When to Hire a Clinical Ethicist

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As evidence that clinical ethicists provide financial benefits to hospitals increases, and as the field of clinical ethics moves more towards professionalization, the number of clinical ethics positions is growing, both inside and outside of Catholic health care. While the Catholic Health Association (CHA) recommends that multi-facility systems have an ethicist at the system level and smaller systems at least have access to one, no organization or entity has yet published or discussed staffing models for ethicists.[1] While staffing models exist for nurses, social workers, hospitalists, and many other health care professions, no comparable guide exists for ethicists. This is a first attempt at a staffing guideline for clinical ethicists at the regional or facility level.[2] (Table 1) CHA describes qualifications for these positions elsewhere.[3]

Table 1

Element	Metric
Necessary (any one of these indicates a serious need)	
Bed Count	≥ 350
Average daily census	≥250
ICU beds (excluding NICU)	≥ 50
Trauma	Level 1
Strongly Recommended (any one of these and at least one from the Conditional list indicate a strong need)	
Case Mix Index	> 1.7
Specialty service line with high acuity	1. NICU - Level3 2. Burn Center 3. Pediatric Hospital 4. Fetal Surgery 5. Maternal Fetal Medicine 6. Transplant Program
Clinical Research	> 100 protocols open annually in > 3 disciplines
Insurance	> 50% Medicare patients
Conditional (3 or more criteria indicate a strong need, 2 or more warrant serious consideration)	
Residency program	Medical, Pharmacy, or Chaplain
Clinic volume	≥ 65,000 patient encounters per year or > 5,000 Medicare patients
Cancer center	> 7,000 patient visits per year
Deliveries	> 3,000 per year
Palliative Care	Median penetration rate or higher (CPAC) • <150 beds, 343 consults per year • 150-499 beds, 718 consults per year • >500 beds, 1,874 consults per year
Ethics Consult Volume	≥ 100 per year
Specialty services	1. Phase 1 Clinical Trials 2. Inpatient Psychiatry 3. Neurosurgery 4. Outpatient Dialysis 5. Inpatient Rental Unit 6. LTACH 7. ACO
Region size	3 hospitals between 200 and 350 beds and ≤ 1-hour drive from each other

CAPC - Center to Advance Palliative Care ACO - Accountable Care Organization LTACH - Long Term Acute Care Hospital

The criteria below are based slightly on evidence from the literature, but mostly from my experience as an ethicist at the local, regional, and system level as well as the experience of multiple outpatient clinical leaders.[4] This warrants four caveats: first, it is very likely some relevant criteria have been overlooked; second, it is possible some criteria below are not relevant; third, some criteria may be better placed in another category; and fourth, the numerical metrics may be too high or too low. Most importantly, this guide represents the minimum staffing levels that are appropriate; they do not address when or why a region might have more or fewer full-time equivalent (FTE) positions devoted to ethics. Thus, they cannot justifiably be used to reduce the number of ethics positions given the amount and kind of evidence currently available.

ETHICS STAFFING CRITERIA

The criteria are divided into three categories: Necessary, Recommended, and Conditional. A facility or region that meets any criterion in the Necessary category has the most serious need for a clinical ethicist. The only criterion with evidence is bed count. A foundational survey of ethics committees in U.S. hospitals found the volume of ethics consults jumps 67% at 300 beds.[5] My own experience suggests 400 beds, so the guide recommends the halfway point between them. Since bed counts are often inflated, average daily census is also included. The rest of the Necessary category is based on the high acuity and volume that come with trauma and intensive care.

The Strongly Recommended category reflects a strong need for a clinical ethicist. As this category is not as strong as the first, a facility or region must meet one of these criteria plus one from the next. The metrics for the criteria and the specific service lines come from hospitals I believe need an ethicist based on my experience working with them. Catholic hospitals with a maternal fetal medicine physician have a particularly strong need for an ethicist due to the acuity and nature of the medical problems these physicians encounter.

Lastly, the Conditional category includes an array of other criteria to consider. Individually, these criteria likely do not warrant hiring a full-time ethicist, but a combination of any three indicates a strong need, while two indicate a need to seriously consider hiring one. Three criteria stand out in the category of outpatient services and palliative care. First, health care has moved beyond hospital-based acute care and the role of clinical ethics is increasing in outpatient care. These metrics come from experienced clinical outpatient leaders and their opinions on what constitutes a high-volume or high-acuity outpatient network. Second, while one might think palliative care reduces the need for ethics consults, in my experience the volume decreases slightly but the complexity of ethical concerns increases significantly. Third, the incidence rates of preeclampsia (1.4 in 1,000 before 28 weeks), premature rupture of membranes (4 in 1,000 around viability), and other causes of induction mean that regions with 3,000 deliveries a year could have up to 12 cases annually of potential induction of labor before viability.[6] The implications for the patients and the hospital warrant the regular discussion and availability a clinical ethicist can provide.

CRITIQUE AND FUTURE DIRECTION

As this is an initial draft guideline, some critiques are worth making to help guide future versions. First, while the guideline includes

outpatient service lines and outpatient visit volume, it is heavily focused on inpatient facilities. More criteria and nuanced metrics for outpatient services would better reflect the entire continuum of care. Second, the guidelines do not account for ethicists responsible for certain areas across a system. For example, a large system might have an ethicist responsible for home health and long-term care, all outpatient services, or clinical research. Third, the Necessary category should be expanded to include criteria that warrant two, three, or more ethicists rather than just one. Similarly, the Conditional category should include options for an FTE divided between ethics and another function, such as a mission leader or social worker who meets CHA's Qualifications for Ethicists and has protected time devoted to clinical ethics.

Clearly more input and review from other ethicists, systems, and organizations are needed before these guidelines see widespread use. Standard recommendations from an authoritative organization would assist health systems in determining where to place dedicated ethics resources and help those arguing for expanded professional ethics support in their facility or region. I hope this initial draft will be used as the basis for just such an effort.

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ENDNOTES

1. Catholic Health Association, *Striving for Excellence in Ethics*, 1.a., 1.b., p 15.
2. These criteria were first presented at the Catholic Healthcare Innovation Forum (CHIEF) at the CHRISTUS Health System Office in Irving, TX on December 16th, 2019. No changes have been made based on discussions at CHEIF.
3. CHA, "Qualifications and Competencies for Ethicists in Catholic Health Care", May 2018, www.chausa.org/docs/default-source/ethics/ethicist-competncies-may-2018.pdf?sfvrsn=0.
4. I would like to thank Mark Repenshek, PhD at Ascension Health for his input on an earlier draft of the criteria.
5. Fox, E., S. Myers, and R. A. Pearlman. "Ethics Consultation in United States Hospitals: A National Survey." *American Journal of Bioethics* 7, no. 2 (Feb 2007): 13-25.
6. Kongwattanakul, Kiattisak, Piyamas Saksiriwuttho, Sukanya Chaiyarach, and Kaewjai Thepsuthammarat. "Incidence, characteristics, maternal complications, and perinatal outcomes associated with preeclampsia with severe features and HELLP syndrome." *International journal of women's health* 10 (2018): 371. Waters, Thaddeus P., and Brian M. Mercer. "The management of preterm premature rupture of the membranes near the limit of fetal viability." *American journal of obstetrics and gynecology* 201, no. 3 (2009): 230-240.