

Embedding Clinical Ethics Upstream: What Non-Ethicists Need to Know

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Introduction

Historically, clinical ethics consultation has been a reactive endeavor epitomized, if not regaled, by tales of the “Friday afternoon consult” regarding the procedure scheduled for first thing Monday morning or, worse, the 2:00 a.m. phone call regarding the mother-to-be in distress. In the best case scenario, we are able to provide quick reassurance that the “medically appropriate” course of action is also “ethically appropriate.” Alternatively and less desirably, we may be called upon to mediate an entrenched and irresolvable conflict between a patient’s family and care-team after a 60 day stay in the ICU. We all already know that most of the time such cases end unfortunately with the patient’s inevitable expiration (despite all our technology), and the ethics service appearing somewhat impotent. The latter of course is not

a result of our failure to respond to the call or any lack of competency in doing so, but rather the fact that the call itself came far too late for anyone who doesn’t carry a magic wand to be successful in addressing it.

In an attempt to improve the services we provide to those we serve and to those clinicians who serve on behalf of our ministry, the Ethics Advisory Leadership Council of Ascension is in the process of developing a model of “Proactive Ethics Integration” that improves institutional capacity to influence clinical decision-making in anticipation of potential ethical concerns.¹ To do this, we are moving away from the traditional paradigm of an expert-centered deployment model of ethics and towards one that embeds systemic approaches and standardized resources for identifying and addressing clinical ethical issues upstream in

existing and emerging clinical and organizational processes as close to the point of service as possible, whether that is at the bedside, in the Ambulatory Surgery Center, the Skilled Nursing Facility or Physician Offices. The first step of developing such a model is equipping a system-wide team of “embedded ethics resources,” comprised of unit and service-line based personnel, with some level of ethics competency in order to be able to proactively identify ethical issues in the course of their daily activities and address at least some of them before they become too entrenched or complex, or to triage those issues that require an additional level of expertise sooner than commonly happens today. The fundamental question in this endeavor, then, is what do busy clinicians with no formal ethics training need to know about ethics, if we are to be successful in proactively integrating ethics upstream in person-centered care.

First Things First

The first thing the non-ethicist needs to know is what ethics even is and how it ought to be conceptualized. While this may seem too obvious, I am not simply referring to the standard Google or even academic definition of ethics, but an understanding of ethics that fits both within a Proactive Ethics Integration

framework and within the medical profession’s understanding of its own fundamental commitments. The task is complicated by the fact that most clinicians bring with them some preconceived notion of ethics, usually from their secular clinical training. Subsequently, clinical ethics is often seen as conflict mediation, especially in the absence of any robust normative framework to situate objective moral truth above and beyond patient autonomy understood simply as “what the patient wants.” Within this framework, the need for clinical ethics services is sometimes subconsciously seen as a signal that the physician has somehow failed to fulfill their obligations in the correct way. Worse yet, clinical ethics services within the Catholic health ministry is sometimes naively viewed as who you call when you do not want to run afoul of *The Ethical and Religious Directives for Catholic Health Care Services* (ERDs) and/or “get in trouble with the bishop.” Regardless, an inappropriate or inadequate understanding of ethics and the clinical ethics service will either lack any incentive or actually disincentivize clinicians to call upon ethics services as a resource.

Within Ascension, we have begun exploring an alternative conception of ethics as a key enabler of the Quadruple aim, i.e., improved outcomes, reduced costs and the best possible patient and

provider experience, with a special emphasis on “Healing without Harm.” While “Healing without Harm” primarily refers to the elimination of medical errors and avoidable mortality,² it provides a good context for grounding the concept of ethics in the foundational norm of the medical profession itself: first, do no harm. From the perspective of the person understood holistically and integrally and adequately, i.e., as an integrated body-spirit unity, this makes sense insofar as ethics can be understood as a service aimed at reducing, minimizing or avoiding spiritual, emotional, psychological and social/relational harm as well as sometimes actual physical harm that results both from illness and the care process itself. As with medical errors, the cause of spiritual, emotional, psychological or social/relational harm is generally not the ill will of individuals, but more often systems and process failures and the inattentiveness of human beings trying to do too much. Thus, just as with initiatives aimed at “Healing without Harm,” ethics within the context of Proactive Ethics Integration ought to be thought of as the systematic implementation of normalized processes intended to identify early opportunities to prevent and reduce spiritual, emotional, psychological and social/relational harm before it occurs as a result of well-intentioned efforts. While it would in fact be

more accurate and perhaps complete to say that ethics supports care-providers and families in addressing complex questions that arise from the sacredness of every person, their unique beliefs, values and life-story within the context of their specific health needs, the concept of healing the whole person without spiritual, emotional and relational harm seems to be one which clinicians can readily grasp and easily buy into.

Ethical Dimensions of Person-Centered Care

Early identification of the ethical dimensions of person-centered care before the point at which one might recognize the presence of a more traditionally understood “ethics case” is vital for Proactive Ethics Integration or any effort to move ethics upstream. Ideally, there would be a set of easily recognizable ethics indicators that would signal the presence of an ethics issue before it becomes entrenched, irresolvable or even just obviously apparent. While some ethicists, such as Carol Pavlish and Katherine Brown-Saltzman, have been doing some excellent work in this area, the focus within the secular literature is generally on ethics understood as a conflict between decision-makers or when one is faced with an unpleasant choice between undesirable outcomes.³ In the clinical context especially, ethics tends to be

seen as relevant only when one is faced with a difficult dilemma. Within the Catholic understanding of ethics as the promotion of human dignity and human flourishing, however, the ethical dimensions of care go far beyond the traditional notion of a dilemma. Thus, once the educational foundation regarding an appropriately robust understanding of ethics has been laid, the next thing clinicians will need to know is what constitutes the ethical dimensions of person-centered care, even in those cases in which a conflict or dilemma is not present or may never even emerge.

Of course, difficult decisions between two bad choices or conflict among decision-makers are ethical dimensions of care that will always need to be addressed. The point is simply that the relevance of ethics is not and ought not be limited to instances of dilemmas classically understood as being trapped between a rock and hard place. Yet it is sometimes the case that we fail to see the ethical dimensions of cases in which two or more *positive* values may be competing for our moral attention. While this scenario is generally not seen as an ethical issue because its resolution properly falls within the realm of patient autonomy (i.e., because the values that are at stake are all positive, it's simply a matter of patient choice), it is easy to make the mistaken assumption that the patient adequately

understands what values are at play or the relationship of the proposed course of treatment to those values. While the role of ethics in this scenario is less about avoiding "harm," it certainly falls within the scope of supporting persons in making complex decisions and healing the person holistically understood.

In other instances, the care-providers may overlook the ethical trade-offs at play when it is clear what ought to be done or what value ought to be pursued from one isolated perspective, say for example the clinical perspective. When we focus too much on only one dimension of the human person, such as patho-physiologic processes, we often fail to recognize the effect the illness is having and our care will have regarding different values of equal or even greater significance when understood from a spiritual, emotional, psychological or relational perspective. The tendency to overlook the relevance of these values can sometimes lead to a false sense of certainty regarding the appropriate goals of care. To be clear, I am not faulting anyone, especially physicians, for approaching medical practice from a clinical outcomes perspective. After all, I wouldn't want my own physician to think any other way. The point is merely that there are often ethical issues at play long before a classic end-of-life or beginning-of-life dilemma rears its head.

What then are the ethical dimensions of person-centered care that clinicians need to be able to recognize and respond to sooner rather than later? While the details and specifics will obviously vary from case to case, we can say in very general terms based on the reflections above that the short list would include, at a minimum: 1) any salient moral values or personal goals of the patient or patient's family that are impacted by the illness, injury or plan of care; 2) any goods or harms that may be in or come into conflict with one another; 3) any lack of clarity regarding the goals of treatment, which may or may not lead to conflict regarding those goals; and 4) any ambiguity about the application of organizational policy and the ERDs.

Regarding numbers 1 and 2, I am not suggesting that these are the clinicians' responsibility to address, but only that Ethics services can help enhance care that is truly person-centered when these ethical dimensions are recognized. Care-providers can and should be aware of how these personal values and goals of the patient may influence their decision-making regarding their treatment options. Regarding number 3, this clarity can often be achieved short of involving the ethics service, and having clarity around these goals will allow

the care team to communicate more effectively with patients and their families as the medical situation changes and the feasibility of those goals of treatment may be impacted. The fourth ethical dimension identified above is important for two interrelated reasons. First, the ERDs articulate the objective normative framework that guides the organizations particular vision of what constitutes holistic, person-centered care. Thus, the role of the ethics service is not merely to mediate conflict or convince the relevant decision-makers to go along with what has been deemed the clinically best decision, but to help all parties—patients, surrogates and care-providers alike—understand both the limits and possibilities of all treatment options in light of the inherent dignity of every human life. Second, the earlier that ERD or policy related issues are identified, the sooner and more programmatically they can be addressed. The more this happens, the more these considerations will be seen as facilitating rather than impeding efficient, person-centered care consistent with the standards of sound medical practice.

Awareness of these ethical dimensions of person-centered care is especially important with regard to the ability of clinicians not only to recognize further upstream when ethics services can be of support, but also to be able to

identify the central question that should be addressed. Adequate isolation and articulation of the specific ethical dimensions of care will help minimize the number of consult requests that are really just questions that no one else wants to deal with and/or don't fall neatly within the scope of accountability of any one specific job description. This also helps reduce the frequency of the ethics service being called upon to give a second opinion because someone didn't like the first answer they received or opine on a matter beyond their expertise, such as a legal or medical judgement. Moreover, it is difficult to come up with the right answer in response to the wrong question. In some cases, just the very act of reframing and articulating the right central question in light of the ethical dimensions of an issue brings clarity as to the resolution itself. Finally, the ability to identify and articulate the right central question will help ensure the type of ethics support that is most appropriate, efficient and effective for addressing a particular issue.

Not All Ethics Issues Are the Same

A key insight in the design of our model of Proactive Ethics Integration was the realization that not all ethics issues are the same and not all issues require the same level of expertise. In a more traditional model, influenced by the

medical model of physician specialization, ethics is often seen as the sole purview of one specific expert. If you have an ethics issues, you ask the ethicist; just like if you have a heart problem, you ask the cardiologist. Proactive Ethics Integration, however, requires that clinicians whose primary expertise lies somewhere besides ethics be willing and able to act as embedded ethics resources right on the unit or within the service line (in the outpatient setting). This function entails that clinicians be able to answer certain types of more basic ethics questions as part of—rather than in addition to—the performance of their primary clinical responsibilities. Within this model, they also need to know when to triage the more complex issues.

Through reflection on the different types of consultations we have been tracking for a couple of years, the Ethics Advisory Leadership Community of Ascension came to the realization that there are essentially four basic types of ethics consultations entailing varying degrees of complexity: 1. General Advisements, 2. Policy Clarifications, 3. Patient Care Consultations, and 4. Retrospective Case Analysis. General Advisement consists of offering an opinion or clarification for informational purposes only, i.e., the response will not formally be used as the basis for altering

a patient's plan of care. An example of this would be when someone hears of a planned procedure or something that has just occurred and is curious as to how it fits with our Catholic identity. For example, a nurse might say, "I heard they are planning to induce the woman with Preterm Premature Rupture of Membranes and Chorio-amnionitis in room 425, I thought we didn't do that in a Catholic hospital?" The response won't be used to affirm or alter the particular plan of care, but it will help to clarify that and how the planned procedure is consistent with the ERDs for those who might not already understand this. With the right training, there is no reason that the OB Nurse Manager can't be equipped to answer this question, which occurs frequently enough on that unit that it really should not require taking the time to reach out to the ethics committee or ethics service.

As the name suggests, Policy Clarification consists of identifying, applying or clarifying relevant institutional policies and/or the ERDs for the purpose of influencing a patient's plan of care. A common example of this is the question of Do-Not-Resuscitate (DNR) orders in the perioperative setting. There should be at least one person in the surgery center who is aware that the institution has such a policy (assuming it does), who is aware of what it says and who is

able to address the concerns of a surgeon who is hesitant to perform the surgery unless the DNR order is suspended.

Patient Care Consultations are what we traditionally associate with the work of the ethics service and entail a process of gathering facts, identifying norms, and engaging various stakeholders in order to arrive at a recommendation intended to influence a patient's plan of care, and therefore will likely need to be documented in the patient's medical record. While a proactive approach to integrating ethics in the clinical life of the organization will not eliminate the need for Patient Care Consultations, it should increase the capacity of Ethics Committee Members to lead these consultations without the assistance of a trained ethicist. And, as previously noted, there will always be instances of conflict between decision-makers and true ethical dilemmas in the delivery of health care. It remains important, therefore, for clinicians to know how to access the ethics committee or ethics consultation service when the complexity of a case requires it.

Retrospective Case Analysis consists of post-discharge review of a specific case for the explicit purpose of improving existing care processes. Within a framework of Proactive

Ethics Integration, a complex Patient Care Consult is not the end of the work of the ethics service but just the beginning of the work to integrate an institutionalized response to address or even prevent repeat occurrences of the issue further upstream in the care process. Being familiar with this taxonomy of ethics consultation will enable clinicians to know who they can turn to for support in the most efficient and effective manner, once they have recognized that there are ethical dimensions within the delivery of person-centered care that might warrant some sort of ethics support whether from an embedded resource on the unit (or service line), the ethics committee or a formally trained ethicist.

Conclusion

I have taken a long and winding route to arrive at a list of the key things clinicians need to know about ethics. I chose this route because what clinicians need to know about ethics depends on the role we want clinicians to have in addressing ethical issues. If we are content with the traditional model of ethics services, then it should be enough for clinicians to know how to recognize the presence of an ethical dilemma or conflict among decision-makers and who to call in response. Of course, in a Catholic institution, they should also be aware

that the ERDs exist, that they are contractually obligated to abide by them when practicing within the institution and, probably, they should know a little something about any specific directives that are directly relevant to their area of medical practice.

If, however, we want clinicians to take a more proactive role in integrating ethics in upstream clinical processes, then clinicians also need to have additional understanding of the value that ethics can contribute to the patient experience by helping to prevent spiritual, emotional and relational harm and keeping the person truly at the center of person-centered care. Along with this more robust concept of Ethics, clinicians also need to understand the different dimensions of an issue that makes it an ethics issue as opposed to a legal, risk, or spiritual care issue, for example. Finally, familiarity with the different levels of complexity entailed by different types of ethics issues will enable clinicians to access the targeted type of ethics support they need in the most efficient and effective manner possible, which just might also lead to improvements in the provider experience as well.

¹ Our model of Proactive Ethics Integration is similar to the model of Next Generation Ethics Committees, but with difference stemming from a greater emphasis on

embedded ethics services rather than on the committee itself. See, for example, Murphy, Kevin. "A 'Next Generation' Ethics Committee." *Health Progress* 87 (March-April 2006): 26-30.

² Pryor, David, Ann Hendrich, Robert J. Henkel, et al. "The Quality Journey At Ascension Health: How We've Prevented at Least 1,500 Avoidable Deaths a Year—And Aim to do Even Better." *Health Affairs*. (April 2011): 604-611.

³ See, for example, Pavlish, Carol L., Joan Henriksen Hellyer, Katherine Brown-Saltzman, et al. "Screening Situations for Risk of Ethical Conflicts: A Pilot Study." *American Journal of Critical Care*. (May 2015): 248-257.