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Qmentum Quarterly: Quality in Health Care is an avenue for sharing expertise, innovation, and Leading Practices across Canada. The publication provides a forum for health and social services organizations that are committed to learning about improving quality and patient safety.
In recent years, contentious ethical health care issues have come to the foreground of public debate, frequently fading away unresolved.

However, what happens when the debate does not involve politicians, national stakeholder organizations and groups, or major media coverage? What happens when a patient or resident, their family, and health care professionals are confronted with unique ethical issues within health care?

In this issue, we focus on resources and strategies that help health care professionals address ethical questions. Ethics-oriented resources have a two-fold effect; they help individuals work through ethical dilemmas, and they can help organizations in the health care system be more transparent. Our authors have made excellent contributions in this area. I’m certain their work will inspire others in similar situations across the country.

Lori Seller, Alexandra Marquez, Farhan Bhanji, and Saleem Razack begin our examination of ethics in health care by discussing why ethics training is vital to medical residents. Their unique, simulated ethics exercises for pediatric medical residents at McGill University Health Center are a valuable part of the training residents receive.

Bonnie Cham discusses the moral distress experienced by some health care professionals when they cannot pursue their preferred course of action. She explores several approaches to help health care professionals deal with the feelings that result, and to better resolve similar situations in the future.

While health care leaders may appreciate that an ethics framework is important, they may be unclear as to how to create, tailor, or implement one. Robert Butcher’s article reviews the four necessary components of an ethics framework.

Hugh MacLeod shares the Canadian Patient Safety Institute’s (CPSI’s) approach to ethical issues around disclosure and patient safety incidents. CPSI has several resources to help organizations share their lessons learned. All of these resources help organizations work through challenges that might otherwise pose ethical dilemmas.

There has long been a gap in the management of ethical issues in emergency medical services (EMS). Recognizing this gap, Ward Eggli and Julija Kelecevic set out to create the first ethics framework for EMS in Canada; they share their approach and story with us.

Whether you work on health care policies or at the point of care, do you and your colleagues have the resources and knowledge necessary to effectively address ethical dilemmas? This issue of *Qmentum Quarterly* provides you with knowledge and strategies to consider as you look to effectively address these challenging situations. Enjoy this thought-provoking issue of *Qmentum Quarterly*!
Ethics simulations for medical residents
Lori Seller, Alexandra Marquez, Farhan Bhanji, Saleem Razack
The McGill University Health Center (MUHC) offers simulated exercises on ethics to pediatric medical residents. This helps them translate what they learn about ethics into practice, and examine/assess ethical dilemmas they might not encounter during clinical training. The goal is to teach them about resources they can use when faced with difficult ethical situations, and to improve their communication skills around difficult situations involving ethics.

In order to meet the Royal College of Physicians and Surgeons’ requirement for a discipline-specific curriculum in bioethics, the MUHC in Montréal, Québec, has implemented a unique ethics curriculum. The MUHC offers a professional clinical ethics service that provides a consistent approach to ethical issues, taking into consideration the MUHC’s institutional values. The service also has a mandate to provide ethics teaching, and created a new simulation-based ethics training program for pediatric residents. In September of 2013, this program was submitted to Accreditation Canada for consideration as a Leading Practice and was accepted.

The curriculum exposes [medical] residents to a wide range of ethical issues ...

Simulation-based education offers an experiential opportunity to address training gaps and better prepare future physicians with knowledge and skills, and the ability to recognize and respond to ethical dimensions of patient care in their practice.

In December 2012, the pediatric division of the clinical ethics service (L.S.) spearheaded a half-day ethics simulation for first-, second-, and third-year pediatric residents. It addressed two important goals:

1. To offer pediatric residents the opportunity to practice ethics analysis and communication skills, so they can respond competently and sensitively to ethical dimensions of their practice
2. To familiarize them with MUHC’s ethics framework in order to foster a consistent approach to ethical issues across clinical specialties and in line with institutional values

The program was developed with significant support from practicing clinicians who were interested in medical education and ethics (F.B., S.R.), and a medical student (A.M.) who took a leadership role in developing the exercise. Today, the simulation continues to be organized by the clinical ethicist, and still relies on the participation of various clinicians with an interest in ethics.
Simulation activity

The simulation activity takes place once each year over the three-year residency period at the Steinberg Medical Simulation Center (McGill).

Following a short information session, participants are divided into groups and rotate through four simulated encounters with a “standardized patient” (a person who plays the role of a patient or parent in the simulation). Scenarios are chosen in an iterative, consensus-building manner by the clinical ethicist and physicians with content area expertise, based on the residents’ perceived needs. A concerted effort is made to design scenarios that are realistic and relevant to pediatrics. Residents take turns leading and observing scenarios, with post-scenario debriefings by expert facilitators occurring after each station. Clear learning objectives are defined for each scenario to guide the debriefing.

At the fifth station, a skilled facilitator reviews the principles of reflective practice; this fosters the residents’ ability to learn from their own professional experiences. Relevant institutional policies, professional standards, and ethical norms are covered to familiarize the residents with the ethics resources that are available to help them address ethical issues in practice. This kind of ethics teaching is important because it:

- Teaches them about existing professional standards and ethical norms
- Helps promote and disseminate institutional values
- Facilitates decision making that reflects institutional values
- Fosters a consistent approach to ethics within the institution

Does it work?

The Kirkpatrick Model (1994) is a four-level program evaluation tool that can be used to objectively analyze the effectiveness and impact of a training activity. The levels are:

1. Reaction: The degree to which the participants react favourably to the training

2. Learning: The degree to which participants acquire the intended knowledge, skills, attitudes, and confidence

3. Behaviour: The degree to which participants apply what they learned during training, in their actual practice

4. Results: The degree to which the targeted outcomes are met as a result of the training

The aim of MUHC’s ethics simulation is to have residents practice identifying and responding to ethical issues they are likely to encounter in their practice, to be able to communicate difficult messages to patients and families in a sensitive, culturally competent, and caring manner and to do so in a way that’s consistent with institutional guidelines. It is not always appropriate for residents to “practice” these skills with real families facing real crises. Furthermore, they may not even encounter these situations during their training so that approaches can be appropriately modeled for them by experienced clinicians. The advantage of simulation is that it provides residents with an opportunity to face ethics situations and be guided by expert facilitators, without any potential negative effects on real patients and their families.

The simulated ethics training program was positively evaluated by participants. Many residents commented on how realistic and relevant
the scenarios were, and that this was an important factor in their engagement with the training exercise. After the first event, 100% of participants said they would recommend this session to their fellow residents, and 95% said it should be a mandatory training session. Following the training, the majority of residents also self-reported increased levels of comfort and preparedness in dealing with ethical issues. Many reported having been unaware that institutional policies exist to guide them when they are faced with an unfamiliar ethical dilemma. They appreciated being made aware of these policies.

It would be nearly impossible to objectively measure the impact of these sessions on residents’ future behaviour, or the effect on patients and families. Yet, we hypothesize that by developing these necessary skills, pediatric residents will be better able to establish positive therapeutic relationships with patients and their families. The goal is to have them foster relationships that are characterized by understanding, trust, respect, honesty, and empathy. The residents’ general approach to ethical issues should also be more consistent than without such training.

What did it cost?
The MUHC already has a pediatric clinical ethicist who teaches. It also has a financial agreement with the Steinberg Simulation Center to provide residency training. Therefore, it was not difficult for the MUHC to use the existing resources to try
to ensure that residents meet a minimum standard of knowledge and competency in ethics and that they approach ethical dimensions of their practice in a way that is consistent with institutional values. The Simulation Center provided a tailored environment, logistical support, and standardized patients to behave as patients and family members in given scenarios.

Given the structures already in place, the simulation was completed without incurring significant costs—there were minimal printing costs and time was spent preparing for the event. Had there not already been a financial agreement between the Steinberg Medical Simulation Center and the MUHC to provide residency training, the Center estimated the cost of the activity at $3,125.

A medical student (A.M.) who took a medical education elective at McGill University was instrumental in designing the first block of scenarios in collaboration with the ethicist, developing character sketches for each of the standardized patients, and assisting in their training. Other scenarios were also developed later by the ethicist with input from the program director. Expert physicians and ethicist facilitators were recruited from within the MUHC according to their areas of expertise. They volunteered their time to participate as teachers/debriefers for this training exercise. For example, a pediatric palliative care specialist facilitated and debriefed a scenario that involved a discussion with a family about treatment limitations for their child.

Can you do it too?

Simulated ethics training is a time-consuming endeavour. This program’s creation was supported by a number of staff with an interest in its development. MUHC’s existing relationship with the Steinberg Medical Simulation Center further facilitated the feasibility of this teaching approach.

Once created, the same scenarios can be used time and again. To avoid repeating scenarios with a given group of residents, we developed a bank that can be reused after three years, the length of pediatric residency training. This means a significant but one-time investment in creating the scenarios.

Any organization that offers clinical ethics teaching can use their existing ethics framework to shape how they teach ethics to their clinicians and medical trainees. While simulation is a novel method for ethics training in pediatric residency, other teaching methods could be used to introduce an institution’s ethics resources and underlying values and to help ensure a consistent approach to ethical dilemmas. Including discussion of institutional policies in ethics lectures or organizing lower-fidelity simulations such as case discussions, or role plays may also be effective and considerably less costly methods. Organizations without a dedicated ethics service or without an ethics service that provides clinical teaching may require significant financial and human resources to introduce or augment their ethics teaching.

Conclusion

We piloted a creative, simulation-based ethics teaching activity to meet medical education requirements and to familiarize medical residents with the institution’s ethics resources. During the post-simulation debriefing, institutional resources related to the ethical issue at hand were reviewed with the expectation of fostering a more consistent approach to addressing ethical issues at MUHC.
By fostering the development of appropriate knowledge, skills, attitudes, and communication strategies amongst medical residents, and by ensuring awareness of systems-level ethics resources that promote a consistent approach to dealing with ethical issues in keeping with institutional values, our ethics activity is thought to make a significant contribution to quality of care and ultimately patient safety.

Although it is difficult to evaluate the program’s impact on patients and their families, the participants evaluated the program positively. They reported that it is useful to be aware of institutional resources when they face ethical issues. Although the MUHC’s ethics and simulation-based teaching resources were already structured in a way that facilitated this ethics workshop, any institution could teach medical trainees about the resources that are available to them when they encounter ethical dilemmas.

Lori Seller

Lori Seller completed her Masters in Philosophy with a specialization in Biomedical Ethics at McGill University. Combining her clinical experience as a Respiratory Therapist with her ethics education, she became the clinical ethicist for the Montreal Children’s Hospital. Her work involves ethics consultation, teaching, policy development, and participation on the clinical and research ethics committees. Her areas of interest include children’s participation in making health care decisions that affect them, and the ethics education of medical trainees.

Alexandra Marquez

Alexandra Marquez, MD, is a resident in pediatrics at Yale-New Haven Hospital. She completed medical school at McGill University and undergraduate at Emory University. Her academic interests are in pediatric critical care, palliative care, and medical education.

Farhan Bhanji

Farhan Bhanji is an Associate Professor of Pediatrics (Pediatric Critical Care and Pediatric Emergency Medicine) at the Montreal Children’s Hospital. He is a member of the Centre for Medical Education and Director of the Fellowship in Health Sciences Education at McGill University. Dr. Bhanji is also a Clinician Educator and Associate Director of Assessment at the Royal College of Physicians and Surgeons of Canada. His academic interests are in medical education, simulation, and pediatric resuscitation.

Saleem Razack

Saleem Razack is a Pediatric Intensivist and Associate Professor of Pediatrics at McGill University. His research interests are in diversity and inclusion in medical education, as well as assessment and core competencies training at multiple levels on the medical education continuum.

References

Moral distress

Bonnie Cham
Moral distress occurs when health care professionals cannot pursue their preferred, or “right,” course of action. There are various factors that contribute to them feeling compelled to act in a certain way, and several approaches have been suggested to assist health care professionals in dealing with the resultant distressing feelings.

The development of moral distress in health care professionals is increasingly recognized as a contributing factor in staff burnout and problems with staff retention. Moral distress was first described by Jameton (1984) as a situation in which one knows the right action to take but is prevented from taking it. Further development of this concept led to the understanding that constraints can present themselves in numerous ways, including policies, staffing patterns, hierarchical structures, and economic restrictions. Most often described as a phenomenon affecting nurses, it is now recognized that any health care professional can experience moral distress.

Often, the underlying issue in moral distress is the gap between being responsible for delivering care and having the authority to determine what that care should be. Examples include staff members in long-term care facilities who feel that inadequate staffing is resulting in the use of medication and physical restraints. Or, a medical student participating in a conversation with a senior staff member who makes derogatory comments about other physicians may feel unable to object due to power differentials.

Ethics-based dilemmas usually arise when there are two or more compelling, but mutually exclusive paths that can be taken. Health care providers often analyze these from varied perspectives, including patient preferences, the just use of resources, beneficence, and non-maleficence. There may not be one obvious solution, but it is possible to develop a robust process for obtaining opinions and data from relevant parties, to help one arrive at an acceptable conclusion. This involves identifying well-recognized ethical principles, and discussing how to balance them in a particular clinical setting. All the parties involved should have a voice in the discussions; no one should be left with the feeling they could have said or done more.

Classically, for doctors, this might involve a situation in which a patient is refusing a life-saving therapy (for example a Jehovah’s Witness refusing a blood transfusion). In this situation, patient autonomy clashes with the principal of beneficence. Analysis of such cases and experience
with the court system tells us that in Canada, autonomy is the overriding principle to be followed in this scenario with an adult patient, and moral distress does not tend to develop. These are cases that can be discussed as paradigm cases and general approaches and education can be provided.

Moral distress, on the other hand, is more difficult to recognize and analyze. The inciting incident is often one in which a personal action is felt to be constrained by a policy or order. The affected individual may suffer from guilt and anguish, resulting in a heightened sense of personal distress. In the example previously mentioned, the nursing home attendant may have applied restraints while feeling that some extra time with the patient was all that was required, and they may feel guilty as a result.

As described in a recent literature review by Burston and Tuckett (2012), a staff member may feel angry with themselves when they know the right thing to do, but constraints make it nearly impossible to pursue the right course of action. “Under these circumstances, the literature further reveals the nurse experiencing horror and anticipatory dread … diminished confidence, self-doubt, and an eventual loss of self-esteem.” If people are unable to resolve an issue, there can also be a crescendo effect (Epstein and Hamric), which occurs when a person is exposed to multiple incidents resulting in moral distress. This results in the development of moral residue, best described by Webster and Bayliss as increasing the intensity of subsequent incidents. Staff may then resort to attempts to work around the system, which simply entrenches systemic dysfunction. Organizations and the communities they serve would be better off if health care providers had tools to help them resolve ethical issues. For this reason, it is incumbent upon us to educate health care professionals about moral distress and how to avoid it.

How can organizations put measures in place to prevent moral distress/moral residue from occurring, and limit its effect on staff and patients when it does occur? Interventions have been suggested in the literature but little outcome-oriented research has been done. Two approaches have been advocated: an individualistic approach and a collaborative approach.

**An individualistic approach**

An individualistic approach targets people’s knowledge of ethical principles in health care. It helps them learn to recognize moral distress when it arises in themselves or others, and teaches them to use reflective learning practices to enhance their ability to deal with issues as they occur. This last technique is receiving more and more attention in medical education. Sandars defines reflection as “… a metacognitive process that creates a greater understanding of both the self and the situation so that future actions can be informed by this understanding.” When we recognize that an event or its outcome causes discomfort, conscious reflection can help an individual deal with the episode so that moral distress is not left to smoulder.

The process, in its simplest form, involves asking three types of questions. The first type involves noticing the event or feeling. The second allows one to process the event through a series of questions about the situation, its outcome, and alternative ways of handling it. The important third set of questions involves developing a
plan to handle future situations. The American Association of Critical-Care Nurses has developed a process called The 4A’s to Rise Above Moral Distress. These involve asking, affirming, assessing, and acting, which are done using a tool that can be very helpful to health care workers (not just nurses) who are experiencing moral distress. Links to this material can be found on their website.

**Collaborative approach**

But what happens when an entire health care team is subjected to moral distress? In a team setting, negative feelings can be accentuated by diverse levels of knowledge about ethics, varied professional development, and even scopes of practice. It has been suggested that conducting ethics education in an inter-professional forum may be a strategy to develop a better understanding of how other disciplines view issues and make decisions. This can contribute to the realization that, at its core, each discipline is working toward the best outcome possible for the patient.

Being able to discuss distressing events in a multidisciplinary forum may facilitate a broader approach to problem solving than would otherwise be available to any one member of the team. By using inter-professional forums, we can help people understand and use a common vocabulary so they are no longer isolated when dealing with distressing events.
How can health care leaders assist in dealing with moral distress? What is clear from the literature is that education regarding moral distress can be a starting point. Initially, educating front-line and managerial staff to recognize and deal with moral distress can be done via multi-disciplinary rounds. A second step could be introduced, involving education about reflective learning, which can enable individuals to gain skills for dealing with these experiences in a way that diminishes distress and prevents a destructive cycle, which can result in moral residue. This can be accomplished by training experienced clinical staff to teach reflective learning practices and help individuals when these experiences occur; this will go a long way in dealing with moral distress. Most health care organizations, if not all, can probably identify current staff from a variety of clinical and professional backgrounds who instinctively practice reflective learning, possibly without having named it, who could act as resources and train other staff.

Conclusion

In order to maintain a healthy organizational culture, moral distress must be alleviated. Our health care service providers will be stronger and healthier if we proactively intervene and prevent moral distress from developing into a pattern. They will be more satisfied and better able to deliver quality care if they are given the tools to resolve difficult ethical issues and moral distress in the workplace.

Bonnie Cham

Bonnie Cham, MD, FRCPC, is an Associate Professor, Department of Pediatrics and Child Health at the University of Manitoba where she has taught medical ethics for 15 years and was a pediatric oncologist for 20 years. She is a past chair of the Canadian Medical Association’s Committee on Ethics. Currently she is involved in the inaugural year of facilitating reflective learning sessions for third-year students in the Faculty of Medicine. She is a board member at Accreditation Canada.

References


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Supporting ethical practice in your community

Robert Butcher
Many organizations know they need an ethics framework, but are not sure exactly what that entails. By understanding a framework’s four components (case consultation and review, policy development and review, education, and research oversight), organizations can begin to address ethical decision making with their staff members.

A homecare nurse calls you with concerns about a client who has been discharged from the hospital. She has questions about his home environment and his ability to look after himself. “The place is squalid,” she says. “He is unsteady and forgetful, but adamant that he wants to be at home. I’m worried.”

During flu season your staff’s vaccination rate is at 70% and the local public health officer has declared an outbreak in the community. Should you require unvaccinated staff to get vaccinated, take Tamiflu, or stay home?

The Executive Director of your hospital’s foundation has just called. They have received a very generous offer from a local businessperson to fund and name a new wing. He is involved in a bitter dispute in the community over the development of large tracts of good agricultural land. The donation is a clear attempt to court public favour; to use your good name and reputation to enhance his.

What should you do in any of these cases? Better yet, what should your organization do?

You cannot engage in health care without engaging in ethical decision making, whether it is in home care, public health facilities, hospitals, or long-term care facilities. The challenges may be different in each environment, but these questions remain the same: what does your organization do to support ethical practice? Does it have an ethics framework?

For more than 20 years Accreditation Canada has encouraged health care organizations to think about their ethics programs and services. The Qmentum Governance Standards and Leadership Standards (Accreditation Canada, 2014) require organizations to have a framework in place to support ethical practice and decision making, but what exactly does that mean?

Most ethics programs or frameworks encourage people to work through a dilemma as close to the source as possible. This might involve using a decision tool such as a framework for ethical decision making. These tools are typically short and designed to promote reflection about the situation from multiple perspectives. They provide questions and may refer the user to organizational values or policies and generally accepted ethical principles. They come as pocket cards, brochures, online worksheets, and so on. There are many of these readily available through organizations or on the web.

Many organizations adopt tools and adapt them to their own needs, which works well because most tools function best when they are tailored to and
embraced by the people expected to use them. This often involves comparing a variety of tools or frameworks and creating a hybrid model that suits the organization’s needs.

All ethics decision-making frameworks work and fail in the same way. They all work to the extent that they encourage and systematize reflection, and help people think things through from a variety of perspectives. They also work in that they encourage users to consider organizational values, polices, and relevant law. They all fail in that they cannot tell people what to do. In many cases there is not a demonstrably right answer, but rather a choice to be made.

Many ethically challenging situations arise precisely because there is good reason to do “this” and good reason to do “that,” but you cannot do both. In many cases there is not a demonstrably right answer, but rather a choice to be made. There may well be a “least worst” option and your decision-making framework should help you find it, but ultimately frameworks cannot make choices. Ideally, in your adopt and adapt process, your organization should settle on something that can be as useful in aiding board decisions as it can be at helping a bedside clinician choose the best option.

Typically, one can think of an ethics framework, or ethics services, as being composed of four major elements: case consultation and review, policy development and review, education, and research oversight. Let’s look at each of these in turn.

To bill or not to bill … a case consultation.

A patient was detained for evaluation and treatment under a province’s mental health act. He was an involuntary patient and was eager to get out of the hospital as soon as possible. He was also a member of a community that does not participate in the provincial health insurance plan. Members of this community are simply billed for the health care services they use. His social worker thought it would be terribly unfair to bill this patient for services he had no choice in receiving.

The hospital has an effective ethics consultation team that can be called upon at short notice, and can include any relevant member of the hospital community. This team convened and included the hospital’s ethicist and members of the finance department and the senior management team. A vigorous and lively debate ensued, involving basic concepts of justice, accountability, and the hospital’s commitment to being sensitive to the diverse character and needs of the communities it serves.

The team concluded that it would be unjust, inappropriate, and contrary to the hospital’s values to bill the patient. This recommendation was accepted by the senior management team.

In many cases there is not a demonstrably right answer, but rather a choice to be made.
Case consultation and review

“I don’t know if this is an ethical issue but...” is the way many ethical puzzles begin. People tend to have a gut feeling about them. They make people uncomfortable, though they may not be able to say exactly why. So what happens next? All too often, people respond by burying the issue and carrying on with their work. This leads to burnout and alienation, and to people shouldering burdens of care that are far better shared. There is a better way.

So what happens if your first stage of reflection on your own does not produce an outcome that is satisfactory? Normally, the next step is a discussion with the manager closest to the issue. If that doesn’t resolve things, what do you do, and how can your organization support you? In such a case, an ethics case consultation is in order. The purpose of case consultation is to help those involved in reflective, ethical, decision making. Case consultation can be done by an ethics consult team with appropriate training in ethics and ethical reflection, by a suitably qualified ethicist, or by both together. Normally the case consultation team and/or the ethicist work with those involved to identify the values and interests at stake and to facilitate decision making. The case consultation team will often use the organization’s ethical decision-making framework as a tool in this process. Case consultation must be timely and responsive, which means that it can be difficult to perform this function with an ethics committee as they tend to work more slowly.

Elder abuse? A case review.

A small rural community hospital conducts case reviews during its ethics committee meetings, and includes the team(s) involved and relevant participants from the hospital community. Over the years, they have tackled a wide range of issues that were clinical and corporate. Typically, a handful of those team members present a situation and a discussion ensues, often resulting in recommendations for the units concerned. This model provides an opportunity for staff to explain a situation that may have been a considerable burden. It is also a time for reflection, education, and making recommendations to improve future practice.

On one occasion the story concerned an elderly patient who went home on a leave of absence to test the viability of a permanent return to her daughter’s home. The patient returned to the hospital after only 24 hours and eventually—with great reluctance—told her social worker that she had fallen and had been unable to get up. Her daughter had told her not to be lazy and to get up on her own, but she could not. Her daughter had brought her tea, a pillow, and blankets, but had left her there for 17 hours. Eventually a neighbour came in and an ambulance was called. The social worker was outraged. “You have been abused,” she said. “I’m going to call the police.” “No, don’t do that,” the patient had said. “I want to go home. Yes my daughter was wrong this time, but we can both be pretty stubborn.”

For the next hour, the ethics group discussed elder abuse, self-determination, autonomy, respect for persons, and protection of the vulnerable. It was a chance to explore the personal feelings and judgments of care providers and to prompt more reflective practice. In the end, the patient’s wishes were respected. While many disagreed with her decision and thought she should not want to or be allowed to go home, most felt that ultimately it had to be her decision. But this is contested territory and it is easy to imagine a slightly different story in which the recommendation would be quite different.
New neighbours

In November 2013 almost 200 members of Lev Tahor, an ultra-orthodox Jewish sect, suddenly left Québec and moved en-masse to the outskirts of Chatham, Ontario. The impact on the local hospital was immediate. About 160 of the community’s members were under the age of 18. Almost all members of the community over the age of 16 were married, and the community had a high birth rate.

Members of the senior management team met with community representatives. A hospital-wide meeting was then called to discuss the impact of this new community and to develop a fair and compassionate but accountable response. The meeting was attended by almost 50 representatives from different parts of the hospital community.

The meeting began with a detailed description of what was known about the Lev Tahor community and its particular needs. The hospital’s values and the ethical challenges of coping with this influx of patients was next on the agenda, followed by a unit-by-unit description of the potential impact of this group. The result was a well-informed hospital that sought to understand and treat members of this community with sensitivity, professionalism, and respect, consistent with the manner in which other patients and families in the community were served.

than case consultation teams. That said, case consultations should be tracked and reported—at least in general terms—back to your ethics committee or other structure, to look for trends and systemic problems.

In order to share the burden of care and learn from experience, case reviews (retrospective analyses of situations) can be done with an ethicist, an ethics team, or an ethics committee. It is important to track cases to look for trends and systemic issues. The bottom line is that case reviews should be done; people involved in them should engage in appropriate reflection, and organizations should support staff, patients, and clients with these types of activities.

The resources available to confront ethical dilemmas vary widely. The first step is to recognize situations that require you to think in ethical terms, and the second is to create processes and structures that support ethical reflection. Look for ways to collaborate and share resources, either geographically or by grouping within a sector. For example, you could create regional or sector-based ethics teams.

Policy development and review

Health care organizations have a range of policies to guide their practice and ensure that similar situations receive similar responses. If you scroll through a list of your own organization’s policies you may be surprised to see how many of them deal with ethical situations or are meant to guide practice when values are in conflict. Some of them are obvious, such as a corporate conflict of interest policy; clinical policies on end-of-life care are often the clearest case. You may be surprised to find that there are many more. One Northern Ontario hospital went through its policy manual and found
106 of its policies had been created to deal with some sort of ethical or values-based issue.

So how do you ensure that ethical reflections and deliberations take place when policies are being developed and reviewed? One approach is to ask drafters if the policy deals with ethical issues or a clash of values. If so, ask them whether they are comfortable addressing those issue or value conflicts. If they say yes, then all is well. If they say no, an ethics committee should be consulted. A particularly troubling case may highlight the need for a new or updated policy, and staff education will be required when it is introduced.

Education

Ethics education can be conveniently divided into two broad strands—awareness education and capacity building education. Awareness education is broad. All members of your health care community need to be aware of your tool/framework for supporting ethical decision making, the processes and tools in the framework for supporting ethical practice, and your method of accessing consultation services. Staff members also need to be aware of organizational values and policies that are relevant to ethical practice.

Capacity building education is usually for ethics teams or committees. This in-depth training enhances participants’ abilities to facilitate ethical reflection and practice. Typically, effective ethics education does not simply provide information; rather, it challenges participants to think more reflectively and more critically about their own practice.

Research oversight

All research conducted on human subjects in Canadian facilities must have Ethics Review Board (ERB) approval. Some larger organizations, particularly those affiliated with research institutions, have their own ERBs. Yet, the majority of health care facilities and organizations do not have that internal capacity. In most cases the research conducted in these facilities receives ERB approval from other organizations that have that capacity.

Conclusion

We have briefly surveyed the general components of an ethics program or framework. How those components are embodied at an organization is a matter for each one to decide. But the benefits are clear—more engaged and reflective staff members, better patient care, improved patient relations, and improved decision-making practices. Q

Robert Butcher

Robert Butcher has a PhD in Philosophy from the University of Western Ontario. Since 1990, he has provided ethics services and ethics education to a wide range of health care facilities and organizations across the country. For the last 10 years he has designed and delivered Accreditation Canada’s ethics education workshops. He blogs (intermittently) at robonhealthethics.blogspot.com and can be reached at rbutcher@healthethics.ca. He is based in London, Ontario.

References


Patient safety incident disclosure and analysis

Hugh B. MacLeod
CPSI advocates full disclosure and an open approach when patient safety incidents occur so that organizations may learn from their mistakes and share their lessons learned with others. It has created three resources to help organizations tackle patient safety incidents in a responsible manner. The Canadian Disclosure Guidelines, the Canadian Incident Analysis Framework, and Global Patient Safety Alerts all help organizations work through challenges that might otherwise pose ethical dilemmas.

Donna Davis and Sabina Robin have both experienced the unimaginable sorrow of losing a child as a result of a patient safety incident. Both are now members of Patients for Patient Safety Canada, a patient-led program from the Canadian Patient Safety Institute.

Donna’s son Vance was only 19 when the severity of his head injury was misdiagnosed following a car accident. Sabina’s infant daughter Mataya had internal bleeding that was diagnosed as less severe than it actually was, which led to a delay in treatment that cost her her life.

Despite best efforts and intentions, patients are sometimes harmed and, in some cases, die as a result of care that was intended to help and heal them. Anger, frustration, and complicated grieving can result when communication and information is not forthcoming and when there are gaps in learning and quality improvement.

In health care settings where there are so many competing demands on providers, patients and families are not always told that a patient safety incident has occurred. Furthermore, even when incidents are discussed openly, they are rarely systematically reviewed so lessons learned can be used to prevent the same mistake from happening again. Rarer still are organizations that are proactive enough to share their lessons learned with others.

“...patients and families are not always told that a patient safety incident has occurred.”

Health care organizations and providers bear an ethical and moral responsibility to do the following so the whole system can benefit:

- Disclose to the patient and family when harm has occurred
- Conduct an appropriate review of the incident
- Develop and implement recommendations and processes to ensure it is never repeated
- Share lessons learned with others

It is critical that organizations and providers that want to provide their patients with the highest quality care—not because they’re obligated, but
because they know it is the right thing to do—manage patient safety incidents effectively when they arise.

The Canadian Patient Safety Institute is committed to helping organizations and health care providers achieve that level of transparency, honesty, and accountability. We strive for a system where disclosure, incident analysis, and information sharing are second nature and are more common than they are right now.

In order to accomplish this, the Canadian Patient Safety Institute offers a trio of resources to help organizations achieve this goal—the Canadian Disclosure Guidelines, the Canadian Incident Analysis Framework, and Global Patient Safety Alerts.

The Canadian Disclosure Guidelines symbolize a commitment to the patient’s right to be informed if they are involved in a patient safety incident. It promotes a clear and consistent approach to disclosure, emphasizing the importance of inter-professional teamwork and supporting learning from patient safety incidents. They emphasize the importance of a clear and consistent approach to disclosure, regardless of the reason for harm.

“When things go wrong, patients and families need to know what happened. We need to know what changes have been made or will be made to prevent a similar event in the future. We need to hear the words ‘I’m sorry’ from those most involved,” Donna Davis says. “Disclosing a patient safety incident with openness, honesty, and compassion shows respect for the patient and
family. It shows that the organization is worthy of our trust and that the needs of the patient and family are paramount.”

As Donna indicated, it is incredibly important for patients and families to know that their suffering was not in vain and that the organization is putting processes in place to ensure such an incident never happens again. This is where the Canadian Incident Analysis Framework can help.

Incident analysis is a structured process for identifying what happened, how and why it happened, what can be done to reduce the risk of its recurrence, and what was learned. It is an integral activity in the incident management process.

“I actually started crying reading it [the framework],” says Sabina Robin. “I can’t help but think how differently it all may have gone for me and my family if we had something like that in existence when Mataya died. That document soothes my soul and brings back a little piece of my heart.”

A commitment to disclose and analyze patient safety incidents is a sign of a great organization—one that puts patients and their families first. But how can these organizations share their findings with facilities across the city, country, or globe?

With Global Patient Safety Alerts, health care organizations can start sharing with each other what happened, what they learned from it, and what they did to improve patient safety. They can make recommendations to other organizations that find themselves in similar situations.

Global Patient Safety Alerts is a one-stop, searchable database with patient safety alerts, advisories, and recommendations; it helps people share what they have learned, and learn from others. For instance, searching for the word “infection” will bring up 77 alerts and 282 recommendations from 15 organizations that have agreed to share their lessons learned. Instant access to this type of information is not found anywhere else on the Web.

Recognized by the World Health Organization and its member countries, Global Patient Safety Alerts contains more than 1,176 alerts and 5,879 recommendations from 25 contributing organizations around the world. Global Patient Safety Alerts help organizations improve patient safety beyond their walls by sharing alerts and recommendations.

Vance and Mataya are just two of the many patients for whom the mistake that cost them their lives could have been prevented. This is why Donna and Sabina continue to work to change the system as members of Patients for Patient Safety Canada. It is also why every provider and organization must do what they can to honour the memory of those who have been lost, by committing to a culture of accountability, learning, and sharing. Transparency is paramount if we want to make the system safer and engender people’s trust in the system. Visit us at patientsafetyinstitute.ca to learn more about these tools and other ways to improve the safety and quality of health care.

Hugh B. MacLeod

Hugh B. MacLeod is the CEO of CPSI. Prior to joining CPSI in 2010, Hugh held senior positions with the Government of Ontario and the Ontario Ministry of Health and Long-Term Care. During his four years with the ministry, he was also the Executive Lead of the Premier’s Health Results Team, responsible for a provincial surgical wait time strategy, a provincial primary care strategy, and the creation of Local Health Integration Networks.
Building an Ethics Framework: Lethbridge Fire and Emergency Services

Ward Eggli, Julija Kelecevic
Traditionally, ethical issues were not well addressed in emergency medical services (EMS) around the globe, and best practices did not exist. Lethbridge Fire and Emergency Services (LFES) recognized that services could be improved with the creation of a standardized ethics framework. They set about creating the first ethics framework for EMS in Canada.

The LFES is the oldest combined fire and EMS provider in North America, with over 100 years in ambulance and EMS work. The unique integration of fire and EMS and the deployment of fully trained paramedics on ambulances and fire engines enhances response times and maximizes support at the scene of an accident or in the care of a seriously ill patient. LFES is currently contracted by Alberta Health Services to provide EMS in our community, the surrounding area, and the South zone (see Figure 1).

Accreditation journey

Accreditation became mandatory in Alberta Health Services in 2008. LFES is an independent organization that has a contractual relationship with Alberta Health Services, which is accredited by Accreditation Canada. Contracted service providers are encouraged to participate in the Accreditation Canada accreditation process in order to align all the services within the system.

In June 2012, LFES began the Accreditation Primer program; it earned an “Accredited” decision in the Qmentum program in 2014. LFES is the only integrated service in the province to become accredited in EMS, and the first contracted EMS provider in Alberta to be accredited under the Qmentum program.

LFES ethics

Prior to the LFES being accredited, ethics were only addressed in professional codes of conduct and in the City of Lethbridge’s corporate policy (Code of Ethical Conduct). In 2012, LFES identified a significant gap between what it provided and the Accreditation Canada standards ethics requirements. The Emergency Medical Services Standards and the Leadership Standards required a process to address ethical dilemmas encountered in daily practice.

“… we discovered a lack of best practices in EMS ethics.”

After conducting an environmental scan that included a literature review and reaching out to colleagues across Canada and the United States, it became apparent that there was a lack of best practices in EMS ethics. The few documents found during the literature review were either outdated or did not include services comparable to those offered by LFES. As the literature outlined, leaders, organizations, and health regions around
the world appreciated the importance of ethics in EMS, and yet, best practices did not exist.

There was clearly a need for and an opportunity to create a standardized ethics framework for LFES.

**Ethics framework**

After meeting the LFES leadership and having informal conversations with employees, we (Ward Eggli, LFES Accreditation Lead, and Julija Kelecevic, then Alberta Health Services Clinical Ethicist for South Zone) agreed that any ethics framework must use the LFES mission, vision, and values as its foundation. We also concurred that the reason for creating the ethics framework was to support the development of a comprehensive culture of ethics throughout LFES. The framework would guide ethical decision making at different levels in the organization. It would be rooted in shared values, including employee wellness, health and safety, teamwork, lifelong learning, accountable leadership, communication, and treating each other with dignity and respect. The framework is a reflection of good governance as well as leadership’s accountability, which supports a culture of ethical decision making.

There are six components of our ethics framework (see Figure 2):

- Organizational ethics
- Ethical policies
- Research ethics
- Project ethics
- Ethics of direct services
- Professional ethics

**Figure 2**
Organizational ethics: These are an expression of organizational values that should be integrated into everything an organization does, including its business practices. Organizational ethics can provide transparent and fair ways of serving the public; they support organizational leaders when they encounter difficult situations such as competing interests.

Ethical policies: These guide an organization’s everyday services and should be created in consultation with key stakeholders. At LFES, we established a step-by-step process for developing and reviewing policies:

- Identify the policy’s sponsor
- Extend the consultation process to ensure all stakeholders are included
- Identify:
  - Why a policy was created (e.g., it addresses safety, reflects best practices)
  - What choices it makes explicit (e.g., who makes decisions, what their limits are)
  - Values that are represented by the policy and values in conflict with the policy
  - Ethical principles that shape the policy and those that are excluded

Research ethics: These protect people who consent to participate in research. To conduct any research in our organization, all projects must align with the ethics principles described in the Tri-Council Policy Ethical Conduct for Research Involving Humans. The University of Lethbridge Human Subject Research Committee reviews our research projects, as outlined in a Memorandum of Understanding.

Project ethics: Quality improvement and program evaluation happen in most publicly funded organizations and these have inherent ethical implications. The quality improvement and program evaluation lead at our organization uses the ARECCI Ethics Decision-Support Tools for Projects to identify risks associated with the project. If a risk is too high, the project lead will seek a Second Opinion Reviewer’s assessment of the ethical components and risks of the project, as outlined in the ARECCI process.

Ethics of direct care: Health care professionals encounter difficult situations in their day-to-day practice. For our staff members, this means facing issues arising from the urgency to provide care (e.g., when and how to obtain informed consent for emergency procedures). Sometimes our staff members have to balance the patient and the provider’s safety against the patient’s dignity, for example, when restraining patients. Although our employees were supported by a code of ethics from their professional organizations, we also believed they could benefit from a practical toolkit to help them make the best decisions quickly or to help them reflect on past difficulties. We therefore adopted the Community Ethics Toolkit as it focused on community delivered services such as those provided by our organization.

Professional ethics: Health care professionals are guided by their respective codes of ethics. We expect all our staff members to be familiar with and to work according to the codes of ethics as outlined by their respective associations and organizations. They have a duty to use their expertise to serve their community while upholding the underlying values of both LFES and their profession.

In the case of our organization, the majority of staff members belong to the Alberta College of Paramedics and the Alberta Fire Fighters Association.
LFES action plan

We had to construct our action plan within the limits of our organizational setting, which meant working around shift work and coverage issues. We needed to set time aside for educational sessions, so we started small with a pilot workshop delivered to 25 front-line staff (one quarter of the current care providers). Julija delivered “Ethics Awareness,” an interactive educational session in November 2013. The learning objectives included:

- Defining ethics
- Discussing different concepts of ethics
- Describing common principles used in ethics
- Reviewing ethics frameworks, focused on the Community Ethics Toolkit
- Identifying ethical concerns and questions specific to the participants’ practice

We acknowledge that creating an ethics framework and establishing related processes are simply the first steps in making ethics an integral part of our work. In the future, we will focus on extensive education throughout the organization, evaluating the ethics framework and supporting processes, and continuing collaboration with AHS Clinical Ethics Services.

LFES plans to continue to engage the Alberta Health Services clinical ethicist for South Zone and to provide consistent, standardized education for LFES staff. All front-line staff will receive this education by the end of 2014.

LFES is also developing an information pamphlet that outlines basic information about an ethics framework. It will be part of the future orientation package for new LFES employees. The first phase of the action plan is heavily focused on reaching front-line providers, so we hope the pamphlet will reach health care providers and people who occupy other roles in the organization.

Every quality improvement lead or project evaluation lead should complete the Alberta Innovates Health Solutions course, an ARECCI level 1 training program. This course allows participants to leave with two tools. The first is a guideline tool, which facilitates project planning and helps uncover and address risks to participants. The second is a screening tool, which helps clarify the project’s primary purpose, and identify ethical risks so project leads and teams can manage these risks. Until employees go through this training, the LFES Accreditation Lead will act as an internal resource to leads requiring assistance.
The second phase of the action plan (into 2016) will focus on solidifying processes for developing and reviewing organizational ethics policies. A comprehensive evaluation plan will be developed by LFES to determine if having a complex, multi-pronged approach to addressing ethical questions in LFES benefits patients and staff. We plan to continue collaborating with Julija on the evaluation strategy, as we recognize the need to demonstrate whether having an ethics framework actually changes the culture of ethics in our organization. Upon completion, the evaluation strategy will be shared in presentations, communications pieces, during EMS field training, and in discussions with staff.

Conclusion

Thank you to our colleagues from LFES and other organizations who helped us throughout this journey and who selflessly shared their knowledge and time with us. We would appreciate any further input from organizations that are similar to LFES and we welcome questions from organizations embarking on their accreditation journey. Remember that the LFES staff and leadership were essential in creating the ethics framework and processes and it was crucial that they felt ownership over these. We wish other organizations success in building a culture that supports tackling ethical issues in a positive and productive manner. Q

Ward Eggli

Ward Eggli, Accreditation Lead, Lethbridge Fire and Emergency Services, is a Senior Firefighter/Paramedic with over 22 years of experience. He is currently finishing a Bachelor’s degree in Health Sciences at Medicine Hat College. He has attained many instructor and leadership certifications throughout his emergency services journey. His work in accreditation has sparked new areas of interest for him in research and bioethics in EMS. You can reach him at: ward.eggli@lethbridge.ca.

Julija Kelecevic

Julija Kelecevic, MD, PhD (ABD), is a regional ethicist at Hamilton Health Sciences. She supports ethics programs in six partner organizations across the Hamilton Niagara Haldimand Brant Local Health Integration Network. Julija is passionate about improving the quality of patient care through enhancing ethical culture throughout the health care sector. Her research interests include cross-cultural ethics, professional ethics, and clinical ethics consultation. She can be reached at kelecivici@hhsc.ca.

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2014 Upcoming events

- Accreditation Forum
  November 24 and 25, Vancouver, BC ►*Registration is now open!*

- Quality Conference 2014 ►*Highlights*

- Lean Yellow Belt training
  September 15-18, Ottawa, ON (English)

- Lean Green Belt training
  September 29-October 3 and November 3-7, Ottawa, ON (English)

Featured workshop

**Ethics in Health Care**

December 1 and 2, Ottawa, ON (English)

Does your organization have an ethics framework that needs tweaking? Do you require coaching and tools to guide staff in ethical, reflective decision making? If so, then this workshop is for you!

Both managers and leaders are encouraged to attend this two-day interactive session facilitated by Dr. Robert Butcher. Learn from amazing programs and approaches that successfully support ethical practices and decision making in health care from the bedside to the boardroom.