearest example of an ethical problem with quality implication came from a ministry in the South. The problem was obvious. Patient satisfaction scores, especially from the emergency department, psychiatric unit and bariatric surgery unit were low. The problem they saw was that patients in the hospital were not receiving coordination of diverse care needs as evidenced in 53.33 percent of documented patient complaints noting a perception of disrespect towards them while at the hospital from 2005-2007.

To address the problem, the hospital adopted a Six Sigma Work Out. This method has several characteristics:
- Problem is obvious.
- The root problem, not symptoms, are identified.
- Solution may or may not be known.

- Minimal or no data analysis required.
- Multiple individuals are needed to "work out" a solution.
- Solutions can be identified in a meeting setting by brainstorming with individuals who are closest to the process (led by a trained facilitator).
- 30 days to implement solutions.

All of these activities are focused on one overriding goal: Listening to the voice of the patient. What does the customer truly want and need? How can we most efficiently meet that need?

The Six Sigma Work Out always focuses on actions that will result in high impact outcome with low effort. With a dozen team members, the group was able to identify the problem and arrive at a quick solution. The causes of the low scores were multifaceted. Morbidly obese patients admitted for bariatric surgery who were shuttled around the hospital for tests stated that stretchers, wheel chairs and commodes were inadequate for their special needs. Psychiatric patients, especially those with aggressive behavior, were not treated respectfully by security and emergency personnel. Finally, patients from minority populations felt that their diverse cultural and religious needs were not respected.

The resulting activities were selected on the basis of having high impact with low effort. Equipment to meet the special needs of bariatric patients was purchased and its use was limited to this population. Emergency department staff and security are receiving special training to safely intervene in aggression control and are learning how to use conflict management with psychiatric patients. Finally, nursing staff are receiving ongoing education in diverse cultural and religious needs and in ways to transfer patients from one service to another, including communication with the patients in respectful ways.

Although implementation of the quality improvement techniques has begun, there are no statistical results yet. Nonetheless a few take-away messages are already surfacing. Members of this ad hoc group were selected because they are professionals who possess the needed competencies. Second, innovators like those in this hospital need to be publicly praised. Like most endeavors, there will always be innovators, and praising them publicly and spending your energies with them has an infectious quality. On every bell curve graph there are late or cautious adopters, a majority of consensus adopters in the middle of the curve, and then there are the innovators or early adopters. We have found it better to focus efforts on innovators and early adopters, learning from them and praising them by imitating their approach. The influence of innovators is critical for the success of the Next Generation of ethics mechanisms.

NOTES

1. See for example, Kevin Murphy, "A 'Next Generation' Ethics Committee," *Health Progress* 87, no. 2 (March-April 2006): 26.
2. See the VA's National Center for Ethics in Health Care's *IntegratedEthics*. It can be accessed at www.ethics.va.gov/IntegratedEthics.
3. See Gerry Heeley, "A System's Transition to Next Generation Model of Ethics," *Health Care Ethics USA* 15, no. 4 (Fall 2007): 2-4; Nancy Bancroft, "The 'Next Generation' Model," *Health Progress* 85 (May-June 2004): 27-30, 55.
4. Ellen Fox, Sarah Myers and Robert Pearlman, "Ethics Consultations in United States Hospitals: A National Survey," *American Journal of Bioethics* 7, no. 2 (2007): 13-25.
5. American Society for Bioethics and Humanities, *Core Competencies for Health Care Ethics Consultation,* Oakbrook, Ill.: ASBH, 1998.