Bonnie H. Arzuaga, "Development of a Clinical Ethics Committee *De Novo* at a Small Community Hospital by Addressing Needs and Potential Barriers," *The Journal of Clinical Ethics* 28, no. 2 (Summer 2017): 153-8.

Development of a Clinical Ethics Committee *De Novo* at a Small Community Hospital by Addressing Needs and Potential Barriers

Bonnie H. Arzuaga

ABSTRACT

Hospital ethics committees are common, but not universal, in small hospitals. A needs assessment was completed at a 155-bed community hospital in order to adapt an academic tertiary center model for a clinical ethics committee to fit the needs of the small hospital community. Of 678 questionnaires distributed, 209 were completed. Data suggested that clinical staff frequently experienced ethical dilemmas. Significantly more nonphysicians indicated that they would utilize a consultation service, if available, compared to physicians ($p = 0.0067$). The data also indicated that the majority of staff (>80 percent) desired more education in clinical ethics. Physicians preferred annual or bi-annual hospital-wide grand rounds, compared to nonphysicians, who preferred more frequent department-based teaching ($p < 0.001$). The data presented in this article were used to subsequently develop a clinical ethics support committee, the process of which is also described.

BACKGROUND

Hospital ethics committees have gained acceptance and have become widespread since their inception during the 1980s.[1] At many larger tertiary institutions, it is now a given that an ethics advisory committee exists within the framework of the hospital, and many of these committees provide real-time consultative services.[2] These services have been found to provide significant benefits to the care of patients, including decreased use of intensive care as well as the increased satisfaction of patients and family members.[3] Despite this, only approximately 80 percent of hospitals in the United States have ethics consultative services, and small non-academic institutions disproportionally lack them.[4]

Previous literature has examined some of the differences between ethics consultative services at large university hospitals and services at community hospitals. One study in particular reported significant differences in the major reasons for requests for consultations between the two types of institutions, thus highlighting different needs based on local culture and environment.[5]

In 2014, a 155-bed acute care hospital serving 12 towns in Massachusetts joined a network of hospitals under the umbrella of a large urban academic institution. The academic center had a widely successful and long-standing ethics committee and consultative service in place. There was interest on both sides in adopting a similar service at the smaller institution. Prior to this merger, there had been no formal ethics committee or consultative service available at the community hospital. If an ethical issue related to patient care arose, an *ad hoc* com-

Bonnie H. Arzuaga, MD, is an Attending Neonatologist in the Division of Newborn Medicine at Boston Children's Hospital in Boston, Massachusetts; is an Instructor in the Department of Pediatrics at Harvard Medical School in Boston; and former Co-Chair of the Ethics Support Committee at Beth Israel Deaconess Hospital Plymouth in Plymouth, Massachusetts. *bonnie.arzuaga@childrens.harvard.edu*

mittee comprised of administrators, legal counsel, and patient advocates would convene to address the specific case. There was a general feeling by the clinical staff that this model tended to feel punitive in nature and, consequently, physicians and other staff members rarely brought forth ethical dilemmas encountered at the bedside.

This article will outline the process used to adapt a university-based system of ethics support to a small community-based hospital. As part of this process, quantitative methodology utilizing a needs assessment in the form of an anonymous survey was presented to the community hospital staff in order to guide program development. The aim of the assessment was to explore the needs of physicians and nonphysician clinical staff at a small community hospital, as they relate to clinical ethics and ethics education. Since the experiences, perspectives, and decision-making processes of physicians and nonphysician staff are often different,[6] a secondary purpose of the assessment was to identify and contrast any variation in the needs of these two groups of stakeholders. The information collected was used to focus committee structure and efforts to maximize the potential impact such an undertaking would have on the clinical, educational, and administrative functions of the hospital and its staff. It is our hope that this article will serve as a guide to similar institutions in the advancement of internal ethics support as well as to promote further discussion and research about the ethics needs of clinical staff working in smaller institutions.

METHODS

The mixed methodology utilized for this article is a combination of an institution-wide needs assessment and a case study reporting the experience and process of adapting an ethics committee and consultative service model that is successful at a large academic institution to fit the needs of the patients, families, and staff at a small community-based hospital.

Needs Assessment Instrument

To provide quantitative data and guidance for appropriate adaptations, a 15-item electronic anonymous survey was sent to all clinical staff actively employed at the community hospital. The questionnaire was developed *de novo,* and multiple iterations were pretested by an expert panel. The final version was piloted by a group of healthcare providers to evaluate the plausibility, validity, and understandability of its content. Respondents were asked for their basic demographic information, such as department of employment, clinical discipline (for example, physician versus registered nurse), and gender. Follow-up questions examined four major domains: the preferred membership profile of potential ethics committee members, the frequency and types of ethical dilemmas encountered within the respondent's department, the respondent's opinion on barriers to requesting ethics consultations, and self-reported educational needs as they relate to medical and clinical ethics.

Survey data were collected using REDCap software[7] hosted at Beth Israel Deaconess Medical Center (BIDMC), and responses were solicited through mass email via internal hospital list serves. Emailed reminders were sent every seven days to nonrespondents for as long as three weeks, to maximize the response rate. The design for this study was reviewed and approved by the BIDMC Institutional Review Board. The questionnaire is available as a supplement to this article.

Statistical Analysis of Quantitative Data

Statistical analysis of collected survey data was done using SAS 9.4 software. *Chi*-square and Fisher's exact tests were employed in a bivariate fashion to detect differences between physician and nonphysician respondents. Due to small numbers, physician's assistants and nurse practitioners ($n = 6$) were grouped with physicians, while respiratory therapists ($n = 1$) were grouped with registered nurses into the nonphysician group for the purpose of analysis. This model was chosen because the clinical role of physician's assistants and nurse practitioners was felt to be more similar to that of physicians, while the clinical role of respiratory therapists is more similar to that of nurses. Bivariate analyses was found to be significant at $p < 0.05$, and multivariate regression was then utilized to examine any potential confounding effect of respondents' gender.

RESULTS OF THE NEEDS ASSESSMENT

Overall, 269 of 678 surveys were completed for a response rate of 40 percent. The majority of respondents were registered nurses (72 percent, $n = 185$); 14 percent were physicians ($n = 37$); 2 percent were physician's assistants or nurse practitioners ($n = 6$); 11 percent designated themselves as "other clinical staff" ($n = 29$); and there was one respiratory therapist. Most of the respondents were female (89 percent, $n = 229$) and were in active clinical practice at the time of survey administration (91 percent, $n = 233$).

Composition of the Ethics Committee

Respondents were asked what they perceived to be the most effective membership composition of an ethics committee (whose primary purposes are to provide clinical consultation services and ethics education). The majority (66 percent) responded that they believed an effective committee would include both clinical members (that is, physicians, nurses, and so on) and nonclinical members (that is, attorneys, administrators). In contrast, 32 percent indicated that a committee of solely clinical professionals would be most beneficial. A small minority believed that a committee made up only of nonclinical professionals (1.4 percent) or only of physicians (0.5 percent) would be optimal.

Educational Needs of the Hospital Community

Both physician and nonphysician respondents indicated an interest in receiving more education in clinical medical ethics (82.5 percent and 82 percent, respectively). The educational needs in ethics identified by respondents are listed in table 1. The educational needs that were most commonly identified by staff were withdrawing and/or withholding treatment (40 percent of physicians, 43 percent of nonphysicians, $p = 0.73$), conflicts of interest (30 percent of physicians, 35 percent of nonphysicians, $p = 0.6$), and advance directives/surrogate decision making (28 percent of physicians, 46 percent of nonphysicians, $p = 0.03$). The least commonly identified need was research ethics (9 percent of physicians, 15 percent of nonphysicians, $p = 0.47$).

Physicians and nonphysicians differed significantly regarding the preferred educational model for learning about ethics (see table 2). Physicians preferred yearly (42 percent) or quarterly (27 percent) hospital-wide grand rounds dedicated to topics in ethics, and nonphysicians opted for quarterly (40 percent) or monthly (20 percent) ethics rounds specific to their department ($p < 0.001$).

TABLE 1. Respondent-identified educational needs in ethics

	Physicians		Nonphysicians		
	%	*n*	%	*n*	*p*-value
Withdrawing and/or withholding treatment	40.0	17	43	96	0.730
Advance directives/surrogate decision making	28.0	12	46	99	0.029
Medical futility	37.0	16	29	62	0.280
Confidentiality	25.5	11	15	33	0.120
Truth-telling	21.0	9	23	49	1.000
Cultural differences	18.6	8	22	48	0.680
Allocation of resources	28.0	12	17	37	0.130
Conflicts of interest	30.0	13	35	75	0.600
Research ethics	9.0	3	15	32	0.470

TABLE 2. Preferred Educational Model for Learning about Ethics

	Physicians		Nonphysicians		
	%	*n*	%	*n*	*p*-value
Yearly grand rounds	42.5	17	12.5	24	<0.001
Quarterly grand rounds	27.5	11	20.0	38	--
Quarterly department-specific ethics rounds	22.5	9	40.0	77	--
Monthly department-specific ethics rounds	7.5	3	20.0	38	--

Providing Clinical Consultations

Respondents were asked how often ethical dilemmas arose in their respective departments. Approximately half (48 percent) indicated that their departments had encountered a clinical ethical dilemma in the past year. Of those who indicated such, 25 percent reported an ethical dilemma occurred at least once, 65 percent reported two to 10 dilemmas in the past year, and 10 percent reported more than 10 ethical dilemmas.

Both physicians and nonphysicians identified a multitude of topics relating to ethical dilemmas that occurred in their departments in the past one year, with no statistical differences found between the two groups (see table 3). The most commonly identified topic was determining a patient's competence or decisional capacity (30 percent of physicians and 27 percent of nonphysicians), and the second most commonly identified topic was disagreement with a patient's family members about the plan of care (21 percent of physicians and 26 percent of nonphysicians). When asked if they would have utilized an ethics consultative service in the past year if one had been available at the hospital, 46 percent of physicians indicated they would, compared to 71 percent of nonphysicians ($p = 0.0067$). This difference persisted when controlled for the respondents' gender.

Respondents were then asked to identify any perceived barriers to receiving consultative help from an ethics committee. Overall, 8 percent of physicians thought that such barriers existed, compared to 20 percent of nonphysicians, however, this dif-

ference did not reach statistical significance ($p = 0.1$). The identified barriers are listed in table 4. No significant differences were found between groups regarding the types of barriers perceived; however, there was a trend that nonphysicians were worried about the possibility of punitive action or reprisal as a consequence of requesting an ethics consultation (8 percent versus none; $p = 0.08$).

ETHICS COMMITTEE AND PROGRAM DEVELOPMENT

The overall findings of these data confirm that, despite the previous literature reporting that ethics committees are not universally present in hospitals with less than 400 beds,[8] there is a need by even a small hospital community for access to formalized ethics consultative services as well as to educate in clinical ethics. With that in mind, over a time period of approximately 10 months, an ethics committee (the Ethics Support Committee, or ESC) was founded, policy was developed, a consultation service was established, and early educational initiatives and goals were identified. Pre-existing interest by some of the hospital staff in joining such a committee served as the initial catalyst for this successful endeavor.

The ESC interest group initially was comprised of a mixed membership of physicians, nurses, a dietician, a chaplain, a social worker, and administrators. The results of the needs-assessment indicated that the hospital staff felt that this indeed was the optimal composition for such a committee, and as such, the membership roster for the ESC was final-

TABLE 3. Respondent-identified-topics of ethical questions or dilemmas (occurring in the past one year)

	Physicians		Nonphysicians		
	%	*n*	%	*n*	*p*-value
Decisions to forego life-sustaining treatment (i.e., withholding or withdrawing care)	16.0	7	21.0	46	0.54
Disagreement with family members of patient about the plan of care	21.0	9	26.5	57	0.56
Disagreement with other healthcare professionals or staff members about the plan of care	14.0	6	21.0	44	0.40
A patient's competence or capacity to make decisions for himself or herself	30.0	13	27.0	58	0.70
Do-not-attempt-resuscitation orders	7.0	3	15.0	33	0.22
Advance directives or medical orders for life-sustaining treatment form (MOLST)	11.6	5	10.0	21	0.78
Informed consent	11.6	5	8.0	18	0.55
Patient confidentiality and/or HIPAA (Health Insurance Portability and Accountability Act of 1996)	14.0	6	7.4	16	0.22
Genetic testing	2.0	1	0	--	0.17
Legal issues related to patient care	16.0	7	12.0	26	0.45
Personal professional responsibility to a patient or family	14.0	6	13.0	28	0.80

TABLE 4. Respondent-identified barriers to requesting an ethics consult

	Physicians		Nonphysicians		
	%	*n*	%	*n*	*p*-value
I do not feel like a consultation with an ethicist would be helpful or useful	0	--	1.4	3	1.00
Questions or dilemmas are easily resolved by treatment team within my department or specialty	0	--	1.9	4	1.00
I am unsure of when it would be appropriate to call for an ethics consultation	7.0	3	10.0	21	0.78
I am unsure of how to contact ethics consultants	7.0	3	8.0	18	1.00
An ethics consultation would be too time consuming	2.3	1	5.6	12	0.70
I worry of the possibility of punitive action or reprisal	0	--	8.0	17	0.08
I worry of the possibility of getting administration involved in the care of a patient	0	--	6.5	14	0.14
I worry of the possibility of getting the legal department involved in the care of a patient	0	--	3.7	8	0.36
I am uncomfortable with having a third party (consultant) be involved in the care of a patient	0	--	4.6	10	0.22

ized and confirmed. The ESC, however, realized that individual members were better suited to different roles within the overall mission of the committee. It was generally felt that the individuals who would provide ethics consultation should maintain an objective role in each clinical case, and any conflict of interest or potential abuse of power should be avoided.[9] Therefore, the ethics consultants should not have had a previous relationship with the patient or family involved in the consultation, nor should they be in a direct supervisory position to the clinical team. Unlike large tertiary centers, in a small community hospital this can often prove difficult, as there are typically only a limited number of clinical careproviders and administrators. Consequently, the nonclinical members of the ESC, who were all in some type of hospital supervisory role, elected not to participate in bedside consultations, but to invest their energies to educational initiatives as well as policy development. Clinical members who had a previous relationship with a patient or family would excuse themselves from a particular consultation. This frequently left only one or two ESC members eligible to provide a consultation; however it was felt that, in this way, conflicts of interest would be minimized and the ESC could maintain objectivity in each scenario it encountered. The implications of a limited number of available personnel to conduct consultations at a small institution include not only the inability to utilize a group consultation model in many instances, but also possibly not always being able to meet the standards of possessing advanced levels of core knowledge and competencies as currently outlined by the American Society for Bioethics and Humanities (ASBH).[10] As the ASBH standards are revised and regulations are created, some focus should be placed on what they may mean for small institutions with limited resources, and effective strategies to ensure the quality, consistency, and accountability of consultation services in this setting should be considered.

It has been established that the main focus of most hospital ethics committees is to provide clinical consultation.[11] As such, questions relating to consultative services made up the majority of our needs assessment, and a concerted effort to establish a clinical consultative service was the newly formed ESC's top priority. First, approximately half of the respondents indicated that they had encountered an ethical dilemma within their respective departments in the past year, and of those, most (75 percent) had two or more encounters. Additionally, two-thirds of the respondents indicated that if a clinical consultative service had been available, they would have utilized it. In the first 12 months of providing consultative services, the ESC received 13 consultation requests; a number that far surpasses the median of three consults per year performed by hospital ethics committees nationwide.[12] This high volume of requests, when viewed in conjunction with the needs-assessment findings of frequency of respondent-identified ethical dilemmas, as well as the respondents' interest in ethics education, further underscores a pervasive need that is present throughout the institution.

Prior to the administration of the survey, there was speculation from some of the ESC members that staff would be hesitant to request consultations due to concern about the status of the ethics consultants and their roles in each clinical case, as well as fears about the hospital administration or legal team becoming involved in patient care (that is, a "big brother" effect). These speculations were not farfetched, as much has been written about the mostly undefined but extremely important political contextual features that may influence ethics consultation.[13] It was felt that, in a small community, these features would be amplified by the intimate nature of the institution. The data collected, however, did not reflect this hypothesis. Most respondents did not believe that there were any barriers to having the ESC be of consultative assistance in their respective departments. Surprisingly, the most commonly identified barriers for both physicians and nonphysicians concerned the logistics of contacting the ESC (uncertainty of when and how). In response, the ESC put forth a blitz of self-promotion and question-and-answer sessions in forums such as departmental chiefs' meetings, medical executive committee meetings, and the hospital-wide monthly newsletter. Business cards and an information pamphlet were designed and distributed throughout the hospital. A webpage was also developed that included contact information for the ESC, examples of ethical dilemmas that may warrant a consultation, and frequently asked questions pertaining to the role of the ESC in consultation and the consultative process.

Finally, the needs assessment indicated that the majority of hospital staff were interested in receiving further education related to clinical ethics. The ESC therefore provided a multifaceted ethics educational program. First, an annual grand rounds dedicated to topics in clinical ethics was established for physicians to attend and receive continuing education credits, with a plan to eventually increase to bi-annual sessions. In order to fulfill the reported needs of the nonphysician staff, an "ethics liaison" program, successful at other institutions,[14] was

thought to be an appropriate way to integrate ethics education into specific departments. Unlike the affiliated academic center, which has liaisons who conduct monthly ethics rounds in every hospital department, there was not enough available manpower to provide regularly scheduled rounds in all departments. Therefore, the ESC members developed a list of key departments on which to focus its initial efforts: Critical Care, Medicine (Hospitalists) and General Surgery. Liaisons were recruited from these areas and invited to attend ESC meetings in order to be introduced to ethical discussion and concepts. At the time of this writing, the eventual goal is to have the liaisons mirror the work done by their counterparts at the academic center by identifying department-specific needs related to ethics, and by providing ethics education to their departments.

Our needs assessment should be viewed in light of a few limitations. First, the overall response rate was 40 percent, with a small number of physician respondents. This introduces the possibility of a type II error in some findings. It is also possible that the findings overestimated the needs of the hospital staff by introducing a response bias. Likewise, the results of the needs assessment and experiences in the development of the ethics committee represent those of a small New England community hospital, and therefore certain aspects may not be able to be generalized to all hospitals. Despite these limitations, the relatively large number of consultation requests received by the ESC during the first year of its inception suggests that the findings of the needs assessment are accurate.

In conclusion, hospital ethics committees seem to be needed and useful even in small community hospitals. There are differences in the needs of physician and nonphysician clinical staff in their willingness to utilize ethics consultative services as well as in their preferred method of education in clinical ethics. Perceived barriers to obtaining assistance from an ethics committee are infrequent. Development of an ethics committee at a small institution where one did not previously exist resulted in a high number of consultation requests, compared to reported national medians. Future studies should focus on delineating the underlying reasons for different rates of ethics consultation utilization among hospital staff, as well as on effective methods to promote universal ethics committee presence at all hospitals, regardless of size.

ACKNOWLEDGMENTS

The author would like to thank Wenyang Mao, MS, for assistance with statistical analysis of the needs assessment data as well as members of the BIDMC Plymouth Ethics Support Committee for their hard work and dedication to the hospital community.

NOTES

1. S.J. Youngner, J. Stuart, and G. Jackson, "A National Survey of Hospital Ethics Committees," Critical Care Medicine 11, no. 11 (1983).

2. A. Slowther et al., "Development of Clinical Ethics Committees," *British Medical Journal* 328 (2004): 950-2; G. McGhee et al., "Successes and Failures of Hospital Ethics Committees: A National Survey of Ethics Committee Chairs," *Cambridge Quarterly of Healthcare Ethics* 11, no. 1 (2002): 87-93.

3. L.J. Schneiderman et al., "Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting," *Journal of the American Medical Association* 290 (2003): 1166-72.

4. E. Fox, S. Myers, and R.A. Pearlman, "Ethics Consultation in United States Hospitals: a National Survey," *American Journal of Bioethics* 7, no. 2 (2007): 13-25.

5. J. La Puma et al., "Community Hospital Ethics Consultation: Evaluation and Comparison with a University Hospital Service," *American Journal of Medicine* 92 (1992): 346-51.

6. R. Grundstem-Amado, "Differences in Ethical Decisionmaking Processes Among Nurses and Doctors," *Journal of Advanced Nursing* 17 (1992): 129-37.

7. P.A. Harris et al., "Research electronic data capture (REDCap)—a metadata-driven methodology and workflow process for providing translational research informatics support," *Journal of Biomedical Informatics* 42 no. 2 (2009): 377-38.

8. Fox, Myers, and Pearlman, "Ethics Consultaion in United States Hospitals," see note 4 above, p. 15.

9. M.P. Aulisio, R.M. Arnold, and S.J. Youngner, "Health care ethics consultation: Nature, goals, and competencies: A position article from the society for health and human values–society for bioethics consultation task force on standards for bioethics consultation," *Annals of Internal Medicine* 133, no. 1 (2000): 59-69.

10. A.J. Tarzian, "Health Care Ethics Consultation: An Update on Core Competencies and Emerging Standards from the American Society for Bioethics and Humanities' Core Competencies Update Task Force," *American Journal of Bioethics* 13, no. 2 (2013): 3-13.

11. G. McGee et al., "A National Study of Ethics Committees," *American Journal of Bioethics* 1, no. 4 (2001): 60-4.

12. Fox, Myers, and Pearlman, "Ethics Consultaion in United States Hospitals," see note 4 above, p. 16.

13. J.E. Frader, "Political and Interpersonal Aspects of Ethics Consultation," *Theoretical Medicine* 13, no. 1 (1992): 31-44.

14. G. Richter, "Greater Patient, Family and Surrogate Involvement in Clinical Ethics Consultation: The Model of Clinical Ethics Liaison Service as a Measure for Preventive Ethics," *HEC Forum* 19, no. 4 (2007): 327-40.