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Cultivating Administrative Support for a Clinical Ethics Consultation Service

Courtenay R. Bruce, Mary A. Majumder, Ashley Stephens, Janet Malek, and Amy McGuire

ABSTRACT

Hospital administrators may lack familiarity with what clinical ethicists do (and do not do), and many clinical ethicists report receiving inadequate financial support for their clinical ethics consultation services (CECSs). Ethics consultation is distinct in that it is not reimbursable by third parties, and its financial benefit to the hospital may not be quantifiable. These peculiarities make it difficult for clinical ethicists to resort to tried-and-true outcome-centered evaluative strategies, like cost reduction or shortened length of stay for patients, to show a "need" for ethics consultation. Likewise, it can be difficult for clinical ethicists to "speak the same language" as healthcare administrators and managers, which, in turn, means that CECSs run the risk of being unable to demonstrate value to those who pay for the service.

The purpose of this descriptive article is to provide practical guidance to clinical ethicists and program directors on how to cultivate administrative support for a CECS. Specifically, we discuss two elements that clinical ethics leaders must critically appraise and successfully argue to meet the expectations of administrators—the value of a CECS and its fit in clinical workflow.

INTRODUCTION

Clinical ethics consultation services (CECSs) do not fit the typical mold for hospital-based ancillary support services. Hospital administrators may lack familiarity with what clinical ethicists do (and do not do), and many clinical ethicists report receiving inadequate financial support for their services.[1] Further confounding matters, ethics consultation is distinct in that it is not reimbursable by third parties, and its financial benefit to the hospital may not be quantifiable.[2] These peculiarities make it difficult for clinical ethicists to resort to tried-and-true outcome-centered evaluative strategies, like cost reduction or shortened length of stay for patients, to show a "need" for ethics consultation. Likewise, it can be

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difficult for clinical ethicists to "speak the same language" as healthcare administrators and managers, which, in turn, means that CECSs run the risk of being unable to demonstrate value to those who pay for the service.

The purpose of this descriptive article is to provide practical guidance to clinical ethicists and program directors (whom we refer to collectively as "clinical ethics leaders"), individuals charged with responsibilities that go beyond simply establishing or maintaining an ethics committee, with specific relevance to: (1) launching a CECS; (2) repositioning, expanding, or strengthening a CECS; or (3) "systematizing" CECSs across hospitals or institutions in connection with a multi-institutional consolidation. Our motivation behind writing this article and a larger manual (titled *A Practical Guide to Developing and Sustaining a Clinical Ethics Consultation Service*[3]) stems from an appreciation that clinical ethics leaders should know how to build and sustain a vibrant CECS that can withstand organizational restructurings and hospital mergers and acquisitions. To do so, a CECS requires considerable buy-in from hospital administrators. Here, we provide some suggestions on how to cultivate administrative support for a CECS. We consider this timely, especially given that data suggest a shift in the field from using a purely volunteer ethics committee model towards a model using full-time, hired clinical ethicists.[4] Thus, we anticipate that clinical ethics leaders might be looking to cultivate administrative support to make a strong case for shifting ethics consultation models.

We began with an essential premise: that it is critical for clinical ethics leaders to provide well-founded justifications for launching, expanding, or strengthening a CECS that fully address how and why a CECS aligns with administrators' goals. It is legitimate and even desirable to take into account the expectations that administrators might have regarding the operation of a CECS. In what follows, we discuss two elements that clinical ethics leaders must critically appraise and successfully argue to meet the expectations of administrators—the value of a CECS (for example, potential cost savings, non-economic value) and its fit in clinical workflow (for example, coordination with other services such as palliative care or pastoral care).

THE VALUE OF CLINICAL ETHICS CONSULTATION SERVICES

Healthcare organizations can no longer rely on a reputation for excellence; rather, organizations need to be able to document excellence in the care of patients. This shift to a culture of accountability traditionally has two focal points: decreasing costs, or at least reining in the growth in healthcare expenditures, and improving the care of patients and outcomes. Clinical ethics leaders should seek to connect the CECS to achievement of these goals, while also making the case for a broader understanding of the potential intangible benefits of a vibrant CECS. The implications of this are that clinical ethics leaders should demonstrate the value (typically defined as encompassing both cost and outcomes; for example, value is "the health outcomes achieved per dollar spent"[5]) of a CECS at two different time points for different purposes: (1) before the CECS reaches maturation, in order to argue for resources to launch, reposition, expand, or strengthen a CECS; and (2) after the CECS is fully vibrant and matured, in order to continue quality improvement efforts and maintain accountability. "Value" can be measured in several ways.

Economic Value

Studies highlight the economic value of ethics consultation, which could be used to justify a need for additional resources to build or expand a CECS. In single-site and multi-site prospective, randomized controlled trials, Schneiderman and colleagues reported fewer days in intensive care units (ICUs) and fewer life-sustaining treatments for patients who received pro-active ethics consultation compared to those who did not. Importantly, the investigators showed no difference in mortality between the intervention and usual-care groups, discrediting fears that ethics consultations would provide a subterfuge for "pulling the plug."[6] Smaller-scale studies conducted prior to the study by Schneiderman and colleagues,[7] as well as other recent studies, have demonstrated similar findings. For instance, Chen and colleagues published a study in 2014 demonstrating that patients in a randomly assigned intervention group (receiving ethics consultation) consumed fewer medical resources as indicated by fewer ICU days and shorter hospital stays compared to the usual-care group.[8]

These studies suggest that ethics consultation saves money, which should strongly resonate with hospital administrators. There are some limitations and ethical concerns, however, in using cost savings as an outcome measure to demonstrate value. First, these cost-savings data, it is argued, could improperly influence consultants' consultative activities, actions, and recommendations, and may introduce consultant bias. For instance, as Mills and col-

leagues have argued, a goal (if not the primary goal) of ethics consultation is to facilitate resolution of value-laden conflict or medico-moral uncertainties within a respectful atmosphere. If ethics consultation is to be evaluated on the basis of cost savings, ethics consultants may change their approach from an ethically preferable and professionally encouraged model of facilitating communication and decision making to one of pushing a particular economic agenda: "It is entirely plausible that ethics consultants, under the guise of 'facilitating' end-of-life decisions, could be used to encourage decisions that could result in cost savings or could perhaps systematically fail to explain or explore alternatives that could be more costly."[9] Even if such expectations are not explicitly or consciously embraced, evaluating a CECS on the basis of cost savings could create unconscious bias that affects the consultations.

Second, if ethics consultation is evaluated on the basis of cost savings, it is possible that clinicians, patients, surrogates, and other stakeholders would view ethics consultation and consultants with distrust, rather than viewing ethics consultants as neutral parties. Were cost savings to become a primary consideration during ethics consultation (routinely overriding other ethically relevant considerations), patients and families could shift from viewing ethics consultants as individuals whose job it is to elicit and balance multifaceted ethical considerations to one of simply cutting hospital dollars. The perception of a conflict of interest alone could cause stakeholders to question the integrity of ethics consultants or ethics consultation.

Moreover, it is possible that the most ethically supportable course of action might be an expensive one, relative to other options. Consider an example from the American Society for Bioethics and Humanities (ASBH) *Core Competencies for Clinical Ethics Consultation* (hereafter, the *Core Competencies*) involving a paralyzed patient who asks for his ventilator to be withdrawn, but changes his mind and chooses to stay on the ventilator after being offered an option for independent living upon hospital discharge.[10] Here, a recommendation to withdraw the ventilator in an effort to reduce ICU length of stay would be ethically impermissible, given the patient's expressed wishes to the contrary. A more nuanced example might be one in which there is insufficient evidence of an incapacitated patient's wishes when a surrogate requests what clinicians believe would be premature de-escalation or discontinuation of life-sustaining therapies.

This is not to say that cost savings could not be used at all in discussions with hospital administrators. Cost-savings data could be used to buttress the case for the creation or expansion of a CECS. The studies that have been done on the economic value of ethics consultation, as described above, are persuasive. They can greatly assist in making a compelling argument to hospital administrators on the value of a CECS before it is established or reinvigorated. But relying too heavily on this justification may be seen as a commitment to cost savings after the CECS matures, which may be difficult to demonstrate in many cases. Further, by taking this approach, clinical ethics leaders are essentially asking administrators to conceptualize and evaluate ethics consultation processes in the same way as they do other hospital-based services, failing to recognize that the goals and roles of ethics consultation and consultants are distinct. The uniqueness of CECSs does not somehow exempt them from rigorous evaluation after a CECS matures. But, we, like Mills and colleagues, believe that CECSs should be evaluated a little differently because of their uniqueness, using non-economic metrics as the most relevant measures of value.

Non-Economic Value

It can be difficult to measure the non-economic benefits of a service, requiring some creativity in how to capture the full breadth of the value of ethics consultation and its benefits. Identifying and measuring the non-economic benefits of a CECS requires first knowing the goals of the institution, to be able to show that a service contributes to achieving those institutional goals. The ASBH *Core Competencies* includes some non-economic outcome measures,[11] and we expand on several of them below.

Cultivating a Healthy Organizational Ethical Climate

One non-economic value is a CECS's role in cultivating a healthy organizational ethical climate, the degree to which clinical practices conform to established ethical standards, and whether and how healthcare professionals feel supported when they encounter an ethical challenge. One way to measure this would be to assess, for instance, how often informed consent is obtained and documented for medical interventions, how often a patient's lack of decision-making capacity is documented in the medical record in cases when a surrogate is making decisions, and how often and to what extent advance directives are followed. These assessments would help to demonstrate that the CECS is delivering high-quality education regarding applicable ethical norms and providing effective support when questions

arise; or, alternatively, that the CECS needs to be created, reinvigorated, or expanded as a means to improve the organizational ethical climate.

A more direct way of measuring organizational ethical climate in relation to a CECS is to do a pre- and post-intervention "study" on particular ethics education initiatives performed by the CECS. For example, take a hospital that has a recurring issue of incapacitated, unrepresented patients. The CECS develops a well-constructed policy or guidance statement on the issue, and one of the procedural steps is to encourage ethics consultation, and the hospital's ethics consultants educate social workers and clinicians on the policy. If a survey were used before and after initiation of the CECS policy to evaluate "preparedness to address the issue of unrepresented patients," this might be a proxy for measuring the value of the CECS. Similarly, we have reported elsewhere that increased ethics visibility on the ICUs (that is, embeddedness) results in indirect educational value to clinicians.[12] This can be captured using qualitative interviewing or survey data to help show how a CECS cultivates a healthy organizational climate through its education initiatives, and, in turn, why expanded resources are needed to continue such efforts.

Reducing Moral Distress or Improving Morale

Ethics consultation activities may have a positive effect on a healthcare organization's morale, which could be assessed using simple questions, such as: "Are you more comfortable knowing your hospital has an ethics consultation service? If so, why?"[13] Another goal of most healthcare organizations is recruitment and retention of nurses, which is linked to healthcare professionals' perceptions of moral distress. One way to evaluate this is to examine factors underlying healthcare professionals' moral distress and to assess the degree or ways in which ethics consultation can mitigate sources of moral distress or increase clinicians' comfort levels with regard to particular moral dimensions of practice. For example, as part of our quality improvement initiatives, we engaged in qualitative interviews with 30 healthcare professionals on two different ICUs in which the CECS became embedded. Recognizing that we saw a dramatic increase in the number of ethics consultations in those units post-embeddedness, we specifically explored how the CECS contributed to healthcare professionals' comfort levels. The results are reported elsewhere.[14] In short, during those interviews, clinicians emphasized that "embeddedness" helped in facilitating longitudinal relationships with patients or their families, which, in interviewees' opinions, facilitated a quicker resolution of ethically challenging cases.

Improving Processes of Patient Care

Finally, there are informal, less value-based indicators that could be used to suggest that a CECS is needed at an institution or, alternatively, that an expanded or strengthened CECS is needed as part of good patient care. One indicator would be a hospital shift from providing basic or general services to providing increasingly specialized or higher-intensity acute care.[15] When this happens, cases will inevitably become too specific for generalist-based ethics committee members who do not have additional, specialized ethics training, competence, or confidence with content-specific domains, like maternal-fetal ethics, transplant ethics, or critical care ethics.

A related indicator suggesting a need for improved patient care processes would be the frequent management of ethical issues by other, less-equipped services. This could be captured by anecdotal reports from other hospital consultants indicating that they are receiving consultations on complex cases with salient ethical issues. For instance, in the absence of an effective CECS, hospital services such as social work, spiritual care, palliative care, or risk management may be "addressing" ethical issues. Although these services are complementary to ethics consultation and often work collaboratively with clinical ethicists, they may not have the skill set and, from a role-boundary perspective, they likely should not be charged with addressing moral matters from a secular and neutrally reflective practice. When these anecdotal reports surface, this suggests that there is not an adequate mechanism in place for resolving ethical disputes in the hospital. As hospitals and the services they provide become increasingly specialized and acute, robust CECSs are arguably warranted to respond to real-time ethical challenges in a time-sensitive way (for example, responding to the consultation within one hour).

Data from satisfaction surveys of patients/families and clinicians regarding the CECS could be used to justify expanding an existing service, particularly as it relates to respondents' perceptions of how the CECS improves patient care. One way to measure satisfaction is by first conducting an ethics needs assessment survey and then measuring satisfaction in meeting those needs. An individual tasked with starting or reinvigorating a CECS could ask department representatives to distribute a survey among their own departments to obtain survey responses.[16]

Interviews with physician, nurse, social work, and pastoral care leaders will provide responses that complement and provide context for the survey data. Such surveys could elicit information relevant to a number of aspects of a comprehensive ethics service or program, with a particular emphasis on awareness, comfort, and frequency-related questions, and on identifying barriers to utilizing services. Examples from surveys from different hospitals with various structures are provided in table 1.

In summary, there are several ways to show the value of CECSs to hospital administrators. The literature on cost savings could be used to support an argument for the potential value of a CECS when launching a service, and so may be effective data to include in service proposals. But we caution against committing clinical ethics leaders to collecting CECS cost-savings data for the purpose of demonstrating efficiency or as part of rigorous evaluation, unless (1) the caveats and limitations of cost-savings data are carefully, explicitly, and pro-actively enumerated to administrators, many of which we describe above; (2) other "soft" outcomes or non-economic evaluative measures are used (for example, satisfaction data, retention rates, comfort levels) that have equal or greater force than "hard" outcome measures like cost savings or lengths of stay; and (3) an agreed-upon plan is established between hospital administrators and clinical ethics leaders about how "hard" outcomes would and would not be used.

Even if generating cost savings for the institution is not a primary goal of a CECS, it is important that clinical ethics leaders demonstrate good stewardship of available resources. The *Core Competencies* describes several methods and tools for evaluating the efficiency of a CECS, with an emphasis on documenting staff consultation work load and standardizing consultation processes to limit waste. By carefully documenting time, clinical ethics leaders can determine how resources are spent and how utilization changes over time.[17] As Carter and Wocial noted, standardized consultative practices "help prevent digressions into anecdotal discussions . . . and helps to avoid costly communication breakdowns."[18] As part of considerations of efficiency, clinical ethics leaders should show how a CECS works in relation to other services and efforts to curb duplicative activities, described immediately below.

HOW DOES ETHICS CONSULTATION WORK RELATIVE TO OTHER SERVICES?

Hospital administrators are tasked with ensuring safe and high-quality clinical services, improving patient care and satisfaction, retaining valuable employees, strengthening ties with the medical staff, as well as maximizing efficiency and looking for other ways to cut costs. To this end, a hospital administrator would want to know the fit between the work of an ethics committee or CECS and the work of other hospital-based services to ensure collaboration and non-duplicative activities. It is important to resist the tendency to think in terms of an "ethics silo," separated from other domains and unique in its language and modes of performance. By showing how the CECS would work in relation to other services, both structurally and in its processes, clinical ethics leaders can help build an argument that CECSs make a unique, complimentary contribution to an institution. To do this, clinical ethics leaders should consider showing: (1) that a CECS can work collaboratively and complement other services, yet (2) also perform a distinct function that cannot or should not be performed by other hospital-based services.

One way to show structural orientation is to create a visual depiction of how the CECS would work with other hospital-based services, perhaps by highlighting unique areas of specialization. In figure 1, we outline broad content domains and specific areas of specialization among ancillary services using decision making at the end of life as an example. A limitation of structural diagrams is that they demonstrate domains of involvement but do not illustrate how a CECS functions in relation to other services. To add levels of specificity, clinical ethics leaders could consider using process information to show how a consultation would work if several services were on the same case, describing how a case typically unfolds and how each hospital service could contribute to the overall goal of high-quality patient care while also performing distinct activities. For instance, consider a case in which a patient with questionable capacity refuses medically indicated treatments. The clinical ethics leaders could show how an ethics consultant would facilitate assessments of the patient's capacity, explore the patient's understanding of the different options using a model of assent in the event the patient is determined to lack full decision-making capacity, and help the patient's surrogate and attending physician evaluate the appropriateness of alternatives including hospice (given what is known about the patient's wishes). The clinical ethics leader could then show how palliative care would work on the same case, assessing and orchestrating hospice transitions, or how chaplaincy could assist with surrogate's bereavement. Here, the case would be

TABLE 1. Sample ethics consultation-related questions from needs assessment surveys

Topic	VA Integrated Ethics Survey [1]	Hamilton Health Services [2]	Ben Taub General Hospital[3]
Awareness	"I am familiar with my facility's ethics consultation a service to help patients, providers, and staff resolve ethical concerns in the healthcare setting." (Likert scale: Strongly disagree —Strongly agree)	"Please indicate if you are aware of the following ethics resources listed below. List resources relevant for your institution, e.g., Clinical Ethics Committee, Ethics Consultation Service, Clinical Ethics Website, Ethicist, Ethics Framework, Patient Education Materials." (Not Aware, Somewhat Aware, Very Aware, Not Applicable)	"Are you aware that a clinical ethics consultation service currently exists at Ben Taub?" (Yes/No)
Comfort	"If I needed help with an ethical concern related to health care, I would be likely to contact my facility's ethics consultation service." (Lickert scale: Strongly disagree—Strongly agree)	"Please indicate if you agree or disagree with each statement, based on your experience in your current program (e.g. I know whom to contact about my clinical ethics concerns when I need support, I feel decisions involving ETHICAL DILEMMAS are made in a fair, consistent, and respectful way…)" (Disagree fully, Disagree somewhat, Agree somewhat, Agree fully, Not applicable)	"Please think about your patient care over the past 6 months. Would you have used a clinical ethics consultation service for any of your challenging cases?" (Yes, No, Unsure)
Frequency-related questions	"At this facility, how often do clinicians give patients sufficient time to discuss treatment recommendations?(Almost never, Occasionally, About half the time, Usually, Almost always, Do not know)	How often do you encounter an ethical issues in your work?" (Daily, Weekly, Monthly, Yearly, Never)	"Have you ever used the clinical ethics consultation service at Ben Taub? (Yes/No) service at Ben Taub?"
Topic-related questions	"Rate your facility on how well it educates you about ethical issues in end-of-life care." (Poor, Fair, Average, Good, Excellent)	"Below are a list of topics which might be appropriate for ethics education. Please indicate YOUR needs in receiving education about each topic listed (Not needed, Somewhat needed, Really needed, Not applicable)	"Below are common ethical issues. Please indicate how important you think these topics are for us to prioritized in our quality quality improvement efforts?
Barriers to utilization	"Rate your facility on how well it provides you with clear guidance on avoiding activities or relationships (including personal, academic, or financial) that could call into question the integrity of research." (Likert scale: Strongly disagree—Strongly agree)	"Is there a need for additional guidelines or policies to support practice in your program?"	"We are working to improve the quality of the current ethics consultation service. Please indicate how important these services are for us to prioritize in our quality improvement efforts?" (Likert scale on items related to: responsiveness, documenting recommendations, facilitating discussion, providing education, policy development, and moving from a volunteer to professional model)
Anticipated use with a new or enhanced program	"Rate clinicians at your facility on how effective they effective they are at integrating a patient's values and preferences into health care recommendations." (Poor, Fair, Average, Good Excellent, Do not know)	"How important do you consider ethics education to support patient care in your program?" (Not important, Somewhat important, Important, Very important)	"If there were a more enhanced, more availabled clinical ethics consultation service at Ben Taub, how often do you think you would use it?"

The information presented in this table is from *A Practical Guide to Developing & Sustaining a Clinical Ethics Consultation Service, 1st ed.* (CreateSpace Independent Publishing Platform, 2015).

Table 1 is continued on the next page.

used to show how each of the services works in complementary but distinct ways, engaging in different consultative activities that are necessary for good patient care.

A case is an engaging way to show how a CECS would work in clinical workflow, but cases are limited in that they may not be generalizable. To complement a case illustration, clinical ethics leaders may want to show triage plans or algorithms to illustrate how the different services would work together across certain types of cases (as opposed to just one case). Several articles have been written about the distinction between and complementarity of palliative care and CECS. These articles suggest that there is often confusion about whether and how the services relate to one another and how they can be viewed differently. Carter and Wocial,[19] and other authors,[20] argue that, while there is potential for overlap, each respective service is most equipped to address specific types of concerns. Palliative care, for instance, is arguably better equipped to handle the clinical care of imminently dying patients, while clinical ethicists might be better equipped to elucidate value preferences for whether, and when, a patient or family is amenable to palliation. By developing triage plans between these two services, clinical ethics leaders could ensure an alignment of expectations between respective services, as well as add more detail about how a CECS would work in clinical workflow. Leaders and administrators can ensure non-duplication of processes while, at the same time, clarifying roles (see table 2).

THE "PITCH" TO HOSPITAL ADMINISTRATORS

Above we described two elements that clinical ethics leaders must successfully argue to meet the expectations of administrators—the value of a CECS and how it does or would work in clinical workflow. Whether the goal is a new, expanded, or reinvigorated CECS, a service proposal is often an effective way to concisely state the need for a CECS in a written format that is familiar to hospital administrators, folding in elements pertaining to value and clinical workflow. The substance of a proposal should make a compelling argument as to why a CECS is mission critical or adds value, and should outline the proposed structure and function of the CECS. A CECS proposal should be organized, concise, and persuasive.[21] A proposal has to convince senior hospital administrators why they should invest in a CECS despite limited resources, and why it should be done in the manner recommended by the proposed individual or group. The proposal should also include a business plan, so that organizational leaders can prepare responsibly for the cost of a CECS.

Starting with an executive summary that is one page or less is often an effective way to concisely and quickly grab the attention of an administrator and invite him or her to read further. The ideal executive summary succinctly describes what clinical ethics leaders are asking for, why such a CECS is important, the expected results, quality measures and processes for peer review, and the projected cost.[22] An executive summary can serve as a source of talking points for an in-person "pitch" to key administrators.

This background section of the proposal should describe CECSs at healthcare organizations that the organization's leaders view as benchmarks. The length and content of the background section is somewhat dependent on whether the hospital administrators are familiar with ethics consultation and CECSs and the purpose of the proposal. Even if a service already exists, an administrator who is new to the organization, new to the responsibility of the CECS, or simply charged with many competing responsibilities may benefit from a quick review of how the service is doing, indicators of its health (or the potential for health), and why additional funding is needed.

If the hospital does not have a CECS, more background information might be needed to frame the request and establish a firm foundation. An administrator who is not very familiar with CECSs or the value of such services may benefit from subsections such as: What is a clinical ethics consultation service? Who are ethics consultants? What do ethics consultants do? How is the quality of ethics consultation evalu-

NOTES

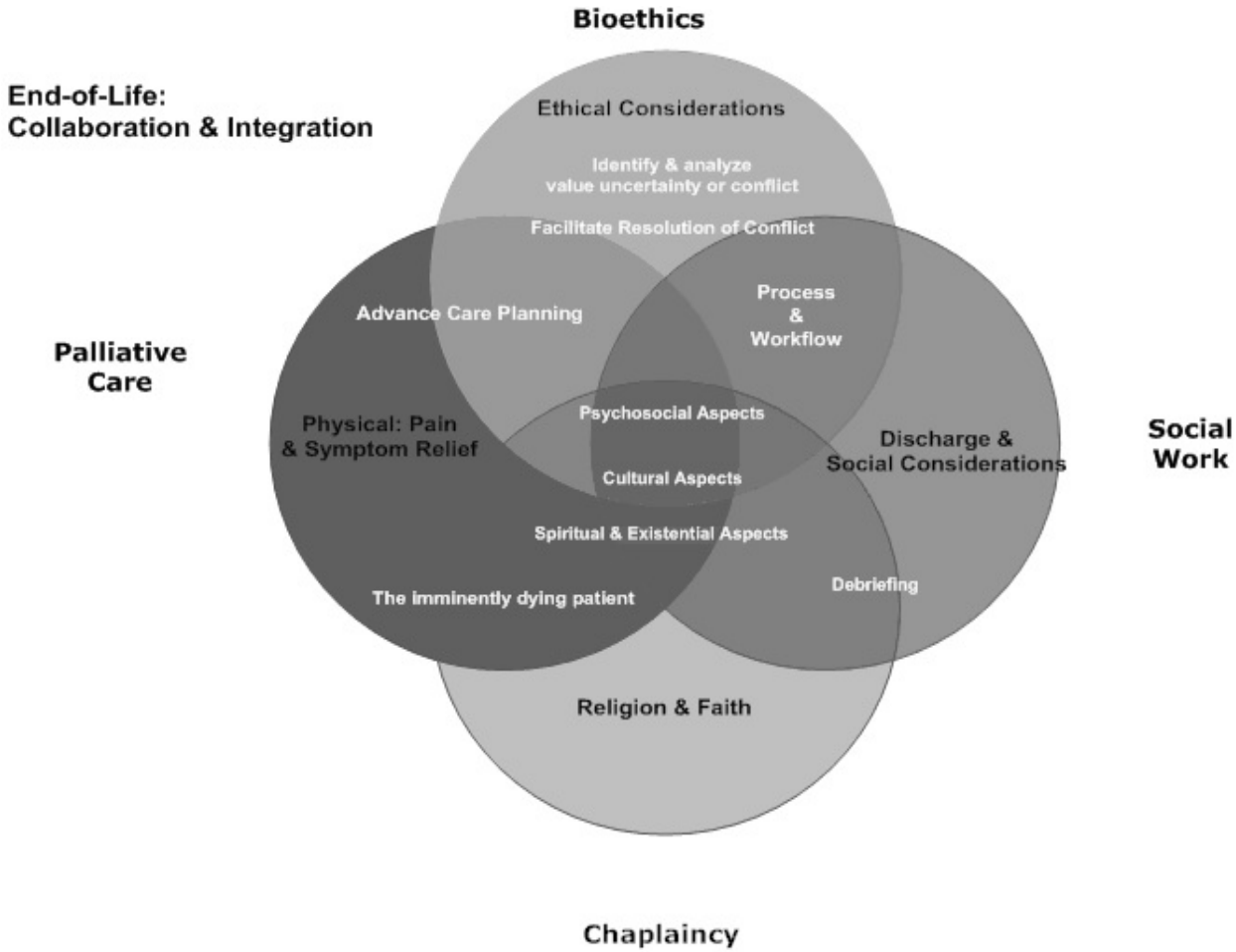
1. "IntegratedEthics Staff Survey," Veterans Health Administration, National Center for Ethics in Health Care, summer 2014, *http://www.ethics.va.gov/docs/integratedethics/IESS/2014_iess_pv_final_04152014.pdf.*
2. A. Frolic et al., *Clinical Ethics Needs Assessment Survey (CENAS)*, (Ontario, Canada: Hamilton Health Sciences, November 2012), *http://www.hamiltonhealthsciences.ca/workfiles/CLINICAL_ETHICS/HHS%20CENAS%20Survey%202012.pdf*
3. Used with permission from S. Greenberg and J. Fisher, "Ben Taub General Hospital Clinical Ethics Consultation Service Needs Assessment Survey," re-printed with permission.

ated and documented? Providing well-researched data that compares other benchmark hospitals that have a successful CECS, including their staffing requirements, can strengthen the argument that additional resources are needed. Gathering data from other benchmark hospitals on the structure of their service is often useful to show how often ethics committees are used, when they are used, and how they function relative to CECSs in hospitals in which volunteer and professional clinical ethicists are used.

Following a background section, the proposal should contain a justification section. This section is likely the most substantive section of the proposal, outlining why a CECS is needed and how it would align with the mission of the facility and its goals. This section can benefit from a CECS mission statement that succinctly displays the goals and objectives of the CECS. A section titled, "What is the institutional value of clinical ethics consultation?" should resonate with administrators who are concerned with matching the objectives and goals of the organization with the services it provides. Here, CECS directors, chairs, or advocates for CECSs have the opportunity to show how the mission and values of the CEC align with the mission and values of the hospital, drawing heavily on the information we provide above for economic and non-economic considerations.

In the core section of the proposal, sometimes called the planning section, clinical ethics leaders will need to describe what they are planning to do, including the scope of work, anticipated activities, the type of consultation model, and projected first-year plans and three-year or five-year plans. Table 3 provides an example of proposed aims. The scope of work should include core CECS activities, such as CECS development and implementation, consul-

FIGURE 1. Content domains and specific areas of specialization among ancillary services



tation services, education and training, and administrative and policy development support. The proposal should specify the scope of each core activity and the role of ethics consultants in ensuring its success. Other details that could be included are: who would participate in the activities of the CECS, how existing institutional expertise would be used, how recruitment efforts would be initiated and monitored, how the CECS would relate to the ethics committee, and an outline of consultation activities.

In the planning section, the proposal should address quality improvement measures that will be undertaken to ensure a robust and healthy CECS. Creating and sustaining an organizational culture of excellent patient care has become essential for healthcare delivery. Excellent, or high quality, patient care

TABLE 3. Examples of proposed aims

1. Provide a first-class CECS.
2. Provide education and training activities for the entire consult team and biomedical ethics committees.
3. Provide ongoing monitoring of CECS and policies.
4. Develop, foster, and maintain research collaborations.

TABLE 2. Example of delineating roles and activities for "conflict cases"

CECS	Both services	Palliative Care Service
Ethical issue	Consultative activities	Palliative issue
1. Identifying and analyzing value uncertainty of conflict 2. Mediating conflict	Attending family and/or team meetings Elucidating values/preferences Elucidating preferred communication and decision-making style	1. Addressing goals of care and 2. Preparing for shifting goals 3. Implementing the shift
Types of "conflict cases" in which a CECS should bring in Palliative Care Service (if not involved already).		
1. A decision for comfort care has been made. (CECS steps out at this point.) 2. The team has come to a consensus that the patient is not a transplant candidate or a candidate for a life-sustaining procedure and the team has communicated this to the patient/family. (CECS steps out at this point.) 3. Technical expertise is required for comfort care/hospice transitions.		
Types of "conflict cases" in which Palliative Care Service should bring in CECS (if not involved already).		
1. Patient has a living will and the surrogate requests something in contravention of the living will. (CECS takes on principal role in these cases.) 2. The patient's advance directive is confusing and interpretation is needed. 3. Surrogate requests withdrawal of life-sustaining treatment at a time clinicians think is premature. (CECS takes on principal role in these cases.) 4. Entrenched disagreement between parties is observed, suggesting that reconciliation will be difficult.		
Types of "conflict cases" in which there is a high likelihood of duplication, so special attention should be paid; high degree of communication warranted.		
1. Family members disagree about code status or continued aggressive measures versus life-sustaining treatment. (Usually Palliative Care Service will take the lead role in these cases.) 2. Continued aggressive measures is considered questionable or medically inappropriate (Equal role; active participation by both services.)		
Types of "conflict cases" in which there is a low likelihood of duplication, so less communication is warranted.		
1. Patient with questionable capacity (or who lacks capacity) strenuously objects to a treatment the team believes is in her/his best interest. (CECS takes on principal role in these cases.)		

should strive to reduce variation in patient care processes, replacing uncontrolled variation with managed variation that is driven by data.[23] To this end, procedural (non-stylistic) variation among ethics consultations should be monitored and, to the extent possible, minimized to reduce unacceptable variation in consultants' practices. That is, ethics consultants should approach consultation activities in the same way, using similar procedures and analytic methods in how they conduct ethics consultations; while there may be insignificant "stylistic differences" in how consultants conduct a consultation, there should be no discernible difference in how they conduct ethical analysis, document a consultation, or facilitate during family meetings.

There are several methods to reduce variation that could be incorporated into a proposal. One method is the peer-review system. Some CECSs use a subcommittee of the ethics committee to review a handful of cases on quarterly bases. Other CECSs meet monthly and have one ethics consultant "deconstruct" her or his cases, providing rationales for how and why certain steps were taken or not taken. Other methods to reduce variation consist of having the director of the CECS monitor its efforts by reviewing documentation, for instance, or meeting on quarterly a basis with stakeholders in the service as "spot checks" to ensure continuous quality. For a nascent CECS, it might be prudent to use a combination of these methods to minimize variation in the formative years, eventually moving towards only using one or two ideal quality improvement measures to sustain quality once it has been achieved.

Delineating clear expectations for each core activity will also help to identify the necessary budget, which should also be included in the proposal. The clinical ethics leader will need to consider the personnel and other operating expenses of the CECS, as well as work with the appropriate administration and finance departments to calculate the annual budget and funding levels appropriate for the CECS. Regarding personnel expenses, the percentage of effort required and corresponding salaries will need to be determined for all personnel, including the director of the CECS, one or more ethics consultants based on level of expertise and need, fellows (if the program will be supporting the training of clinical ethics fellows), and administrative and research support as determined by the CECS director or chair. The levels of effort should be justified by using material from the justification section. Examples of operating expenses include: malpractice insurance for consultants, supplies, travel to professional conferences, and other associated operational expenses. If the organization will support the cost, the budget should also provide for outside consultants to come in at the early stages (year 1) and then later (year 3 or year 4).

CONCLUSIONS

In the above sections we have suggested ways in which the value of a CECS can be demonstrated and how it can be differentiated from other ancillary services. We have also offered concrete approaches for specifying these general value proposals within a particular hospital and communicating the findings to administrators. It is important, however, to keep in mind that every institution is unique. A clinical ethics leader's overall approach as well as the specifics of the service proposal will need to be tailored to the institution's structure, culture, and context. The personalities and attitudes of administrators, medical staff, and clinical ethics leaders must be taken into account. We offer the above suggestions as a starting point for individuals who are working to create, expand, or reinvigorate a CECS in the hope that they will help garner both the financial and political support needed to be successful in this important work.

NOTES

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