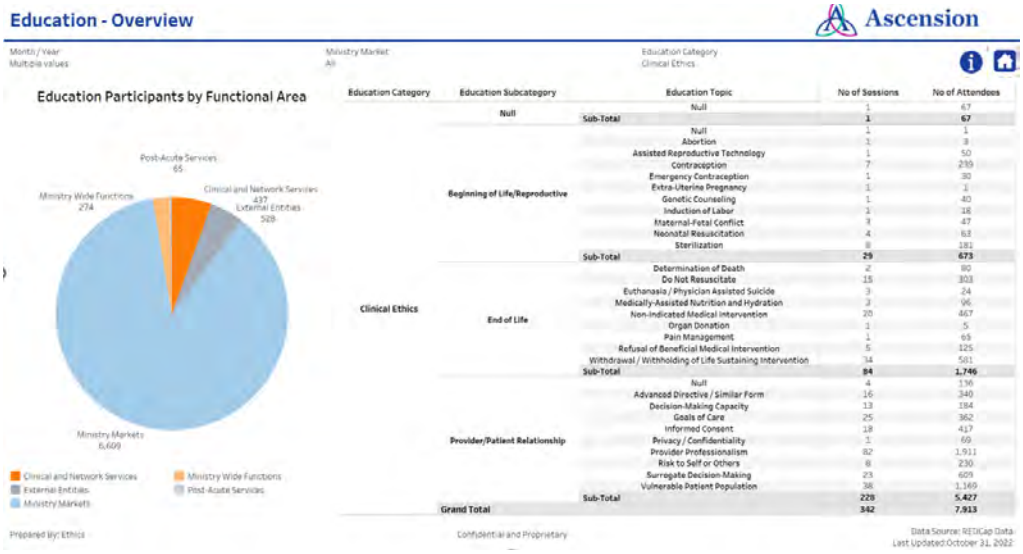
Ethics Consultation and Education: The Chicken or the Egg?

Matthew R. Kenney, Ph.D.

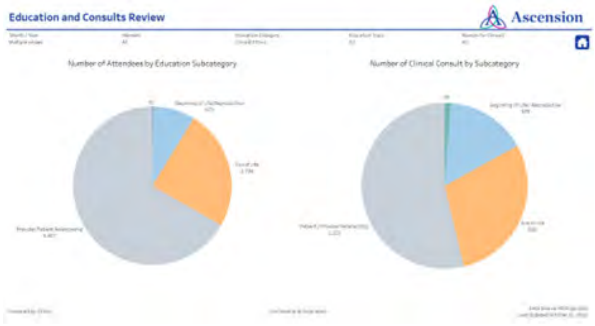
By comparing data visualization charts utilizing Tableau which delineate both clinical consultation and ethics education categories, this article will explore a correlation between the proportions of the number of attendees in clinical ethics education sessions and the number of clinical ethics consultations in the same subcategories. This correlation gives rise to a question:

Is clinical ethics education being provided in response to the level of clinical consultation requests, or do education sessions lead to a greater awareness of the topic and a correspondingly higher volume of related consultations?

The graphic below shows the total of clinical ethics education activities and participants broken down by functional area (see pie chart on the left) and by education topic (see table to the right), for FY21 - FY22 combined. Ascension's Ethics Center of Expertise provided or co-presented 342 clinical ethics education opportunities reaching 7,913 participants in FY21 and 22, in addition to the 475 Ethics Integration Committee members who participated in 57 virtually-delivered or in-person Clinical Ethics Intensive events. Of those 342 education sessions, the vast majority (228 sessions reaching 5,427 attendees) were related to provider-patient relationship topics.

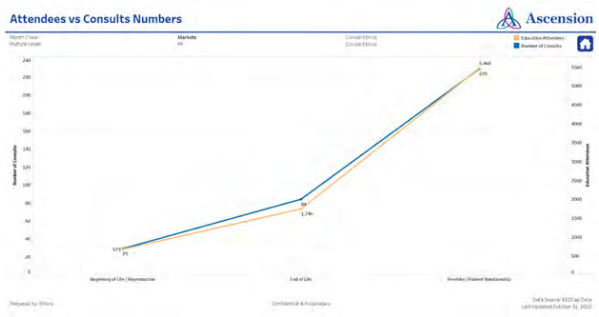


The remaining sessions were divided across beginning of life/reproductive topics (29 sessions reaching 673 attendees) and end of life topics (84 sessions reaching 1,746 attendees). The pie graphs below illustrate a correlation between the proportions of the number of attendees in clinical ethics education sessions and the number of clinical ethics consultations in the same subcategories. In other words, the number of attendees in clinical ethics education regarding beginning of life subcategory and the number of clinical ethics consultations in the beginning of life category are the smallest segments of the pie; the end of life subcategory in both number of education attendees and clinical consultations are the next biggest segments; and, finally, the provider-patient relationship subcategory is the biggest for both clinical ethics education attendees and subcategory of reason for consults.



This correlation gives rise to the above-mentioned "chicken or egg" question: is clinical ethics education being provided in response to the level of clinical consultation requests, or do education sessions lead to a greater awareness of the topic and a correspondingly higher volume of related consultations? Two competing hypotheses emerge in response to this question. The first concerns whether the education topics are determined in response to the volume of clinical consultations, implying that education efforts are predominantly within the "responsive service modality." The responsive service modality essentially consists of ethicists responding to clinical consult requests and supporting organizational decision-making at the discretion of clinicians and operational leaders. The responsive service modality is more like traditional consult support but with the goal of being less reactive (i.e. putting out fires in the 11th hour) and -- to a greater extent -- informed by communal reflection in light of shared experience, data analysis and best practices from across Ascension. The goal, here, is to use the data collected through our Ethics Integration Database (EID) and the collective wisdom and experience of Ascension's Ethics Advisory Community (EAC), comprised of ethicists across the system, to minimize those scenarios where the urgent and emergent issue does not allow time for critical thinking and reflective practice. The second hypothesis concerns whether more clinical consults arise as a result of attendees' ability to better recognize when a consult is appropriate as a result of the education. In this sense, Ascension's education efforts serve a more "embedded service modality," insofar as they are equipping and empowering those receiving the education to more effectively participate in the ethics process. Further analysis of these hypotheses is merited, as we have now seen a significant correlation in this trend over two fiscal years (FY21 and FY22). It would not be surprising if the answer turned out to be a "both-and" where we both provide additional education in response to increasing or significantly complex clinical consults in a given area, and where increased education on a topic leads to a greater awareness of the ethical dimensions of care at play within the topic, and the need for ethics support in navigating these issues.

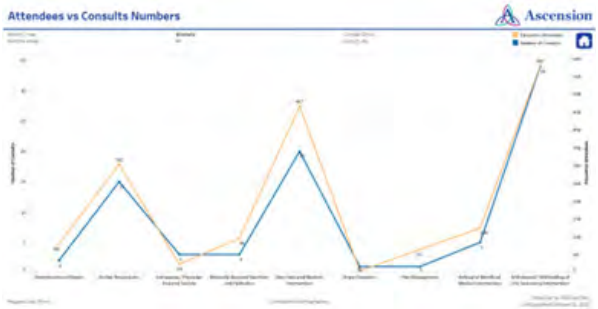
Though we will not undertake that additional analysis here, the graphs below provide a view of how the number of attendees of education sessions on particular topics in the clinical realm correlate with the number of consults per clinical consultation on the same topic. At this level of generality, the correlation is close enough that the two lines representing the number of attendees in relation to the number of consults per clinical consultation subcategory (i.e., Beginning of Life, End of Life and Provider-Patient Relationship) overlap almost perfectly, suggesting a strong relationship.



When we look even deeper into the attendees of education sessions by topic relative to the same reason for clinical consultation within the subcategories (i.e., Beginning of Life, End of Life and Provider-Patient Relationship ordered as such below), as demonstrated in the line graphs below, we see that there is only slight variation. Even without being able to read the full details of the chart, one can see that the general shape of the lines of the graph still follow the same pattern, suggesting that the substantial correlation between the number of education attendees and the number of clinical consults extends beyond the broader categories of Beginning of Life, End of Life and Provider-Patient Relationship to the more granular level of "reason for consult."

BEGINNING OF LIFE/REPRODUCTIVE (FINANCIAL YEAR '21 AND '22)

END OF LIFE (FINANCIAL YEAR '21 AND '22)



PROVIDER-PATIENT RELATIONSHIPS (FINANCIAL YEAR '21 AND '22)

Although we have not delved deeply enough into these data to answer the questions posed by the two hypotheses above, we already know that the responsive modality of ethics education is an important activity that supports an ethical culture of care and strengthens

Ascension's identity as a healing ministry of the Catholic Church. Ascension's Proactive Ethics Integration (PEI) paradigm was never intended to eliminate the need for ethicists to be available to respond to requests and needs of the organization. To the contrary, the idea of being responsive to the needs of those we serve and those with whom we serve is critical to the success of the PEI paradigm. What this approach does seek to eliminate is a reactive posture, in which the need to respond urgently and quickly takes precedence over reflection regarding all relevant values given our Catholic identity and both short-term needs and long-term solutions. In short, it is much more difficult to provide high quality ethics services that shape the ministry identity and culture of the organization consistent with our Catholic values, if one is only and constantly "putting out the next fire." A responsive posture, on the other hand, enables a quick and timely but still comprehensive response at the right time, in the right place, by the right person.

MATTHEW R. KENNEY, PH.D.
Vice President, Ethics Integration and Education
Ascension
St. Louis, Missouri
matthew.kenney@ascension.org