Responses From Beta Group Participants

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Heyl: Having participated in ethics consults at a large tertiary-care Catholic medical center for six years, I eagerly anticipated the ethics consultation database that Mark Repenshek had developed in conjunction with Harmony Technologies, and enthusiastically agreed to participate in the *Beta* group. While understanding that the larger goal was to assist in the development of a tool and processes to use ministry-wide, my personal hopes for the database lay in three areas: 1) to measure work done and demonstrate the value of ethics consultations to my organization; 2) to validate (or correct) the direction in which the ethics committee had been moving in addressing issues upstream; and 3) as a result of the first two, to pave the way for ethics to collaborate with other departments to address quality improvement in systemic issues. Over six years I had collected a good deal of data that had, for the most part, gone unanalyzed. This gave me all the more reason to hope that the *Ethics Tracker* database could, at the very least, confirm or correct the direction that the ethics committee had pursued over the years. We had already started proactive ethics screening for certain indicators in order to address issues we had seen frequently in ethics consults. Again, the hope was that the analysis would show if we had pinpointed the correct indicators and to what degree the proactive screening was successful.

Mark has made a strong case for the Catholic health care ministry to engage the literature on *the* model for ethics consultation along with *the* standards of what constitutes an ethics consult. Upon reflection on my participation in the *Beta* group, I realize that I let my personal hopes for the database outweigh the larger goal for the Catholic health care ministry. I would like to share some of the challenges I've encountered while working with the *Ethics Tracker* database and end with why I believe this work should continue.

Procedurally, the first challenge was finding the time and/or talent to input the data. The retrospective data did not contain all of the data fields for *Ethics Tracker* so some reconstruction of the case was necessary. Secondly, the timing of the *Beta* group activities coincided with the implementation of the electronic medical records (EMR) at my organization. Priorities of the IT department with the EMR rollout precluded any work on interfacing the database with other systems or the EMR itself. Finally, with competing obligations, data input took the lowest priority. The major conceptual challenge was defining what constitutes an ethics consult. Mark comments that it was a given; however, because one of my goals for the database was to illustrate the scope of requests made to the ethics department and the time taken to appropriately address those requests, I expanded the definition beyond the data field parameters. I discovered late in the game that by adding numerous "Discerned Reasons" for consult requests, my results would not fit into the larger goals of the *Beta* group.

My motivations were directed locally rather than globally, and perhaps I was remiss in not keeping in closer contact with the members of the *Beta* group to ask what challenges they faced and how they were addressing them. On the local level, I had hoped to have data entry completed on ethics consults for the previous two fiscal years (July 2007-June 2009) with reports generated in time for our January 2010 Ethics Committee Meeting.

However, due to the logistical challenges of retrospective data input, as well as the need to correct my expanded definition of what constitutes an ethics consult, I was unable to realize the first two local goals. I expect that this can be completed by March 2010. With regard to the third local goal, ethics has been included in collaborative efforts with other departments addressing quality improvement in systemic issues. However, I'm convinced that with hard data, ethics can have a greater influence in setting the priority of projects to address these issues. I remain convinced that the *Ethics Tracker* database is a useful tool to achieve these goals. Moreover, I believe that with further work and direction from the *Beta* group this can expand to other members of the ministry as we work to, as Mark says, "discern standards for those entering the privileged space of the patient-physician relationship to offer ethics consultation."

Sanders: Mark argues in his article that there is an obligation outlined in the *Ethical & Religious Directives for Catholic Health Care Services,* Directive #37, for Catholic health care ministries to develop standards for ethics consultation practice, measures for its quality and effectiveness, and qualifications for ethics consultants. Mark parallels his argument with the developing literature addressing standards and quality for ethics consultations outside of Catholic health care. Although Catholic ethics consultations are not exclusive from the quality measures outlined in this literature, Mark suggests

that it is time for the Catholic health care ministry to address these standards within its own understanding and purpose of an ethics consultation.

There is no doubt in my mind that using a program like *Ethics Tracker* can make significant contributions to establishing standards for ethics consultation in Catholic health care. Many Catholic institutions already track their ethics consultations, at least on paper. Although my evidence is anecdotal, I suspect that, at minimum, these records include information such as who requested the consult, when the consult was requested, the reason for the request, relevant patient information, ethical analysis and recommendation.

What struck me about *Ethics Tracker* was the drop down menu for the discerned reason of the request, and how it might appear to a staff member and/or physician who accessed this menu in a Catholic health care setting. The list included options that might be considered routine for ethics consultation in any setting, such as *'Conflict-code status'*, *'Concern regarding non-beneficial interventions'*, and *'Discerning decision-making capacity'*. The list included other options that are unique to a Catholic health care setting, such as '*Direct/Indirect-ERDs,* and '*Pre-term mature rupture of membranes-ERDs.* Finally, the list included options that may not be considered unique to Catholic health care, but with a unique lens or perspective, such as *'mission/care values'*, *'stewardship'*, and *'common good'*.

As the pace of health care and demand for quality increases, staff will increasingly rely upon the information they need to enter into a medical chart (most likely electronic) as a measure of their obligations to patients and families. Increasingly, patient and family care may be directed by what information is required and available in an electronic medical record. From this perspective, a program like *Ethics Tracker* holds great potential to sustain and expand ethical discernment in Catholic health care by making easily identifiable categories of ethical concern available to professionals who frequently change jobs and practice in numerous settings.

In my mind there is both an opportunity and a word of caution here. Mark's plea is for the Catholic health care ministry to develop standards for ethics consultation within the ministry's own understanding and purpose of ethics consultation. Much of this understanding and purpose will be outlined to physicians and staff through the 'reason for request' categories, such as listed above. I believe it is imperative to be aware that an effort to standardize the practice of ethics will also likely provide the lens through which professionals view ethics in Catholic health care in the future.

If such tools provide and shape the moral lens of the professionals who use them, attention to the breadth, depth and clarity of the categories will be key. In my mind categories such as *'mission/care values'*, and *'common good'*, can help shape and sustain

ethical discernment in Catholic health care, but they may need more development. What does a mission or care value look like in health care? How does an issue of the common good arise in patient care? Such categories may help to educate staff and empower them to address ethical concerns in unique ways in Catholic health care beyond prohibited procedures, provided they are listed in ways in which staff and physicians can easily recognize them in patient care.

Sujdak-Mackiewicz: In a three-year period of ethics consultation data collection at OSF Saint Francis Medical Center (SFMC) and Children's Hospital of Illinois (CHOI), we observed an average increase in consultations of approximately 75 percent per year. We believe that an important reason for this increase has been the introduction of dedicated ethics personnel at the medical center, who were made available because the staff recognized their importance to the interdisciplinary care team. Thus, when the opportunity to participate in the CHA Ethics *Beta* project arose, we were eager to investigate benefits of *Ethics Tracker*, especially given its development as a resource for Catholic health care by its use of the ERDs. The opportunity to participate in the *Beta* group provided a needed tool for taking the next steps in collecting and analyzing data about ethics consultations.

The benefits of utilizing *Ethics Tracker* outweigh the challenges. On a practical level, one of the most beneficial aspects of the software is the ability to communicate

about ongoing consultations with other ethics consultants who can provide a rationale for their approach to a case that, for various reasons, might not belong in the medical record. If the consultant responsible for the case changes or is working with other consultants, the others can access the record and note progress, next steps, or need for follow-up.   The database also allows a consultant to quickly learn whether there has been a consultation on a particular patient during the current or a previous hospitalization.

The *Ethics Tracker* tool has met our expectations for providing a systematic means to enable standardized data collection of ethics consultations. In addition, by providing a common platform for the collection of standardized data points, the software helps to identify areas for quality improvement. Often a consultation may point to a need for education or for the revision/development of a policy. Such findings underscore the important role of ethics consultation in improving patient care.

The *Ethics Tracker* also highlights the ERDs. It links the various sections of the ERDs to the reasons for consultation, offering additional benefits. First, this linkage demonstrates an approach to ethics consultation unique to Catholic health care. It integrates not only ethical principles easily recognizable by our colleagues outside of the ministry, but also the ethical principles guiding Catholic health care with an emphasis on the human dignity of the patient and caregiver and the responsibility of

Catholic health care as it relates to ethics consultation per Directive #37. Secondly, it recognizes the role of the ERDs in guiding organizational and clinical practice, giving attention to areas of the ERDs where there may be a need for education, policy development or review, a better understanding of the ERDs themselves, or of the foundational principles underlying Catholic health care.

An unexpected benefit of a formal mechanism for recording ethics consultations has been the opportunity to more carefully define the scope of practice for ethics consultation specifically as it occurs in Catholic health care. By defining the scope of practice within the ministry, ethics will be positioned to demonstrate its unique role in and contribution to the interdisciplinary care team and the organization in general, while simultaneously acknowledging where overlap occurs (e.g., with those working in palliative care). This in turn can provide opportunities for collaboration and sharing of resources. This is particularly important for establishing standards for ethics consultation within Catholic health care and for justifying educational, financial and consultation resources within the ministry.

As the scope of practice in ethics is more clearly defined, those in ethics will be better able to work with interdisciplinary teams both at the bedside and at the organizational level. It will enable them to speak the language understood by the interdisciplinary team -- a language that includes quality improvement -- while

highlighting the application of the ERDs to patient care at all levels, integrating them more naturally within the existing quality improvement culture. Ultimately, if a tool such as *Ethics Tracker* is adopted throughout the ministry, it will standardize the scope of practice and establish Clinical Practice Guidelines (CPGs) for various types of consultations. For example, CPGs might be developed for consultations regarding ectopic pregnancy, sexual assault protocols, or cooperation with non-Catholic entities. The development of CPGs may be a logical next step in the professionalization efforts currently being undertaken by those in ethics.

OSF SFMC/CHOI has further expanded the *Ethics Tracker* software with the assistance of Harmony Technologies to track ethics education. This function provides a simple means of correlating consultation data with ethics education. It can track the number of people who participated in an educational event, their field of practice, whether the education was provided because of a consultation or due to the recognition of a particular need (for example, one or more of the ERDs).