Institutional Ethics Resources: Creating Moral Spaces

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Introduction

Since 1992, institutions accredited by The Joint Commission (TJC) have been required to have a process that allows staff, patients, and families to address ethical issues or issues prone to conflict[1]. The standard does not require a particular process nor does it define quality measures for judging whether the standard is met. While TJC's expectations clearly have increased the prevalence of ethics committees and other ethics resources, simply having a resource in no way demonstrates its effectiveness in terms of the availability of the service to key constituents, the quality of the processes used, or the outcomes achieved.

Beyond meeting baseline accreditation standards, effective ethics resources are requisite for quality care for another reason. The provision of care to the sick is a profoundly moral practice. Clinicians need reflective spaces within institutions in which to explore and communicate values and ethical obligations as they undergird goals of care. In 1993, Margaret Urban Walker defined institutional moral spaces as "those patterns, structures, routines, and channels of communication that clarify the moral responsibilities and mutual accountability of all parties"[2]. Walker proposed that ethicists needed to be concerned with the design and maintenance of these moral spaces[3]. Cleary such concern needs to extend beyond ethicists to institutional leaders. This essay uses Walker's idea of moral space to describe actual and potential ethics resources in healthcare institutions. We focus on four requisite characteristics of effective resources and the challenges to achieving them, and identify strategies to build them. In our view, such moral spaces are particularly important for nurses and their colleagues on interprofessional teams, and need to be expanded and strengthened in most settings.

Actual and Potential Moral Spaces

Since TJC does not require any one model for resolving ethical concerns, a variety of resources may meet the performance standard. We define ethics resources as those human resources, whether individuals, teams, or committees, charged with addressing ethical problems and fostering ethical reflection at any level in an institution. These resources should be legitimized by the institution and recognized for their expertise by staff who consult them[4]. The most common resources include ethics committees, an ethics consultation service, and/or an

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individual ethicist. Ethics committees generally perform three major functions: providing clinical ethics consultation, developing and/or revising ethics-related policies, and providing education about ethics issues. A clinical ethics consultation service is focused primarily on addressing ethics issues that arise in the care of individual patients; it may be a subset of or separate from the institution's Ethics Committee. Individual ethicists may perform any one or all three functions typically done by a committee or serve as the head of an institution's Ethics Committee.

The list of ethics resources expands if one considers a broader view of where actual or potential moral spaces exist. Chaplains and palliative care consultants may serve as additional ethics resources. Interprofessional team meetings, family meetings, institutional practices for managing error disclosure, Schwartz rounds, even shift huddles are potential reflective spaces where the moral responsibilities and accountabilities of team and patient/family can be clarified.

Requisite Characteristics of Effective Moral Spaces

At least four factors are crucial to making moral spaces effective: ethics resources must be *knowledgeable* about the ethical dimensions of clinical practice and how to reason ethically; they must be readily *available* in the 24/7 environment of most healthcare settings; the resource must be *known* by healthcare providers (and in some cases, by patients and families); and, their use must be *sanctioned* by all levels of clinical and administrative leadership. All are interconnected and necessary to achieve active moral-reflective spaces in an institution's life where, in Walker's prescient words, "a sound and shared process of deliberation and negotiation can go on. It is precisely in busy, bureaucratized, and balkanized acute care settings where the maintenance of these spaces will be most urgent"[5].

Resources Must be Knowledgeable: To realize a deliberative moral space, individuals serving as ethics resources need both conceptual grounding in key ethical approaches and communication skills to enable "*critical, reflective,* and *collaborative* moral thinking"[6].

Professional organizations, notably the American Society for Bioethics and Humanities (ASBH), have done significant work to identify the qualifications needed for individuals involved in ethics deliberations[7,8,9,10]. In spite of these efforts, there is no universally agreed-upon requirement for training. In the case of many institutional ethics committees, members constitute a "volunteer army": busy clinicians with interest in ethics who may or may not have received formal training in ethics[11]. It is conceivable that such a committee may be the only

resource for addressing ethical concerns. In the authors' past experiences, committee discussions with individuals not schooled in ethical reasoning may devolve into individual opinions or experiences, an undue emphasis on clinical particulars, or a superficial review of the four principles rather than identify clearly and reflect on the ethical issues at stake. In similar fashion, an institution's ethicist may have philosophical, or increasingly, bioethics training but little preparation in the nuances and complexities of the moral life and how it is lived out in an institution[12]. Of concern, one study found that some nurse and social work respondents did not access ethics consultation because they perceived the consultants as unqualified (10%) or believed that consultation would make the situation worse (7%)[13]. As a result of all these factors, in too many places ethics discourse is pallid and virtually invisible.

Expanding the list of potential ethics resources could allow for added support for clinicians, but ensuring that these resources are knowledgeable is important. For example, palliative care clinicians may possess expert communication skills essential for high quality end-of-life care. However, these skills may not be sufficient to sort through the complex ethical deliberations needed when there are conflicts regarding quality of life, surrogate decision making, or when capable patients make decisions that appear not to be in their best interest. Likewise, chaplains are skilled at supporting the spiritual lives of patients and staff yet some may have limited ability to navigate the complex interplay between spirituality and ethical obligations. In the case of less formalized resources, the clinicians at hand for a family meeting or shift huddle may not see the need for a reflective moral space or have the skill to help establish one.

Resources Must be Known: Those who could benefit from using an ethics resource first must know of its existence. While seemingly straightforward, it can be a particular challenge to make the nursing or other 24/7 clinician workforce aware of ethics resources. In one study, almost 38% of nurses were unaware of the existence of an ethics consultation service even though they had worked at the institution for years[14]. In another study of nurses and social workers in four states, 39% reported having no institutional resource to help them with ethical concerns[15].

Health care facilities are complex; professionals with diverse training and backgrounds work around the clock to deliver care. Ensuring that all levels of staff on all shifts are fully aware of the existence of various ethics resources and how/when to access them can be daunting.

Complex organizations are made up of many microcultures: one unit may fully embrace and utilize ethics resources, another may not be aware of what exists, and still another may be aware but actively shun and avoid help with ethical problems. Fostering an institution-wide understanding of available ethics resources is necessary to have open and productive moral spaces.

Another barrier to knowledge of ethics resources can be traced to clinician self-assessment, most often articulated as, "I'm a good person; I know the right thing to do". Clinicians deal with a variety of ethical challenges daily and generally the issues are resolved. Because of this, many clinicians feel they are capable of handling ethical conflicts and are surprised when confronted by a situation that cannot be resolved with their usual strategies. Misunderstandings such as, "if the patient has capacity, you cannot call ethics" or attitudes such as "it isn't time to call ethics yet" can complicate matters. Situations can fester, often leading to intense negative emotions, moral distress, and polarization between team members and patient/family or within the team. These heightened emotions make resolution more difficult.

Resources Must be Available: When an ethics resource is needed the situation is often time sensitive. Unless the information about how to access the resource is readily available, even a high quality ethics resource may be out of reach. Rather than search for the resource, clinicians may simply "deal with the problem" and hope for the best. Gordon and Hamric[16] found that only 25% of the nurse respondents in their study indicated that they knew how to request an ethics consultation.

Nurses are busier than ever, adapting to electronic health records, collecting data for quality monitoring, implementing evidence-based practice changes, all while meeting immediate patient care needs even as nursing numbers are constantly flexed so that institutions remain fiscally responsible. Multiple competing demands on nurses' time and attention reinforces the illusion that faster is better. Paradoxically, the opposite is true: the busier we are the more likely we are to need a reflective moral space to pause and consider our actions. Yet the pressures of external forces make it less likely that nurses will push for such a space. Rather, the temptation is to focus on the ever-increasing "To Do List" and don moral blinders that block out complex ethical aspects of care. Grady and colleagues found that 38% of nurses and social workers with access to ethics consultation found the process too time consuming and 28% said the process was difficult to access[17]. Even as seeking help with ethical problems appears to be too time

consuming, the reality is that robust moral deliberation and early resolution of ethical conflict can save tremendous time in the long run.

Are resources readily available on any shift every day to any front line provider? Do clinicians feel that they have the time to take advantage of the resource? These are the true tests of availability.

Resources Must be Sanctioned: Any clinician ought to feel empowered to raise the question, "Should we be doing what we are doing?" when there is a concern. Support from unit managers, administrators, and clinical colleagues is needed for open communication among providers and the use of ethics resources to become a reality. Evidence suggests clinicians fail to speak up and confront important challenges in patient care[18]. Although members of the team may have equal moral standing when it comes to evaluating the ethics of a plan of care, if an ethics resource is rooted in the medical hierarchy, the inherent authority gradient may both intimidate others from raising concerns and/or override legitimate concerns in favor of the moral position of physicians. Many ethics committees are housed in the hierarchy of the medical staff. Although most institutional policies allow any clinician to avail themselves of the committee, in some institutions unwritten "rules" allow physicians or administrators to block cases from being heard by ethics consultants; or, fear of reprisal may prevent clinicians from voicing ethical concerns. These are particular issues for nurses. Studies demonstrate that nurses often feel they do not have the resources necessary, they feel powerless, or fear that they will experience significant negative repercussions if they do seek ethics guidance, particularly over the objection of their physician colleagues or unit manager[19]. Because nurses are the largest workforce in health care and the discipline with the most consistent and frequent contact with patients, nurses are in a strategic yet vulnerable position to raise ethical concerns.

When it comes to a patient's plan of care, if anyone other than the attending physician has an ethics concern or conflict, fear of retribution can be a powerful negative sanction that may inhibit that individual from seeking assistance from an ethics resource. In some cases, retribution is not a fear but a reality[20]. Medical students in one study reported an unwillingness to speak up about their moral distress because of their fear of reprisal from physician supervisors[21]. Simply having a resource "on the books" is clearly insufficient. As Walker comments, "sensitivity to configurations of authority and dynamics of relationship…can either help structure that [moral] space or deform it"[22].

Comment: These four characteristics of effective ethics resources are interconnected; most often more than one is missing when an ethics resource is poorly utilized. In our view, the litmus test of effectiveness is whether a weekend night shift frontline provider such as a registered nurse knows how to call for ethics help, receives timely assistance, is fully supported by *ALL* members of the clinical team as well as his manager, and views the encounter as sufficiently beneficial that he is likely to seek the resource again. Positive public recognition "on the ground" (e.g. on rounds) by an attending physician, other team members and administrative leaders when anyone on the team accesses ethics resources provides strong evidence that an organization has a culture that values and supports reflective moral spaces that support clinicians dealing with ethical problems. Such evidence is more than words on a page found in some distant policy.

Strategies for Achieving Effective Ethics Resources

What, then, is needed to create effective and widely utilized moral spaces in healthcare institutions? Strategies for clinical and administrative leaders to consider:

- Advocate for the importance and benefits of creating and sustaining reflective moral spaces. Decreasing clinician turnover, avoidance of patient/family/team conflict, improving interprofessional team communication, and promoting a culture of safety are all justifications supported by evidence.
- Examine the current care-giving culture to identify actual and potential moral spaces and the resources required to populate them. Question whether the four characteristics are in place for each ethics resource, or if action is needed to address deficiencies. Set a goal to build an institutional culture that demands high functioning interprofessional teams where calling on ethics resources is *expected* rather than *exceptional* (i.e., used only in a crisis or as a last resort). The goal requires clear support at all organizational levels for those who speak up.
- Invest in ethics preparation and administrative support for the individuals charged with creating or maintaining the institution's moral spaces. If ethics committee members, palliative care clinicians, chaplains, and others are charged with addressing ethical issues, they must receive the requisite ethics education needed. Education in ethical dimensions of practice, conflict resolution, and collaborative problem-solving that includes a communication skill demonstration component is needed. There are multiple continuing

educational opportunities for this education, but administrative investment in the form of money and time to send staff to such training will be required.

- Consider building discipline-specific resources if the institution is not ready for a significant investment in developing moral spaces. This may be particularly important for nursing. Despite clear language in the Code of Ethics charging nurses to establish and maintain healthy work environments[23], there is abundant evidence that nurses often fail to speak up when there is a need in high stakes situations[24]. Given that nurses are the largest professional group and the most present in direct patient care encounters, continuing ethics education for nurses can be an important investment, as the ability to identify and raise ethics concerns requires ethics education and some skill[25]. If nurses are trained to navigate ethics challenges and utilize ethics resources, believe their moral concerns are important, and translate this belief into action on behalf of patients, they will lay the groundwork for interprofessional efforts to change an institution's culture to create health care environments that contain truly reflective moral spaces.
- Promote routine utilization of ethics resources rather than in response to crises. The current reactive model in many institutions perpetuates the myth that there is someone with greater moral knowledge who can identify the one "right answer". Building a variety of moral spaces represents a proactive approach to creating environments where respectful dialogue and identification of ethical alternatives can flourish.
- Encourage professional bodies (associations, licensing boards) to develop policies that expand the minimum requirements for ethics support set forth by TJC. In spite of significant efforts by ASBH[26], if TJC does not raise their minimum standard, it is unlikely that institutions will expend the time and money to develop more effective resources. Pressure from professional organizations could be helpful in raising standards.

Creating Moral Space: An Exemplar

We here provide a case example of a resource that was initially reactive but became proactive in assisting clinicians to create a moral space:

> In an organization with a policy of open access to ethics consultation, a nurse approached a physician about an ethics concern. The physician failed to acknowledge the concern; the nurse first collaborated with her manager, then requested assistance from the ethics consultation service. Initially this action was met with outright hostility from the

physician, who publicly chastised the nurse on patient care rounds, raising his voice and questioning the validity of the nurse's concerns. Begrudgingly the medical team agreed to meet with the ethics service, the nurses involved, and other members of the team caring for the patient. The ethics team skillfully managed the tension in the room, revealing the ethical complexity of the case. During the discussion, the ethics team reviewed the open access policy for ethics consultation and offered coaching to both nurses and physicians should future ethics concerns arise. The positive impact of this intervention was clear when within the month, the same medical team requested assistance from the ethics service to facilitate a team discussion about the ethical complexity of a different patient. The second consultation provided clear evidence that a reflective moral space had been opened.

Conclusion

TJC's mandate for a mechanism to address ethical issues could be considered "the letter of the law" and Walker's call for moral space in institutions "the spirit of the law". Adhering only to the letter of the law can lull administrators and clinicians into thinking that they are meeting their ethical obligations to patients, families, and each other. Having ethics resources that respond only in crises does little to address the everyday challenges to ethical practice and the need to build moral capacity within an institution. A culture that is receptive to reflective moral spaces does not just happen. Cultural transformation requires professionals dedicated to developing their ethical knowledge and skill, deliberate attention, financial support, and persistent vigilance. Such effort is necessary to achieve an institution that meets its moral responsibilities to the stakeholders it serves.

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