Shared Ethics Call: Responding to the Needs of the Organization and the Health of Its Ethicists

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Even the most proactive and high-functioning ethics consultation programs have a need for quick access to expert ethicists when emergent and sensitive issues arise in the field. To respond to clinical ethics concerns quickly and with the right level of expertise, ethicists frequently make themselves available around the clock.

However, for a multi-facility health care system, there is an opportunity to coordinate response efforts to increase work-life balance for the team of ethicists and meet the demand for expertise in addressing time-sensitive clinical ethics issues. The solution for Mercy was the creation of one shared call number, accessible for all facilities, for ethics support during weekend and holiday hours. This seemingly simple transition changed the way the team of ethicists engaged, increased teamwork across facilities, solidified continuous learning opportunities and created a healthier work-life balance for the individual ethicists.

Prior to moving to shared ethics call coverage, the team of ethicists individually covered their facilities or geographic areas. This approach worked well because it allowed for easy *navigation through the challenges of different state laws and reinforced well-established* relationships with the facility's resident ethicist. However, this approach also perpetuated an "always on" mentality for our clinical ethicists, making personal time away an illusion versus a reality. In order to meet the needs of both the organization and the well-being of the ethicists, Mercy transitioned to a call model where ethicists rotate coverage for weekend and holiday call across the entire organization. In addition to increasing work-life balance, the new shared call solution created standardized processes for responding to consultation requests across all facilities and facilitated the collection and cataloging of local resources and contacts.

In order to make the transition from facility or geographic coverage to shared ministry-wide coverage, seven critical steps needed to occur. The first five steps were accomplished before the switch to the new shared call model, and the last two continue to occur to this day.

1. **One shared phone line –** The ability to rotate call between several ethicists using one consistent phone line

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required the use of telecom technology[1] to set up a unique number that could be "publicly" shared across all facilities. This shared number prevented the inevitable challenges that come with rotating coverage when phone numbers are unique to the individual providing coverage (e.g., communicating last minute schedule changes). With the use of the technology, calls are forwarded to the personal line of the ethicist on call, and changing those personal lines is accomplished on the back end with no disruption to the publicized shared call line number.

2. **Share and access resources –** To ensure all ethicists had readily-available access to specific information about the local facilities (e.g., contacts, call schedules, policies), a website-based collaboration system[2] is used to house and share all resources. All ethicists have the access to share and pull information from the system as needed.
3. **Scheduling –** The shared call schedule covers all weekends and holidays. The start and end times are defined on the schedule for ease of educating and disseminating the appropriate contact for ethics consultation depending on the time. For weekends, call begins at 4:00 p.m. on Friday and ends at 8:00 a.m. the following Monday. Holidays follow a similar time structure and are either an extension of the weekend or stand-alone depending on the day of the week. Ethicists equally share number of holidays and weekends throughout the year.
4. **Education on local laws, procedures and cultures –** To prepare for the switch to shared call coverage, intentional education and conversation about local laws, procedures and cultures were crucial. While each ethicist had access to information regarding these local details, education sessions allowed all ethicists to dive into the nuances of state laws or local cultures.
5. **Socialization to the process –** The transition was a big change, not only for the ethicists, but also for the facilities who were very comfortable knowing whom to call for emergent ethics consultation needs. For the transition to be successful, each local ethicist had to educate, advertise and make resources available for the clinical teams to readily access the new shared call number. Each local ethicist was charged with ensuring the right teams had the correct contact information and understood the new process in preparation for the switch to the shared call model.
6. **Proactive prevention and "Heads Up" –** As each weekend or holiday approaches, the team sets the weekend call ethicist up for success in two ways. First, the local ethicist seeks to resolve or stabilize any ongoing ethics concerns before the start of the call time. Second, the local ethicist provides the on-call ethicist with information regarding any lingering or potential ethics challenges that could surface over the shared call time. The ethics "heads up" allows for continuity in response between the start and close of the consultation regardless of the ethicist responding.

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7. **Ongoing process improvement –** This final step is one of the most important as it allows the team to continue to develop the best possible ethics support over time. Each Monday, the team of ethicists meets and discusses the ethics concerns addressed over the weekend/holiday. These discussions allow for faster recognition and response to growing organizational concerns, enable continuous learning in clinical ethics consultation across different states, and provide a quick assessment of the ethics consultation activity throughout the organization.

Each health care organization has a slightly different structure and process for addressing emergent ethics consultation needs. However, even with these differences, the task of ensuring the right level of expertise is available at the right moment remains a responsibility for all health care ethicists. The shared call model represents one possibility for extending the reach of ethics expertise throughout the organization and contributes to efforts to create healthy balance for the scarce resource of highly trained and skilled ethicists.

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ENDNOTES

1. Technology platform is Cisco's *Unified Communications Self Care Portal*
2. Initially, SharePoint was the platform used for collecting and sharing resources, but the team later migrated content to Microsoft Teams. Both platforms work well for storage but migrating to Microsoft Teams made the resources a little easier to access and edit.

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