The Clinical Ethics Consultation Benchmarking Collaborative Initial Findings

Identifying commonalities between and among ethics consultation services remains a difficult task given the lack of uniformity in data collection efforts.[1,2] Numerous studies have demonstrated the value of robust data collection, including the need for a shared set of variables[3] to assess case complexity,[4] determine volume,[5] and standardize data collection practices[6] so to make intra-institutional comparisons[7] and ultimately improve ethics consultation services in the United States.

Ethics leaders from various health systems and hospitals came together to form the Clinical Ethics Consultation Benchmarking Collaborative (CECBC) to build a broad, enduring coalition to identify, develop, and recommend metrics for a robust data set for empirical studies of ethics consultation activities across institutions and geographies. These data would include consult volume, time spent in ethics consult work, consult distribution across clinical units, as well as emerging metrics of interest to understand and improve the quality of clinical ethics consultation work.

The CECBC created an online data collection instrument which was distributed in May 2022 via a variety of clinical ethics listservs, such as the Medical College of Wisconsin's Bioethics Listserv, the Clinical Ethics Consultation Affinity Group (CECAG) of the American Society for Bioethics and Humanities (ASBH), and the ASBH general membership mailing list, as well as other email lists, requesting 2021 ethics consultation data at individual ethics services. The CECBC hypothesized that aggregated data on consult volume, distribution across units, time spent engaging in consult work, and other metrics of interest would be a valuable resource to better understand of the work of clinical ethics and improve high-quality ethics consultation practices. There were 22 variables requested with 17 coming from publicly available sources related to the composition of a particular hospital, for example, number of staffed beds, trauma designation, etc. From the collected data, the CECBC team calculated specific metrics to assess the ethics services at the hospitals and describe their activities. One calculated metric derives from a measurement created by Glover et al 2020 to describe the proportionate need (and response) of ethics consultation by licensed bed size of a facility. The consult-to-bed ratio (CBR) allows a hospital to see their relative consult volume as 'high' (CBR greater than 0.500) and 'low' (CBR less than 0.500).

Respondents from 330 hospitals within 24 health systems (3 Catholic) across 32 states provided significant insight into the ethics resources within their respective services. Close

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to ten thousand (9,759) ethics consultations were conducted across 68,587 staffed beds and among 2.78M annual admissions. While the bulk of the ethics literature around ethics consultation services has been derived from academic medical centers[8,9] only 8.5% (n=28) of CECBC submissions were from academic medical centers. Close to half (45%) of the responses were from acute care general hospitals (n=148) followed closely by 28% from community hospitals (n=91), 14% critical access (n=45), and 4% specialty hospitals (n=13). Less than 2% of submissions came from children's hospitals (n=5). Close to 40% of responses (n=125) were from hospitals with 0-99 beds followed by 70 (21%) 100-199 bed hospitals, 52 (16%) 200-299 bed hospitals, 37 (11%) 300-399 bed hospitals, 20 (6%) 400-499 bed hospitals, and 27 (8%) were 500+ beds. To put this into perspective, the American Hospital Association reported 6,129 hospitals in the US in 2021.[10] Of those, 3,474 hospitals were 6-99 beds, 1,176 were 100-199 beds, 603 were 200-299 bed hospitals, 352 were 300-399 bed hospitals, 178 hospitals had 400-499 beds, and 346 hospitals had 500+ beds.

A significant finding came when the CECBC team stratified bed size by the average number of ethics consultations. Hospitals with 6-24 beds reported less than one consult per year whereas hospitals with more than 500 beds reported almost 160 average consults per year. The difference between smaller (100-199 beds) and mid-size hospitals (200-299 beds) is striking; a jump from 12 consults per year to 30 consults per year. Yet the difference between the 200-299 bed hospital and the 300-399 bed hospital is only one additional consult. Unsurprisingly, there is significant increase in volume when bed size increases with an average of 72 consults per year at 400-499 bed hospitals. Small hospitals (25-49 beds) averaged about two consults per year and hospitals with 50-99 beds reported about six consults per year.

The CECBC team calculated a mean consult-bed ratio (CBR) of 0.11 (median: 0.0395). The CBR for each of those facilities are as follows: CBR = 0.33 at academic medical centers (low volume), CBR=0.1 at acute care hospitals (low volume), CBR=0.050 at community hospitals (low volume), CBR=0.024 at critical access hospitals (low volume), CBR=0.054 at specialty hospitals (low volume), and CBR=0.108 at children's hospitals (low volume).

Despite accounting for less than ten percent of respondents, 93% of the services at academic medical centers received funding compared to 43% of acute care general hospitals, 15% of community hospitals, 41% of critical access hospitals, 31% of specialty hospitals, and 50% of children's hospitals. Just over sixty-six (66.17) full-time equivalents (FTEs) were devoted to ethics services.

This initial data collection demonstrates a novel and important starting point for ethics services across the United States. As previously argued,[11] the vast majority of ethics services provide care for patients in other-than-academic medical centers but as these findings also show, there is significantly less funding for those services than at academic medical centers. Catholic hospitals comprise 665 hospitals in the United States accounting for almost 5 million inpatient admissions[12] yet we heard from only a fraction of those facilities (about 250). Our hope in the next round of data collection that we understand more about the barriers and challenges to providing high-quality ethics consultations. The unexpectedly high number of submissions suggests a desire of many

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ethicists to establish benchmarks and to better understand the field beyond one's own practice environment. For example, another metric developed by Glover et al has the same goal of the CBR but attempts to account for the fact that a hospital's licensed bed count does not always correspond to the volume of patients admitted annually. The consult-to-admission ratio (CAR) is a companion to the CBR and adds nuance. The differences between a 'high' consult volume (CAR greater than 6.00) and a 'low' consult volume (CAR less than 2.99) can be better assessed when CBR and CAR are analyzed together. This metric is currently review by the CECBC team and will be analyzed for a future publication.

The collection for 2023 data will occur later this year in 2024. We encourage all our colleagues and anyone responsible for clinical ethics consultation in Catholic healthcare to contribute to the Collaborative in future years. To find out more information, please visit the CECBC website www.cecbc.net. A larger set of data will hopefully lead to the development of normative and predictive metrics which could help support more dedicated resources to this crucial work. A strong representation of Catholic hospitals will allow us to better describe the nature of this work and promote the common good of clinical ethics across our ministry. ✠

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ENDNOTES

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