Early Indicators for Ethics Reviews

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Six years ago as a newly hired (and new to the field) clinical ethicist at a large Catholic medical center, I quickly became aware of the frustration and accompanying feeling of powerlessness when called for an ethics consult long after dividing lines had been drawn, opposing positions were entrenched, and suspicions abounded on both sides of the table. Invariably in those cases, one of the bedside nurses would say, "I could have told you on day three this was going to happen!"

Two questions quickly emerged; What did that nurse see on day three? And why didn't I know there was a patient here that long with these types of issues?

About that time several articles in the literature discussed the value of ethics consults in the ICU as well as proactive bioethics screening.[1] This article will discuss a process developed at the Sisters of Mercy Health System and implemented at a member facility to address some of these common frustrations with the goal of getting ethics resources involved earlier.

Identifying the problem

In an article describing a process for proactive bioethics screening, Leon Morgenstern from Cedars Sinai begins with a familiar scenario, "A fragile octogenarian with advanced dementia and a host of co-morbid conditions is now unresponsive, ventilator dependent, in renal failure, and suffering grade-four decubitus ulcers. Death is expected in the near but undeterminable future. There is no advance directive. Of her remaining kin, her daughter insists that 'everything be done'; the time has come to consider tracheostomy and feeding gastrostomy."[2] While Morgenstern uses the concept of the "ethically vulnerable" patient, this case can also be discussed in terms of missed opportunities along the way. Questions along those lines might include: What discussions took place around her plan of care when each diagnosis was made? What were the goals of treatment? What attempts were made to discuss this patient's values and end-of-life wishes? What did the daughter understand to be the possible outcome of placing her mom on the ventilator? Does the daughter truly understand what 'everything done' really entails?

There are numerous ways to avoid these missed opportunities. The approach discussed here is just one way to get resources involved further upstream to identify potential ethical issues and rally the appropriate parties' involvement. With the blessing of the senior leadership of the health system, this task was undertaken concurrently by the Corporate Ethics Committee of the Sisters of Mercy Health System and the ethics committee at the local member organizations. The Corporate Ethics Committee focused on defining the indicators that would trigger an ethics review based on our collective experience on difficult cases, while the local ethics committee addressed how this process might be feasible within its local environment.

Indicators

The Corporate Ethics Committee, which consisted of the ethicists or vice presidents for mission and ethics from the local member organizations along with - for this issue - clinicians, case managers, nurses and a lawyer, developed the following indicators:

1. Patients for whom the goals of treatment are unstated, unclear or unrealistic.
2. Patients for whom there is conflict over the goals of treatment or treatment options.
3. Patients for whom their Durable Power of Attorney for Health Care Decisions or family are requesting that life-sustaining treatment be withheld or withdrawn absent an end-stage disease or when there is reasonable expectation of recovery.
4. A resource utilization outlier, specific to the individual member organization and used primarily as a means for a database of patient cases.

Purpose and development

The purpose of the "Indicators for Ethics Review" process at

St. John's Mercy Medical Center reads, "For ethics to be more proactive in addressing difficult cases there has been a system-wide effort to identify the characteristics of these difficult cases. In the future when these indicators are identified, ethics resources can be involved at the appropriate level."

Being sensitive to the primacy of keeping caregivers at the patient's bedside and reducing the amount of time in meetings, combined with the fact that we did not yet have electronic medical records where these indicators could be triggered electronically, it was imperative that this process tap into systems and processes already in place. Several members of the ethics committee joined with the manager and director of the Care Coordination Department (otherwise known as case management) to discuss how this might work. The chair of critical care, a long-time member of the ethics committee, charged the group to develop a process that is grounded in the practical and is a help, not a hindrance, to the health care team.

Care coordinators, nurses and social workers who work with patients and families on discharge planning, meet weekly to review patients whose length of stay is 25 days or longer. These meetings include the manager and director of care coordination as well as their medical director. This situation met two requirements: a process already operational and a resource utilization outlier which would create a database of patient cases. I was invited to attend these weekly case review meetings.

Team approach

Now that I was invited to the weekly case review meetings, it was important to determine who else should sit at the table. In many of the cases reviewed by the local ethics committee, we found that the patient or family had already contacted the patient advocate expressing concerns over some aspect of their care. Additionally, many of the patients in these difficult cases would have benefited from a palliative care consult; therefore, representatives from patient relations and palliative care were invited to attend. Those now at the table included: ethics, patient relations, palliative care, the nurse and social work care coordinators, leadership from care coordination and their medical director.

Interdisciplinary patient care conferences are difficult to orchestrate in the current health care system; they are time-consuming and often seen as ineffective. The weekly case review is the closest that many services can manage, so while we expanded the number of disciplines at the table, it certainly is not fully representative. Most notably, due to time constraints and staffing requirements, it is not possible to have bedside nurses, chaplains, attending or specialist physicians at these meetings. However, input from those individuals is sought at the unit level.

The process

Weekly case review meetings are a flurry of activity. Care coordinators report individually so that as one exits the room another enters. During the care coordinators' brief reports, those at the table must pick up on nuances of the case related to their own discipline. They can ask questions and, if potential issues or actual problems are identified, offer suggestions on possible next steps. If the situation has already developed into conflict, the other parties at the table can get involved or, if already involved, become the point-person for resolution. The principle of subsidiarity is at work here: the person closest to the patient and family with the best relationship is encouraged take a leadership role to coordinate efforts to resolve the issue or conflict. When the leader needs assistance, others are brought in. The leader acts as a liaison to physicians, health care team, and patient and family members. Often the situation requires a patient care conference to be followed by a patient and family conference with the health care team. The entire team is active behind the scenes until their personal involvement is required.

Results

Our results to date indicate that there is increased communication among the health care team as well as with patients and families. There is heightened awareness of and sensitivity to ethical concerns which have led to earlier intervention. Individuals who perhaps were not otherwise inclined to speak up have been empowered to have a voice in troubling situations. This process has also facilitated team building, so the coordination of the patients' care more closely resembles the integrative element of *interdisciplinary* care rather than merely *multidisciplinary*. We believe that we have come together to anticipate needs and concerns that result in more ethically appropriate practices in the delivery of health care.

Emblematic of this process, two types of occurrences have become common. In one, a care coordinator will look up

from her paperwork, point at me exclaiming, "Have I got a patient for you!" This turns out **not** to be a patient on the '25 day' list, but rather a patient whose case has raised some ethical concerns. Now the care coordinator can voice concerns, get direction, and not have to answer the (often accusatory) question, "***Who*** called ethics?" In the other, while discussing a case, someone besides the ethicist says emphatically, "Well, if the patient still has decisional capacity then ***why*** are we letting the daughter make decisions?" This type of responses should become second nature to everyone on the health care team.

The capability of triggering these reviews via an electronic medical record will be a reality at St. John's Mercy Medical Center in the next twelve months. However, my preference is that the electronic trigger will be a complement to the weekly case review meetings to preserve the team building and interdisciplinary nature of these meetings.

Continued challenges

While these results have been promising, we continue to have challenges. We have not yet determined a way to measure the success of this process. Additionally, the team continues to be challenged by time constraints in getting representatives from ethics, patient relations and palliative care to the table each week. It has also continued to be a quandary as to when to have the ethicist directly involved with patients and families. Depending on the circumstances and dispositions of the patients and their family members, the introduction of the "director of ethics" can elicit counterproductive responses. Perhaps these challenges can be part of the dialogue this article prompts.

NOTES

1 Schneiderman LJ, et al. "Effects of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial. *JAMA*. 290(9): 1166-72, 2003 Sep 3.
Leon Morgenstern. "Proactive Bioethics Screening: A Prelude to Bioethics Consultation." *The Journal of Clinical Ethics.* Vol 16, No 2 (Summer 2005) pp. 151-55.

2 Leon Morgenstern. "Proactive Bioethics Screening: A Prelude to Bioethics Consultation." *The Journal of Clinical Ethics.* Vol 16, No 2 (Summer 2005) p. 151.