FEATURE ARTICLE

Building a Lasting and Effective Health Care Ethics Program: Insights from the Field

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Introduction

This paper examines two interrelated frameworks for success in health care ethics. While both are meant to advance an effective health care ethics program within the organization, one focuses on the importance of laying out specific goals for the program and the other centers on organizational dispositions that can promote success. In the programmatic arena, I focus on the importance of setting attainable and practical goals that form the basis for a comprehensive and strategic ethics work plan. In the organizational realm, I focus on elements within the organization that can promote effective work in health care ethics.

This paper is written with an important assumption: there is a significant difference between acquiring the proper academic knowledge for entering the field of health care ethics and being effective once in the field. I am more interested in exploring the latter. I argue that a foundational step in building an effective ethics program, as well as for creating the conditions for success for a new ethicist, requires the establishment of a framework for success. My goal is to promote more explicit attention to elements that help create a lasting and effective ethics strategy within the organization.

A Framework for Success Part 1: A Programmatic Strategy

Success in this field, as in any other, requires discernment around what is meant by success. Without such intentionality, any success would seem coincidental. By definition, then, it would not be success since it would neither be repeatable nor sustainable. Therefore, there must be an established set of goals upon which any ethics program must be built. Such goals define success and advance effective work. They drive daily operations, overall performance, programmatic strategy, and promote good outcomes for the organization. In part, these goals will reflect the particular character, priorities, and values of distinct organizations as well as the biases of individual ethicists. Our health care system has benefited from defining success in health care ethics around the following five goals:

1. To integrate ethical inquiry into organizational decision-making, practices, and processes.

2. To advocate for the implementation of leading ethics practices within the organization.
3. To build ethical capacity, competency, and sensitivity through comprehensive ethics education.
4. To provide high quality, standardized, and timely services.
5. To evaluate our outcomes, policies, practices, and procedures for continuous improvement.

It is beyond the scope of this paper to address the history and development of these goals. For now, I am interested only in highlighting their general importance for an effective health care ethics agenda. First, from these goals one can create a network of accountabilities and responsibilities, collaborative relationships, staffing needs, strategies, timelines, and work-products that contribute to accomplishing the goals. In this sense, they serve as a basic road map for programmatic success within the organization.

Second, ethicists will not typically have a staff of people tasked with implementing these goals. For ethicists new to their role, this adds increased demands on time, thereby creating even stronger reasons for creating such goals. Having this kind of explicit vision for the program helps to promote the focus required to achieve one's goals, which is especially necessary for new ethicists seeking to be effective.

Third, from these goals, a set of practical and on-the-job skills can be enumerated and acquired that will help insure the successful attainment of the stated goals. This is precisely where the discussion around the importance of knowledge and skills-based competencies in health care ethics enters the framework.[1] Success in ethics is difficult without an indepth understanding of ethical theory and its practical application. Success is difficult without excellent teaching and facilitating skills. Success is difficult without rhetorical skills to help one advocate for certain practices. In this era of electronic medical records, success is difficult without an ability to utilize computer information systems and databases for record keeping, continuous quality improvement, and for demonstrating the impact that an ethics program can have on improving clinical quality.

Fourth, and perhaps most important for the purposes of this paper, these goals are a necessary set of criteria for the professional maturation of a new ethicist. No single ethicist, whether new to the role or experienced in it, has every skill required to succeed in the field. One cannot underestimate the importance of having dedicated volunteers from within the organization, as well the support of influential senior leaders, working in cooperation with an ethicist in order to achieve these goals. Developing the skills is the obligation of the employee in concert with one's supervisor. In addition, organizations as a whole are responsible for creating a culture of employee development that can support the kind of maturation that many within the organization require. This is particularly true for younger, terminally-degreed

ethicists, for many enter organizational life in a role that should carry significant decision-making influence with little or no practical organizational experience that will help create the success which the organization demands. Most, if not all, of their professional development will occur on the job. Given this, it is essential that organizations foster important attitudes and practices that can promote effective ethics work.

Framework for Success Part 2: An Organizational Strategy

At this point, our attention shifts from the programmatic and daily operational dimensions of success to more organizationally-oriented aspects of success. The central question becomes: how can Catholic health care organizations assist ethicists (especially new ones) in being effective in their role? I suggest that there are at least four specific elements that must be present within organizations in order to promote effective ethics work.

Promote a Career Trajectory for Catholic Health Care Ethics

This means, among other things, that the ethicist community come together to create an ideal trajectory of the professional growth of health care ethicists within the ministry. Recognizing (and appreciating) a diversity of opinion on the issue, one such trajectory could be the following:

1. Graduate school completion[2]
2. Clinical practicum rotations and hospital experience as part of graduate school.
3. Health care ethics fellowship / dissertation fellowship for one or two years[3] during one's dissertation phase.
4. If no dissertation fellowship, then consider post-doc fellowship in hospital/clinical ethics.
5. Full-time ethics work at the hospital level, e.g., community hospital or academic medical center.
6. Full-time ethics work at the local level, e.g., regional or statewide system.
7. Full-time ethics work at the corporate level, e.g., national system office.

Admittedly, this is a broad "ideal" trajectory, and very few ethicists that I know have been this deliberate in terms of their career growth. But it is this kind of education and training that would create a coherent set of practices geared toward a single goal: the development of effective ethicists. The assumption is that at each successive step in the progression an ethicist will mature and develop the diverse set of skills required to succeed in virtually any ethics role he or she would hold in the Catholic health care setting. With planning, cooperation, and intelligent design, I believe this kind of approach is possible within the ministry.

In this trajectory, breadth and depth of experience are important. The breadth refers to the opportunity one has to

acquire skills in various settings, e.g., community hospital, academic medical center, regional system, and national system. From my own experience, I was struck by the significant difference between what success required in a single hospital versus what it requires in a far more complex and integrated regional health care delivery system in which I work.

Depth of experience refers to the level of integration one achieves while working in a given environment. Generally speaking, the longer one works at the same location, the more opportunity one has to develop this depth of experience. Therefore, any ideal trajectory needs to pay attention to both the venues in which one works as well as the time frame in which one works at a particular location.

Because the system-level ethics position appears at the "top of the rung" in the proposed pathway, one might conclude that I believe it is the most important ethics role. I am not suggesting that. There are different gifts and skill sets that line up better in one environment or another. Because salaries are generally higher in system level roles, however, many young ethicists are climbing their way to what they think might be the top of the field. I would strenuously argue against that kind of thought and action pattern. Prior success at the hospital or regional system level would be important for one to build an effective ethics strategy, and the skills to move it through a large and complex health care system.

The notion of a career trajectory requires some practice change on the part of organizations keen on hiring ethicists. In the first place, they need to refrain from hiring inexperienced ethicists into roles that require more breadth and depth of experience. They also need to use caution in hiring ethicists into full-time positions when they are not yet through with their formal studies, which includes the dissertation—assuming an organization is seeking to hire a terminally-degreed individual.

While there are always exceptions to the rule, I would argue that such strategies might help promote the necessary personal growth and professional maturation the role requires. It takes time to figure out the role. It takes time to gain the trust the role requires for success. It takes time to learn and develop one's personal approach to ethics work. If there is a need to make an exception to these suggestions, then indepth clinical immersion experiences as well as vigorous mentoring would be essential for those who are hired into roles that are not commensurate with their experience.

Build Effective Ethics Structures

Broadly speaking, structure refers to the components and parts that come together to comprise a system or entity—be it a committee, department, division, or entire organization. Such structure helps build permanence and sustainability though, of course, it also can promote complexity and bureaucracy.

When I arrived at Bon Secours Richmond Health System five years ago, each of the four hospitals in the regional system had an ethics committee. Each "reported" to the respective medical executive committee. They were unorganized and lacked leadership, membership, and purpose. Today, we have one system-wide ethics committee for the region. Not only do we have the geography to support this move, but membership is diverse, engaged, and active. We have better committee meeting attendance, sub-committee participation, and, increasingly, members who push me to move more boldly and quickly in our initiatives. We have enhanced the opportunities for members to serve in roles that actually match their gifts and interests, and we have been supported by increased budgetary allotments in order to operate well. Could our committee and its members be even more effective? Yes—and that will come in due course. But, overall, we are in a better place today precisely because we made an unconventional structural change that was necessary.

In addition to changing the actual structure of the ethics committee, we also changed our reporting relationship. The committee no longer reports to the medical executive committees of our hospitals. It reports to the quality committee of our board of directors. From a strategic perspective, this provides a significantly higher degree of visibility and exposure for our clinical ethics program. Every other month, we have the opportunity to report our activities to the senior clinical and executive leaders within the organization. We are now advancing an agenda, instead of reacting to one imposed by others. Moreover, this change in reporting encouraged our committee to create and monitor a clinical ethics dashboard. We are doing all this and at the same time creating more lasting structures—the kind that will help promote the programmatic goals discussed above.

In addition to building a more effective ethics committee and reporting structures, we made a significant decision three years ago to establish and grow our health care ethics fellowship program. Fellows are full-time employees of our system for one or two years. During their indepth clinical ethics immersion experience, they shadow leading clinicians within the organization, participate in various rounds and committees, lead case conferences, perform clinical ethics consultation, build survey and assessment tools for program evaluation purposes, and push important project work (e.g., the revision and integration of system-wide ethics policies, the development and maintenance of an online ethics presence, the design of a system-wide ethics education process to help build knowledge and skills-based competency in health care ethics). Time is built into the fellowship for the fellows to complete their dissertation and mentoring processes. Professional development opportunities are also provided. We employ two fellows, one in each of our local markets within the state of Virginia, i.e., Central Virginia and Eastern Virginia. This helps our ethics services and provides

a paid opportunity for graduate students to hone their craft before looking for employment elsewhere inside or outside the ministry. The addition of graduate students extends the reach of our entire ethics service and structure, thereby paving the way for a deeper, more effective level of ethics integration within the system.

Develop an Appropriate Balance between Inquiry and Advocacy

In ethics, inquiry or advocacy is sometimes necessary. Inquiry entails creating the space necessary to encourage the thoughtful integration of an ethical lens into organizational discourse and decision making.[4] The nature and tone of inquiry are facilitative and egalitarian.[5] Group dialogue processes are encouraged. Diverse voices are heard. Such an approach to ethical discourse is generally open-ended and less concerned about advocating specific agendas or outcomes.[6] There is a distinction between statements of fact or observation and expressions of value. Open questioning is allowed and encouraged. Some organizations embrace this spirit more than others. Either way, I would argue that effective ethics work requires this approach to communication, especially as it relates to understanding the nature, implications, and significance of particular strategic decisions within the organization. By definition, practical ethical issues are prone to disagreement. As a result, dialogue is necessary and must be fostered. With such an approach, an organization might not "get it right" all the time, but they have practical tools to help them work hard toward getting it right every time.[7]

Advocacy refers to the promotion of good ethics practice and the dissolution of poor ethics practice. Primarily, it entails a commitment to a kind of ethical activism in which just practices are promoted and unjust practices are discouraged.[8] One such area that has received much attention in the bioethics and clinical literature consists of health disparities that certain groups experience both in the treatments that are offered as well as in the outcomes of those treatments.[9] To what degree are ethicists involved in redressing such inequities? Should they only focus on discussing the issue and thus promoting awareness? Or, should ethicists be more out front actively leading the way toward change? There is a healthy debate about whether, and to what extent, bioethics should take on an activist role. In the best of the Catholic tradition, both approaches are critical. Therefore, it seems to me, both should be promoted within the organization.

Clearly, both inquiry and advocacy are needed for the ethics function to flourish. It takes inquiry to understand unjust practices and advocacy to remedy them. Hence, there needs to be organizational support for both inquiry and advocacy. If advocacy is a goal of ethics inquiry, then discernment practices such as mission due diligence are not enough. They must be coupled with an activist sensibility.

It takes experience for an ethicist to understand when to inquire and when to

advocate. Finding this balance, however, is not simply the task of individuals—ethicists or otherwise. The organization needs to foster each of them. If each is cultivated within the organization and demonstrated by the leadership of the organization, individual ethicists—as well as the "program" he or she is promoting—will stand a much more significant chance of being effective over time.

Utilize Data and Surveys to Demonstrate Value and Promote the Credibility of Ethics

Over the past three or four years in particular, I have asked myself many times whether, and to what extent, the work I do makes a difference organizationally. The internal conversation runs something like this: If ethics work matters, how do I know? Intuitively, I think it does matter. But, empirically, I cannot demonstrate that it matters. Do I need to demonstrate it empirically? Is it not self-evident that ethics work makes a practical difference within the organization?

Resoundingly, I argue it does matter that we demonstrate the value of ethics programs. It seems unfair and unsophisticated for ethics programs to have a pass in this context. The question is whether we need to demonstrate this value empirically through data or qualitatively through experience, narrative, and rhetoric, or through a combination of approaches. We have taken a modestly quantitative approach on this question. Mostly, our current practices revolve around the use of data tracking and survey tools to gain baseline understanding around specific behaviors and perceptions that impact ethical decision making. However, over time, I see the value that embracing a more vigorous quantitative approach can add to the work we do on a daily basis.

The justification for this is partly philosophical and partly pragmatic. Philosophically, I see no legitimate reason why ethics programs should not have the opportunity—just like other important clinical programs—to allow data to help demonstrate the clinical and economic value that solid ethics can have for the organization. Pragmatically, clinicians appreciate this approach. They tend to bring a more scientific lens to the world around them. If they are going to be important partners for the development of ethics programs, then we ought to make every attempt to speak each other's "language."

Like many systems, ours is investing heavily in an electronic medical record (EMR). Exciting plans are underway to utilize the EMR for a myriad of benefits in the ethics arena. I want to take every opportunity to use this system to investigate ways to demonstrate the value we add and then make that value known throughout the system. The clinical ethics arena is particularly keen on developing more evidence-based practices.

Until we gain the full utilization from our EMR, we have invested in an ethics database tracking software system that helps us keep abreast of important

variables that can provide some rudimentary evidence of our value. For instance, knowing something about the average days between admission and clinical ethics consult can tell us something about the depth of our integration at the clinical level. It has always been my belief that the earlier we can be involved in cases, the better the opportunity for an explicitly ethical perspective to help shape the trajectory of clinical care. The database can help provide actual evidence of that assistance rather than relying on a hunch.

Knowing that our clinical ethics consultants went through all of the ten steps we identify as being important in a clinical ethics consultation tells us something about our commitment to doing quality work. Comparing the outcomes and care processes of patients with similar diagnoses who underwent clinical ethics consultation versus those who did not can, over time and with enough cases, tell us something about how clinical ethics consultation can impact the trajectory of patient care and clinical decision making. This is not a zealous attempt to drown in data. Rather, it is information that can help build a strong and effective ethics process.

One of the more exciting developments within our ethics work centers on the use of surveys to gain baseline understanding of current practices and perceptions within the organization. Our clinical ethics committee, for example, is committed to doing one clinically-oriented ethics survey per year. Our first, which will launch in January 2011, is related to clinician practices and knowledge around informed consent. We have had far too many ethics consults in the past year that involve what I could only call basic and elemental lapses in informed consent practices. This experience sparked interest to investigate more about what our clinicians actually know about informed consent. The electronic survey will go out to all physicians, nurses, and advance practice providers in the system—employed and unemployed. Results will be used to inform policy changes and promote practice improvement in this area. While not traditional normative ethics, the results will help inform ethical decision making in a number of important areas.

Two other surveys might be classified more appropriately as "organizational" ethics surveys. One examines the perceptions that our leaders have around (1) the ethical environment of the organization, (2) the ethical practices of leaders within the organization, and (3) the adequacy of ethics resources available to support leaders should an ethics issue arise. This will go out to 300 employees who serve as leaders in one of our markets. This data will be used to inform the best way to roll out increased ethics support to leaders within the organization. The other seeks to capture baseline data regarding the relationships and activities that vendors have within our medical group practices. This data will be used to inform a revision to our vendor relations policy within the medical group.

Conclusion

There are many elements that can contribute to a successful health care ethics program. I have addressed two essential elements: (1) the importance that explicit goals can have for programmatic success, and (2) the significance that certain dispositions or elements within the organization can have for building an effective health care ethics program. The relationship between the educational and knowledge-based competencies of a full-time ethicist is a discussion that is related and distinct from building an effective health care ethics program. This particular relationship merits increased attention within the ministry as discussions around competencies and potential licensure for health care ethicists move forward.

Organizational Ethics Survey

BSVA Medical Group Vendor Assessment

NOTES

[1] Both the Catholic Health Association (CHA) as well as the American Society for Bioethics and Humanities (ASBH) have published competencies in healthcare ethics. For the CHA version (open only to members) go to: http://www.chausa.org/ethicistcompetencies/. For the ASBH version (open to all), go to: http://www.asbh.org/uploads/files/pubs/pdfs/CCUpdateNov09.pdf. Each site was accessed

[2] I am assuming a "traditional" educational model in the humanities. That model generally consists of a bachelor's degree followed by a master's degree followed by a doctoral degree in the humanities, particularly some combination of bioethics, moral philosophy, or moral theology. What program and courses the student takes is beyond the scope of this paper. Depending on one's academic background, any trajectory would most likely require some revision.

[3] I would distinguish between a fellowship in an administrative sense and one in a clinical immersion sense. That is, one could have a "fellowship" for an entity while still in graduate school coursework and work largely on project management. Though potentially worthwhile, this experience is different than gaining clinical ethics experience while employed through a formal "fellowship" program in the Catholic healthcare setting.

[4] Margaret Urban Walker, "Keeping Moral Space Open: New Images of Ethics Consulting," *Hastings Center Report* 23 (1993): 33-40.

[5] For an overview of managing conflict in an "inquiry" fashion see Nancy N. Dubler and Carol B. Liebman, *Bioethics Mediation: A Guide to Shaping Shared Solutions* (New York: United Hospital Fund, 2004).

[6] For a concise presentation of one particular method for addressing challenging ethical issues see Marvin T. Brown, *The Ethical Process: An Approach to Disagreements and Controversial Issues* 3rd ed. (Upper Saddle River, NJ: Prentice Hall, 2003).

[7] For a discussion on the requisite elements for creating a climate open to ethical reflection see Marvin T. Brown, *Working Ethics: Strategies for Decision Making and Organizational Responsibility,* (Berkeley, CA: Basic Resources, 2000): 180-204.

[8] On the relationship between bioethics and activism see Lisa S. Parker, "Bioethics as Activism," in *The Ethics of Bioethics: Mapping the Moral Landscape* eds. Lisa A. Eckenwiler and Felicia G. Cohn (Baltimore: Johns Hopkins University Press, 2007), 144-57. See also Howard Brody, *The Future of Bioethics* (New York: Oxford University Press, 2009), 217-31.

[9] For a comprehensive review of the issues of unjust disparities in healthcare see Elizabeth A. Klonoff, "Disparities in the Provision of Medical Care: An Outcome in Search of an Explanation," *Journal of Behavioral Medicine* 32 (2009): 48–63.