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BENO

BIO QUARTERLY

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Collaboration, Not Contention: At The Interface Between Individual Healthcare Ethics Consultants And Healthcare Ethics Committees

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A recent national survey of hospitals' and healthcare systems' mechanisms for addressing ethical issues that arise in patient care found that, since the early 2000s, it has become less common for institutional ethics committees to directly handle patient-specific ethics consults. Although more institutions still use a committee of some sort to address ethical issues in patient care than deploy individual consultants, it is more common now than at the beginning of the millennium for individual healthcare ethics to handle patient-specific ethics consults. [1] A related analysis found that ethics consults were more commonly requested at institutions where individual healthcare ethics consultants handled ethics consulta-

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President's Greetings

Greetings from sunny Cleveland (at least for the last five minutes)!

I am excited to draw your attention to a number of new elements in *BioQuarterly* and to share my gratitude for the creative minds behind them. So, thanks first to Kathy Grannan and Alan Murphy for their on-going editorial efforts associated with *BioQuarterly*. They have continued to innovate content that is timely and valuable to BENO's members across Ohio. In the last couple of issues, you may have noticed that *BioQuarterly* now includes a regular book review of texts that are relevant to our readership, an art piece with corresponding commentary, a list of upcoming education (with content both in and out of state), and a comic that touches on topics in healthcare ethics. It's great to have these new elements to complement other articles of interest. We hope you find them enjoyable.

Fall is my favorite time of year. If your schedule follows a similar ebb and flow as mine (as much as it ever ebbs), this time of year comes after the hectic rush of late summer and ASBH. Whether it's finishing projects that have been put on hold, preparing to interview for a new class of trainees, turn attention to teaching, or simply maintain the status quo of clinical work, I encourage you to find time to enjoy the fall foliage and other autumnal activities.

I look forward to sharing more details with you about the BENO conference and other exciting resources after the first of the year. In the meantime, please consider renewing your membership and recruiting new members. There are additional benefits for institutional and system memberships as well, so if you are in a position to make such decisions or are connected to those who are, please also consider supporting BENO through these membership types.

My Best,

Josh

Collaboration *continued from page 1...*

tion requests. This study did not establish causation: were individual ethics consultants more successful in identifying genuine need than ethics committees, or did they merely make themselves useful regardless of whether they were genuinely needed? But what was clear was that an institution's ethics mechanism was more frequently used when individuals or small groups, rather than committees, responded to ethics consults.[2]

Trends that seemingly favor individual ethics consultants have the potential to generate tension between institutions' established ethics committees and more recently-arrived individual healthcare ethics consultants (e.g., paid clinical ethicists). I include the word "potential" advisedly: some institutional ethics committees may never have relished patient-specific consultation and may welcome healthcare ethics consultants' assumption of that responsibility. But other institutional ethics committees may be more ambivalent, and understandably so. In one common narrative of the rise of ethics committees in US healthcare, ethics committees arose in response to institutions' needs to address thorny patient care issues of the sort manifest in the well-known cases of Karen Quinlan and Nancy Cruzan.[3] If individual healthcare ethics consultants are now attending to patient cases, what is left for ethics committees to do?

It's easy to exaggerate the potential for tension between ethics committees accustomed to handling ethics consultation and individual ethics consultants. That isn't the route I'll take here. Rather, I will walk through three commonly-identified areas of endeavor shared by ethics committees and ethics consultants — policy development, ethics education, and patient-specific ethics consultation — and sketch opportunities for collaboration across those areas.

Ethics committees have a great deal to offer to the development and revision of institutional policy on healthcare ethics topics. In my observation, almost all institutional policy is developed and revised by a whole sequence of committees representing constituencies affected by those policies. An ethics committee that focuses carefully on policies' ethical significance and impact can identify ways in which policies can improve ethically that might not come to light in committees focused on the interests of specific constituencies (e.g., a medical specialty or Human Resources). Similarly, a committee approach to the ethical analysis of policy can create opportunities for representatives of various constituencies to identify ethical impacts that might not be obvious to those outside those constituencies. For these and related reasons, even organizations that have dedicated individual healthcare ethics consultants do well to ensure that policy relevant to healthcare ethics is reviewed and revised by ethics committees, not just an individual. Or so it seems to me.

Ethics education is another area in which ethics committees can and do work very constructively alongside individual healthcare ethics consultants. As Amy Patterson and Steven Squires pointed out in their article in the last issue of *BioQuarterly*, regarding ethics committee members as the primary endpoints of ethics education is a mistake that can result in the content of ethics education never reaching the wider audience that would benefit from it: clinicians as a whole. But empowered by education, ethics committee members can both spread their awareness of ethical issues throughout their units, departments, and professional peer groups and identify units, departments, and professional groups within the organization that could stand to receive targeted ethics education on a topic of concern. The organizational reach of an active ethics committee will exceed that of all but the largest clinical ethics consultation services: putting that reach to the service of ethics education is one of the great values that ethics committees provide that individual healthcare ethics consultants would be hard-pressed to duplicate on their own.

Even the tension between ethics committees and individual ethics consultants can readily be overdrawn. George Annas and Michael Grodin, in a 2016 commentary, opine that, "because ethics committees are not on duty 24 hours a day […] only a representative or two of the committee can

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Collaboration *continued from page 3...*

help in real-time conflict resolution." [4] Like Annas and Grodin, I haven't seen an ethics committee that was on duty 24 hours a day. But the consequent Annas and Grodin supply, that the ethics committee as a whole cannot help with real-time conflict resolution because it isn't available 24 hours a day, doesn't necessarily follow. True ethics emergencies are fairly rare: at least on my service, the vast majority of ethics consults will be addressed in plenty of time if they receive same-day attention. It does take an unusually active and committed ethics committee to convene on less than a day's notice to elicit patient and surrogate perspectives and discuss with clinicians, but such committees do exist. At smaller hospitals that might see a dozen ethics consults in a year, a high-functioning ethics committee can engage promptly and constructively in ethics consultation. Even at hospitals that see a higher volume of ethics consultations that are primarily addressed by individual healthcare ethics consultants, an active and engaged ethics committee can be convened ad hoc to offer advice on the most complex or convoluted ethics consults. In either case, having more eyes on the case can help diminish the likelihood that something vital will be missed in deliberation. Just as with education, only the largest clinical ethics consultation service will begin to approach the size and professional diversity that an active ethics committee can readily achieve.

In the foregoing, I've alluded frequently to the advantage that ethics committees inherently have over an individual ethics consultant, no matter how capable: a group of people generally will exhibit greater variation in perspective, expertise, and opinion than could any one person. But to really live up to that potential, ethics committees need to be conscientious about ensuring that diverse perspectives and professions are included. Healthcare ethics committee chairs do well to actively recruit representation from across specialties and professional roles and to balance membership across these same categories. In addition to heterogeneity in membership, committees need to deliberately pursue competence in the areas of endeavor in which they remain involved. In a 2016 article, Cynthia Geppert and Wayne Shelton identify a couple core skills ethics committees need in order to realize their potential: expertise in developing policy and the ability to distinguish healthcare ethics issues from other areas of concern, such as "clinical, political, legal, organizational, regulatory, and human resource-based." [5] With regard to expertise in policy, including members on the committee who do routinely develop and revise organization policy will help; so too will deliberately including the ethics committee in policy development and revision for topics in and adjacent to healthcare ethics.

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Reflections on a Summer Nursing Ethics Internship:
How Professional Development Opportunities in Nursing Ethics Help Nurses Thrive

Cristie Cole Horsburgh, JD is a Staff Ethicist at Cleveland Clinic and Associate Director of the Nursing Ethics Program. She is also a Co-Director of the Cleveland Fellowship in Advanced Bioethics, Associate Director of the Clinical Ethics Immersion Program and directs ethics programming and consultation services in four community hospitals within the Cleveland Clinic Healthcare System.

Zoey Casa, RN graduated in the spring of 2021 with her BSN from Case Western University. She currently works for Cleveland Clinic Main Campus as a nurse in the ENT operating rooms. Her interest in nursing ethics is generally focused around issues with establishing informed consent and maintaining dignity for patients while undergoing surgery given that it is such a vulnerable part of their lives.

Savannah Pate is a junior in the nursing program at The University of Akron in Akron, Ohio. She is originally from Seattle, Washington and currently resides in Portage Lakes. She is an Emergency Department Nurse Technician at Cleveland Clinic Akron General and has an interest in trauma, critical care and ethics! Her interest in ethics stems from a strong belief in bodily autonomy, specifically in creating a comfortable environment for patients and consent along every step of the way.

Georgina Morley, PhD, MSc, RN (UK) is a Nurse Ethicist at Cleveland Clinic and Director of the Nursing Ethics Program (NursE). Georgina has expertise in qualitative research methods (in particular phenomenology), empirical bioethics, moral distress, nursing ethics and clinical ethics.

Introduction

This past summer, the Center for Bioethics and the Stanley S. Zielony Institute for Nursing Excellence at Cleveland Clinic welcomed the first two nursing ethics summer interns – Savannah Pate and Zoey Casa. The internship is part of Cleveland Clinic's Nursing Ethics Program (NursE Program), which is designed to create and sustain a network of nurses with special interest in ethics, support nurses navigating the ethical dimensions of nursing practice, and build nursing ethics scholarship and research. One of the core objectives of the NursE Program is to develop and administer experiential professional development opportunities for nurses and nursing students in the field of clinical ethics to empower them to examine ethical issues through the lens of nursing practice.

Interns participate in weekly journal clubs, develop and participate in research and quality improvement projects, participate in Nursing Ethics Huddles and ethics rounds, shadow the clinical ethics consultation service and observe Moral Distress Reflective Debriefs. Mentored by NursE leadership, interns are also expected to conclude the program with a completed work product, which can be a publication, presentation, educational product or a practice tool to address a specific ethical issue in nursing care.

The following are reflections from Ms. Pate and Ms. Casa on their experiences during this program, lightly edited.

Zoey's Reflections

During my interview for the Nursing Ethics Internship I was asked what I wanted to get out of this opportunity and without even thinking I knew it was to participate in the Ethics Consultation Service (ECS). As I was just finishing up my last semester of nursing school at that time, it had repeatedly been drilled into my mind that my role in distressing situations was to attempt therapeutic communication and if I couldn't, getting other people involved who had more training (management, social worker, etc.), was as far as my duty went. It would almost feel like I was pushing the patient out of my hands and there wasn't much more that I could do. I was already feeling trapped, unheard, and as if, for better

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or for worse, this was the life I was signing up for, even though my official nursing career had not even started yet.

When I started learning about the ECS I was so thrilled to be able to learn about a process for bringing concerns to a source who values all levels of assessment and input, including nursing, in taking care of patients. Most of the work I participated in at first was over the phone with consult intakes and potential treatment plans and looking over every aspect of patient charts. This was enjoyable and it taught me so much about interprofessional communication and the importance of proper charting, but I missed bedside, patient communication.

One day, I had the chance to go visit one of the consults on the CCF Main Campus and speak with the patient directly about what he was feeling and understood about the circumstances of his procedure and recovery. Even though I had scoured every note of this patient's chart, talked with the nurses and doctors who had been seeing him, and knew just about everything I thought I could about this patient, I was almost flabbergasted watching my mentor do a casual interview with him. She was letting him talk about his treatment goals, what in life matters to him (he really loved going fishing), and his frustrations and fears with his possible upcoming surgery. In that moment I learned so much about how I am able to help, even without saying much. After spending years as a student and soon-to-be nurse, I always felt like I had to walk into a room showing how much I already knew in order to be somewhat listened to or respected. Watching my mentor sitting, listening, and empathizing with this patient to understand his feelings and experiences, and help give him a sense of support and control in his hospitalization was truly eye-opening.

If I had to pick one thing to pass on as the most important lesson I have learned throughout this internship it has been that as a nurse, I am not my patient's only advocate. It can often feel powerless and futile to be in a system that feels like it is built to diminish your voice and dismiss your input, but there are always resources to help you navigate this distress and help you feel heard. Though it can be hard to remember in a heated moment, every member of the healthcare team is there to deliver the best possible care to our patient and help them as much as possible. Being able to not only step back and listen to what everyone has to say, but also to listen to, and voice, my own thoughts are lessons I will continue to take with me on the next part of my career.

Savannah's Reflections

Nursing School doesn't truly touch on the subject of bioethics, let alone moral distress and moral residue. As soon as my university had sent out the notice for applications for the internship in the Bioethics department at the Cleveland Clinic, I knew I had to apply. Before interviewing for the internship, I had read several papers by Georgina Morley specifically on moral distress and I was fascinated. Once I was offered the position, I was elated and ready to learn.

On my first day at Cleveland Clinic Main Campus, I was nervous but still excited. I started by shadowing the Ethics Consultation Service to build upon my foundational knowledge. This experience helped me to understand ethics through a nursing lens. I thoroughly enjoyed my time shadowing but was excited to dive more into nursing ethics huddles and moral distress research. We had weekly journal club meetings that discussed various topics such as moral distress, how the pandemic played a role in healthcare, and informed consent. These meetings helped me to understand topics that I had never been exposed to before and opened the opportunity for some very interesting conversations.

One of the most rewarding aspects of this internship was being able to sit in on and eventually lead a nursing ethics huddle. My mentor, Georgina, developed a method of huddling nurses before their shifts to create space to discuss any ethical issues arising with the patients on their units. This was a way to almost "pre-round" on cases and provide advice on how to handle specific situations and address any moral distress. Sometimes these huddles lead to consults, almost fast tracking the process. These huddles resonated with me because oftentimes, in my own experience, nurses don't feel as though they have a voice to use to advocate for their patients or a place to go to discuss their moral distress. The huddles provide an outlet for nurses while providing a solid foundation on basic ethical knowledge in medicine. Towards the end of my internship, I was able to lead one of these huddles myself and I found it very rewarding as I had finally understood why we were asking all of these questions.

This internship has taught me so much that it's difficult to pinpoint one specific take away. This experience has deepened my general knowledge of ethics through the nursing lens and for that I am forever grateful.

Conclusion

Given the dearth of opportunities for nursing students in clinical ethics, this internship provides a unique opportunity for them to closely examine and gain a deeper understanding of the ethical issues they will encounter in nursing practice. It also often introduces them to a potential career path in nursing ethics and clinical ethics. Creating safe moral spaces for nurses to critically engage with ethical issues in nursing practice is vital to excellent patient care and helping nurses to thrive. We hope that this program will be the first of many such programs at other institutions and a building block towards creating a network of nurses and nursing students with specialty knowledge in nursing ethics.

For individuals interested in the Nursing Ethics Internship or interested in starting a similar program at your own institution, please e-mail bioethics@ccf.org. We would be happy to answer your questions.

BOOK REVIEW

Moral Resilience: Transforming Moral Suffering in Healthcare

by Cynda Hylton Rushton

Steven J. Squires, Med, MA, PhD,
Vice President Ethics Mission Integration, CHRISTUS Health

Moral Resilience: Transforming Moral Suffering in Healthcare by Cynda Hylton Rushton (Oxford University Press, 2018, 300 pages) was an all-too-relevant, non-fiction book of interest for several reasons. My studies have included moral distress and the more recently-popularized moral resilience for at least the past ten years. Professionals' moral distress, compassion fatigue, burnout, and suffering are impossible to ignore after being in health care for any amount of time. Similar to the pandemic accelerating the clinical use of virtual appointments, the pandemic and its waves have seemed to accelerate and heighten the levels of professionals' suffering. The need for wisdom, guidance, and tools is nothing less than imminent. If someone requested a list of my top five moral distress and resilience experts, the book's author Cynda Hylton Rushton would be on the list, along with other colleagues such as Georgina Morley at Cleveland Clinic. *Moral Resilience* includes some of the author's prior writings along with new material and contributions from co-authors Alisa Carse, Alfred Kaszniak, Roshi Joan Halifax, and Monica Sharma.

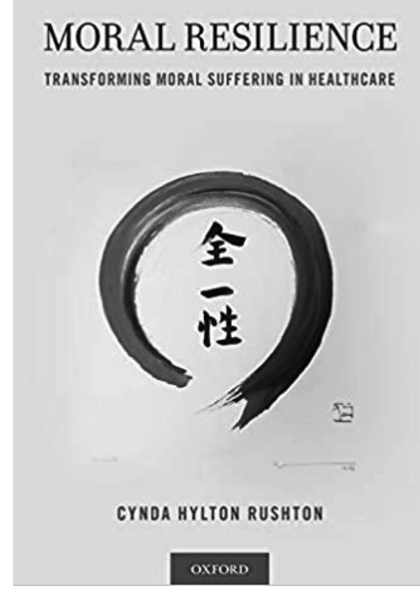
The book is well-written and provides needed tools. In the first third of the book, Rushton introduces the problem and the clinical reality. Readers may appreciate the attention to and definitions of interrelated concepts such as moral residue, crescendo effect, and burnout (p. 41) as well as the visual conceptual map of related moral concepts (p. 54) including moral suffering and moral injury, further explained in chapter three. The second third of the book focuses on resilience and its anchor, integrity. Moral suffering impacts mind, body, and spirit; not surprisingly, the different types of resilience – neurobiological, psychological, and social ecological – discussed in chapter five address suffering's multifaceted dimensions. Systems and strategies for integrity, resilience, and ethical practice comprise the book's final third. Chapter nine is a roadmap for framing responses with the often-repeated ethical refrain to be careful about assumptions. In this case, providing strategies and solutions without truly understanding causes puts the cart before the horse. Responses are partial and incomplete without deep dives into causation, and attention to who we are, what we do, and patterns we observe (pp. 210-238).

Many years ago, a health care executive said at a leadership meeting "don't expect things to go back to the good old days" with respect to staffing levels, productivity, and relative value units (RVUs). Nursing and advanced practitioner shortages were significant – even then. I heard clinicians ask each other: "Okay, but where is the bottom if it just keeps getting worse?"

The elephant in the room is organizational viability. My bias is that much of the current context is characterized by increasing stakeholder numbers and demands, competitive markets, and declining reimbursement rates, with money at the heart of viability. Personnel and payroll are one of, if not the, biggest expense in health care. More patients do not equal more money, as the pandemic has reinforced. However, less money often equals fewer professionals, higher productivity standards, and more patients with the pandemic, with the result that we see more individual and professional moral distress.

Rushton acknowledges that some factors are controllable and some aren't. My concern is that any CFO would simply confirm that a large part of money, and organizational viability, is beyond our control…and what we are able to control individually and organizationally seems more topical. But assuming that clinicians' moral resilience is mostly outside of our control is the fatalistic assumption Rushton warns against. Rushton does not overprescribe with a too-detailed method, delve into problems without knowing particulars. Neither does Rushton guarantee success. She leaves acting on her blueprint for an organizational ethics consult on moral resilience and moral suffering to the readers. I will recommend *Moral Resilience* within my organization and discuss what I learned from it with my chief clinical officer, chief nursing officer, and chief medical officer. Putting their work to use is one of the greatest compliments I can pay an author.

The views represented here are my own, and not necessarily those of my organization, CHRISTUS Health.



UPCOMING EDUCATIONAL OPPORTUNITIES

International Conference on Clinical and Medical Ethics Dilemmas

ICCMED
Date: 12/9-10/2021 New York City
https://waset.org/clinical-and-medical-ethics-dilemmas-conference-in-december-2021-in-new-york

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Medical Marijuana:
Ethics and Pain Management

Live Webinar
Date: 12/22/21
Offered by Michigan Social Work Continuing Education Collaborative
http://www.corelearninginc.com

Ethical Reflection:
Finding Our Way Forward

Ethics of Caring NNEC
(National Nursing Ethics Conference)
Date: 3/17-18/2022   UCLA
https://ethicsofcaring.org

Diagnosing in the Home: Ethical, Legal, Regulatory Challenges and Opportunities of Digital Diagnostics and Therapeutics Outside of Traditional Clinical Settings

Petrie-Flom Center at Harvard University
June 2022
https://petrieflom.law.harvard.edu/events/category/conference

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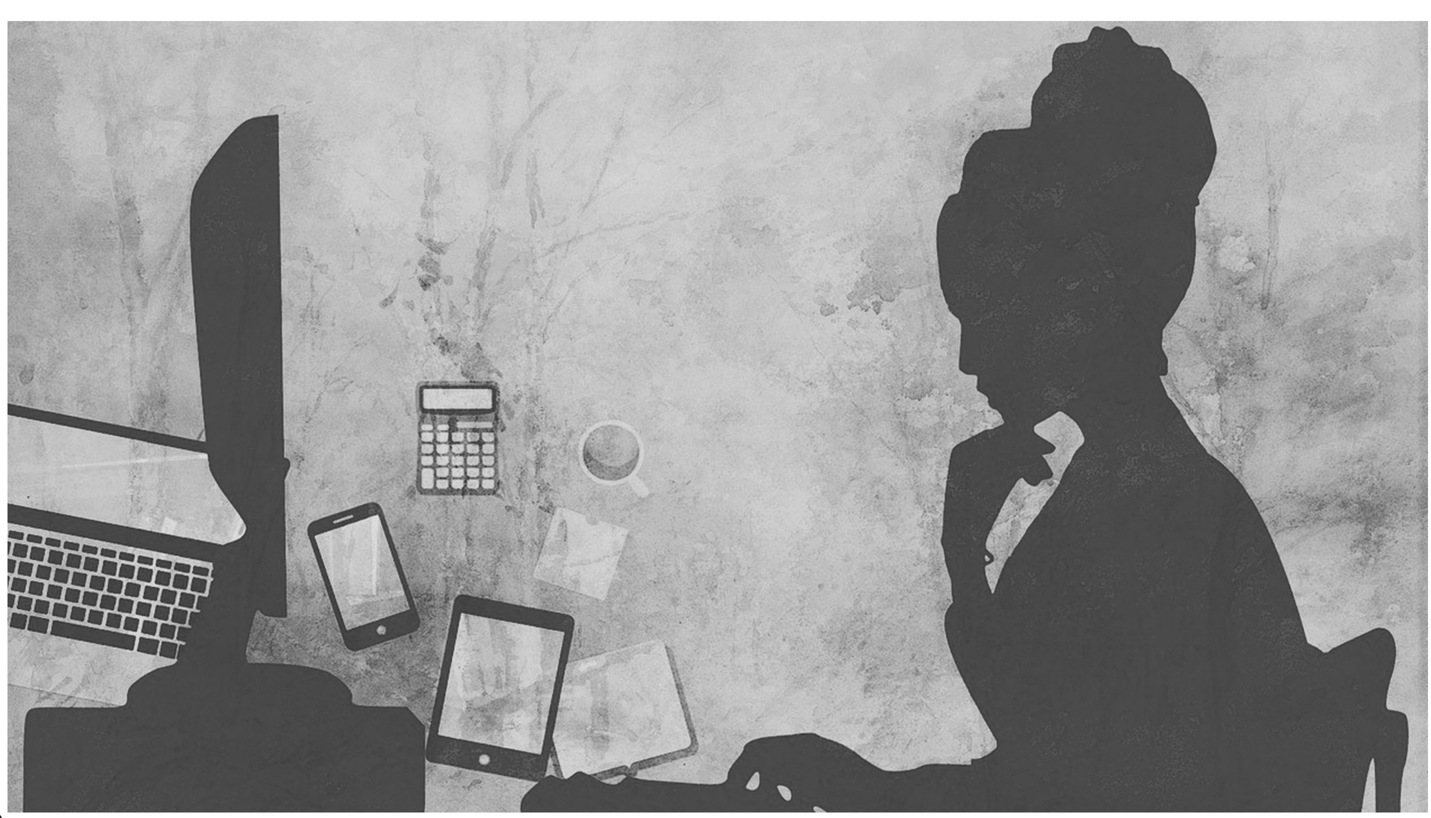
The BioQuarterly invites readers to inform us of upcoming ethics education opportunities. Events occurring after each publication deadline can be added to this column.

Please email Title, Date(s), Location/Virtual, and contact link to Gena Cohen at genacohen@yahoo.com.



SAVE THE DATE

for the BENO 2022 Conference

THEME:

Moral Courage in the Changing Healthcare Landscape

DATE:

Friday, April 22, 2022

TBD whether in person or virtual (or both)

NEW MEMBER SPOTLIGHT

WELCOME TO OUR NEW BENO MEMBER

Rachel Wolthoff
Pharmceutical Science student
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Cartoon courtesy of Kathy Grannan

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ART SPOTLIGHT

This past year and a half has been a difficult one in many respects; and yet there have been a few bright spots. One has been the ability for many people, whether they want to or not, to slow down and reevaluate how they live their lives. (I certainly realize this has not been true for most of us working in healthcare, but please bear with me!) Some of that time has been spent cultivating and preparing food, taking time that has not typically been available. Another has been the ability to stay connected through social media; while it's a poor substitute for in-person interactions, social media has provided an immediacy and reach unavailable to other generations.

An acquaintance posted a picture of produce from her garden last fall, and I felt compelled to paint it. Not only did the image remind me of my friend (in North Carolina) whom I hadn't seen in a long time, but I was also struck by the perfect imperfection of the organic shapes and colors, and the way the diversity of the produce formed a cohesive whole. Painting this allowed me to also slow down and take time to appreciate the interplay of colors and textures. While the past year and a half has not given most of us in healthcare a break, it's still important to stop, breathe, and find the beauty in the mundane once in a while.

Craig Dove, Fall Harvest, acrylic on panel 2020