Getting to Know You: Building an Ethics Consultation Service From the Ground Up

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A perennial difficulty in building a new ethics consultation service is trying to explain and to advertise the service to health care professionals. While health care workers in a hospital don't need a primer on the cardiology service, for example — what they do, and when they might be needed for patient care — ask any physician or nurse in a hospital with a new ethics service what ethics is and when they think it's appropriate to call a consult, and you're likely to get shrugged shoulders, a comment about "legal issues," or even an angry "we act ethically so we don't need ethics on our unit."

In our 800+ bed, adult quaternary care Catholic academic medical center, we recently reorganized and relaunched our ethics consultation service that had previously been dormant. We established a 24/7 on-call service staffed by a mix of professional and trained volunteer ethicists using an individual model, in which the consultant on call was available to come to the bedside in real time to talk to stakeholders and help resolve ethical issues. Our first, and biggest obstacle, was to let people know we existed. Our second was to dispel several myths about ethics. Among these myths were fears that we were the "ethics police" who were only called in when a doctor had done something wrong; that calling for an ethics consult meant convening a committee to deliberate over a case, which seemed excessive for "minor" ethical issues; that ethics was merely another arm of the legal/risk management team; and that ethics deliberation was just about "what feels right" and therefore lacks any standardization or objectivity.

Faced with these challenges, we implemented two projects simultaneously to try to share the purpose and usefulness of the ethics consult service far and wide across the institution: embedding in daily multidisciplinary rounds (referred to as the "huddle") and meeting with the nursing staff on each floor to distribute a resource binder and explain the service. These approaches have taken our service from 12 consults in the year we launched to over 100 consults a year two years after reestablishing our service.

We began by visiting the medical ICU and introducing our service to the physicians and nurses with the help of an intensivist who

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was involved with our ethics committee. They already had a daily multidisciplinary huddle where the attending physician met with the nurse manager, social worker, and chaplain, among other professionals, to discuss each patient in the unit and primarily discuss disposition or other social work needs. We asked to sit in on those meetings, and in time started asking questions during the meetings about identification of surrogate decision makers or if the team was having difficulty with family dynamics. We took those opportunities to explore how we might be able to help the difficult situations they faced, and our consults from that unit increased.

When the critical care service decided that such daily huddles needed to be standardized across all ICUs, the care line chief also asked that the ethics team be included given the benefit we had offered in the MICU. We expanded our attendance to all five medical and neurosurgical ICUs, and our consult numbers increased dramatically. We found that often the care teams not only were having to figure out how to navigate ethically challenging situations on their own, but also didn't know what questions they needed to be asking. Within a few weeks of rounding, these ICU teams gave us feedback that our presence and contributions to the discussion were invaluable, especially regarding questions about surrogate decision makers and various aspects of informed consent.

Our second intervention was to create a resource binder containing the most salient ethics-related information for each nursing unit and ICU. There were two components to this intervention: the binder itself, which remained on each floor and ICU for the benefit of the staff, and the short meeting with the nursing staff to give them the binder and introduce its contents.

The binder is separated into four main sections: the Ethics Consultation Service; Ethical Guidance; Important Forms; and Policies and Procedures. Our Ethics Consultation Service section describes our service and what we can offer, as well as suggested scenarios in which it may be helpful to call ethics and how to call for a consult. It also includes a magnet with our contact information for display.

Ethical Guidance begins with a one-page curated summary of the most helpful *Ethical and Religious Directives for Catholic Health Care Services*. This was an important addition, as the hospital had been affiliated with the Episcopal Church and was only recently acquired by a Catholic health system. For this reason, many of the physicians and staff were unaware of the *ERDs* or unclear about how they were relevant to patient care. This section also includes a table summarizing the statutory hierarchy for surrogate decision-making, which in Texas is different depending on whether the decision to be made is regarding routine or life-sustaining treatment. Finally, we include a table summary of advance directives, describing the purpose of various AD forms, why they are chosen, and the benefits and drawbacks of each.

The Important Forms section is one that is often referenced by staff. It contains copies of statutory advance care planning forms to help staff identify the type of document a patient has brought in: Medical Power of Attorney; Directive to Physicians; Out of Hospital DNR; and Statutory Durable Power of Attorney. Each form is annotated to point out the most important features, including

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witness requirements, as well as how the staff is permitted to participate in completing the documents depending on their role on the health care team.

Finally, we included the most ethically relevant hospital Policies and Procedures, which the staff has stated is most helpful for them in their everyday practice. This includes policies on Medical Decision-Making, Advance Directives, End of Life Treatment Decisions, DNAR orders, and advance directives for Mental Health Treatment.

Rather than merely drop off the binders on each unit, I scheduled a time with each nursing director to speak with the entire nursing staff during their daily morning huddle at handoff. This allowed me to meet with as many nurses as possible during their shift change. I began by describing our service, dispelling the myths I articulated above and answering questions (or fielding concerns). I then explained the contents of the binder, drawing attention to the front cover which prominently displays our service call number. Many of the nurses during these meetings had not even heard of our service, but a few who had were able to tell stories about ethics consults they had been a part of in the past. This had the benefit of increasing our consult volume, as well as encouraging nurses to attend our educational offerings and become more involved in our ethics events. Some nurses who heard about ethics through these huddles went on to join our Ethics Committee as well.

While we are still in the building phase of our consult service, these two interventions have helped to increase awareness of the consult service throughout the hospital and address concerns of the physicians and staff that we are unhelpful, punitive, or only involved in big, messy cases. We have built relationships with many nursing directors and physicians, which have enabled us to offer educational sessions for specific care lines and act as a resource for departments across the hospital. While each hospital's culture — and resources — vary widely from one institution to the next, we hope that by sharing some of our tools that other services may be able to use them to build their services and gain buy-in from stakeholders.

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