

**REGIONAL ETHICS REPRESENTATIVES FORUM  
TUESDAY MAY 10<sup>TH</sup>, 2005  
RED DEER, ALBERTA**

***DRAFT OVERVIEW OF PROCEEDINGS***

**Attendees**

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**Chinook Regional Health Authority**

Nafisa Jadavji	University of Lethbridge, 3 <sup>rd</sup> Annual Undergraduate Bioethics Conference
Thaine Olsen	Chinook Health Region Ethics Committee
Michael Stingl	University of Lethbridge, Philosophy Department

**Calgary Health Region**

Susan Gilbert	Foothills Hospital Ethics Committee
Brian Farewell	Regional Ethics Service
Glenys Godlovitch	Office of Medical Bioethics, University of Calgary
Gordon McPherson	Board
Carolyn Miron	Peter Lougheed Centre Ethics Committee
Ian Mitchell	Office of Medical Bioethics, University of Calgary
Kelly Mrklas	Office of Medical Bioethics, University of Calgary
Kimberly Smith	Rural Health Ethics Resource Team
Andrea Scott	Bow Corridor Ethics Committee
Darlene Weger	Carewest Ethics Committee

**David Thompson Health Region**

Kim Adzich	Rimbey Medical Clinic, Rimbey Hospital and Care Centre
David Belcher	David Thompson Health Region Ethics Committee
Sandy Doze	David Thompson Health Region
Nancy Goddard	Red Deer College, Nursing Department
Debbie Leitch	David Thompson Health Region Ethics Committee
Evan Lundall	Trochu Medical Associates
Heather McElroy	David Thompson Health Region Ethics Committee
Perry Mill	David Thompson Health Region Ethics Committee
Sylvia Simmons	David Thompson Health Region Ethics Committee
Donna VanBruggen	David Thompson Health Region Ethics Committee

**East Central Health**

Rachel Dart	The Bethany Group Ethics Committee
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**Capital Health Authority**

Marie Edwards	Royal Alexandra Hospital Clinical Ethics Service
Kathy GermAnn	University of Alberta
Gary Goldsand	Royal Alexandra Hospital Clinical Ethics Service
Brendan Leier	John Dossetor Health Ethics Centre, St. Joseph's College
Margaret Plain	Board
Vince O'Shea	St. Joseph's Auxiliary Hospital Ethics Committee
Barbara Russell	John Dossetor Health Ethics Centre, U of A Hospital/ Stollery

## Children's Hospital Ethics Committee

### **Aspen Regional Health Authority**

Joan Cody	Extendicare Athabasca, Palliative Care Ethics Committee
Carol Connolly	Aspen Regional Health Authority Ethics Committee
George Fernhout	Aspen Regional Health Authority Ethics Committee
Donna Grier	Aspen Regional Health Authority Ethics Committee
Wendy Harrison	Aspen Regional Health Authority Ethics Committee
Yolanda Lackie	Aspen Regional Health Authority Ethics Committee
Catharine Millson	Aspen Regional Health Authority Ethics Committee
Rick Saint	Aspen Regional Health Authority Ethics Committee
Gina Stanley	Aspen Regional Health Authority Ethics Committee
Shirley Toporowski	Aspen Regional Health Authority Ethics Committee

### **Peace Country Health**

Marcia Fried	Peace Country Health Regional Health Ethics Committee
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### **Northern Lights Region**

Allan Nicholson	Northern Lights Region Ethics Committee
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### **Alberta Health and Wellness**

Liz Kohle	Alberta Health and Wellness, Population Health Strategies Branch
Dawn Friesen	Alberta Health and Wellness, Population Health Strategies Branch

### **Manitoba**

Sheila Toews	Winnipeg Regional Health Authority
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### **Saskatchewan**

Marilyn Sargent	Cypress Health Region
Dennis Moore	Heartland Health Region Ethics Advisory Committee

### **British Columbia**

Gerrit Clements	Ministry of Health Services, University of Victoria
Bashir Jiwani	Providence Health Care

### **Yukon Territory**

Ain Leetma	Whitehorse General Hospital Ethics Committee
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### **Health Canada**

Catherine Chabot	Centre for Workplace Ethics, Health Canada
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### **USA**

Helena Hoas	National Rural Bioethics Project, University of Montana
Ann Cook	National Rural Bioethics Project, University of Montana

### **Provincial Health Ethics Network**

Deb Fisher	
Joe MacGillivray	
Amy Middleton	
Tara Murphy	
Al-Noor Nenshi Nathoo	



Provincial  
Health Ethics  
Network

## Regional Ethics Representatives Forum 2005

Red Deer Lodge & Convention Centre, Red Deer, Alberta

May 10, 2005 8:00 am – 12:30 pm

### Agenda

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- 8:00 Breakfast Served
- 8:15 Welcome  
*Al-Noor Nenshi Nathoo, Executive Director, Provincial Health Ethics Network*
- Chair's Opening Remarks  
*Perry Mill, Member, Ethics Committee, David Thompson Health Region*
- 8:20 Why Clinical Ethics is Like the NHL: Burgeoning Demand for Ethics Services at the Royal Alex  
*Gary Goldsand, Clinical Ethicist, Royal Alexandra Hospital, Edmonton*  
*Marie Edwards, Resident in Clinical Ethics, Royal Alexandra Hospital, Edmonton*
- 8:35 Amalgamation and Moving Forward: The Experience of the David Thompson Health Region  
*Debbie Leitch, Chair, David Thompson Health Region Ethics Committee*
- 8:50 Reviewing the Review: Reflections on an Ad Hoc National Ethics Committee Process  
*Gerrit Clements, Health Lawyer, University of Victoria & B.C. Ministry of Health*  
*Bashir Jiwani, Health Care Ethicist, Providence Health Care & PHEN*
- 9:05 Questions & Discussion
- 9:25 Regional/Ethics Services & Committees Updates I
- 9:50 Break
- 10:05 Regional/Ethics Services & Committees Updates II
- 10:35 Ethics Resources and Support for Health Organizations: What's Needed?
- 11:05 Ethics Committees and Liability: Necessary Precautions  
*Glenys Goldlovitch, Office of Medical Bioethics, University of Calgary*
- 11:15 Alberta Research Ethics Community Consensus Initiative (ARECCI): Implications for Alberta's Clinical Ethics Committees  
*Michael Stingl, Assistant Professor, University of Lethbridge*  
*Sandy Doze, Manager, Information Management, David Thompson Health Region*
- 11:30 The Challenge of Providing Ethics Support in Rural Healthcare  
Ethics and Medical Errors: Alice's Guide to Patient Safety  
*Ann Cook, Director, National Rural Bioethics Project, Montana*  
*Helena Hoas, Research Director, National Rural Bioethics Project, Montana*
- 12:00 Questions & Discussion
- 12:30 Adjournment

## **Why Clinical Ethics is Like the NHL: Burgeoning Demand for Ethics Services at the Royal Alex.**

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*Gary Goldsand, Clinical Ethicist, Royal Alexandra Hospital, Edmonton*

*Marie Edwards, Resident in Clinical Ethics, Royal Alexandra Hospital, Edmonton*

Gary and Marie provided some insight into what they felt contributed to the success of the Royal Alexandra Hospital's clinical ethics service, formed in 2001. Since a single person is less intimidating and more approachable than a large committee, they found that one-on-one discussion worked better than a group committee. They stressed that being accessible during non-crisis times helps to build trust and recognition and increased the chances of their being consulted prior to a crisis. Having informal discussions in the hallways, attending meetings, and being sure to interact with the staff all contributed to building trust. Gary and Marie also suggested that education and empowerment were important when doing a consultation and suggested passing along any interesting articles for the medical team to read. They stated that the staff and family often welcome the intervention and appreciate having someone present to help them out, create moral space and keep it open for discussions.

## **Amalgamation and Moving Forward: The Experience of the David Thompson Health Region**

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*Debbie Leitch, Chair, David Thompson Health Region Ethics Committee*

In amalgamating four regions into the David Thompson Health Region, there was a fear that if an ethics committee was formed it could destroy the doctor/patient relationship. However, the region had previously done a needs assessment of the staff and they decided to form an ethics committee with a clear vision of what it would entail. They lobbied their senior executives for support to allow staff to join the committee by payment for staff time. They lobbied for a small budget and optimized this funding by investing it in the development of their committee members and advertisement of their committee and its successes. Every committee member has a PHEN membership, two members per year take the PHEN Distance Education course, and members alternate attending conferences. The committee created a brochure and advertise and host workshops. They also promote their committee and the framework they follow. As well, they developed an operational plan that outlines their strategies and goals.

Most importantly they do not try to be something they are not. There are no experts in bioethics on the committee. They built their team by asking those that were interested, not through assignment positions. The only prerequisite to be a member is persistent commitment to the committee. There is no hierarchy in the committee; the workload is shared among them. The committee spends 20 minutes at the beginning of each meeting to learn more about each other in order to facilitate trust within the group.

## **Reviewing the Review: Reflections on an Ad Hoc National Ethics Committee Process**

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*Gerrit Clements, Health Lawyer, University of Victoria and BC Ministry of Health  
Bashir Jiwani, Health Care Ethicist, Providence Health Care & PHEN*

A particularly difficult and controversial case arose recently within an Alberta healthcare institution. Given the complexity of the situation, the ethics committee and senior management of the institution felt that it may be beneficial to have a secondary ethics review by an ad hoc committee struck for this purpose. As an external, 'neutral' third party, PHEN was approached and put together, in a short time, a committee composed of individuals with appropriate expertise and experience from various parts of the country. The group met by teleconference, having been sent as much information as possible in advance to provide the appropriate background and context. While the committee did not reach a consensus, there was a majority opinion/agreement regarding the local institutional ethics committee's original recommendation. One of the fears, in setting up the process, was that it would appear to undermine the authority of the institutional ethics committees. However, this did not appear to happen, particular as the local committee had done an excellent job of processing the issue prior to its going to the ad hoc committee. While this process may set a precedent for addressing ethical issues of unusual complexity or difficulty, there were a number of limitations, including those of meeting by telephone, time constraints, and lack of interaction and relationship with care providers and patients/families. Legal issues such as liability and access to the individual recommendations from the ad hoc committee members were a concern as child welfare officials were involved as well as, potentially, the medical examiner.

## **Summary of Reports From Respective Regional Ethics Representatives**

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*Representatives of ethics committees, health regions, ethics centres, and hospital/ regional ethics services provided an update on recent activities.*

*Dennis Moore – Heartland Health Region in Saskatchewan*

- The committee is working strongly towards education within the region and with staff on ethical issues.
- They have Father Mark Miller to assist and support them.
- The committee finds that consultations to staff and patients affect the culture of the organization.

*Ian Mitchell – Office of Medical Bioethics, University of Calgary*

- A process is underway that will likely increase integration between the Office and the Regional Ethics Service.
- The Office is composed of a number of highly qualified individuals (see <http://www.fp.ucalgary.ca/medbioethics/>)
- Dr. Mitchell is the president of the Canadian Bioethics Society (CBS). This year the CBS annual conference is being held in Halifax in late October. The theme is Money, Money, Money, Dollars and Cents. All are encouraged to attend.

*Darlene Weger – Carewest Ethics Committee, Calgary Health Region*

- The Carewest Ethics Committee has been going strong for several years and is looking for ways of increasing the committee's profile.
- They do ongoing committee education through various events
- The committee encourages their members to attend conferences and has had two members complete the PHEN Distance Education course.
- They would like to include ethics consult brochures in all staff orientation packages
- On behalf of the committee Darlene thanked PHEN and the Calgary Health Region for their support.

*Yolanda Lackie – Aspen Regional Health Ethics Committee*

- The committee has developed a terms of reference which their executive reviewed and they would now like PHEN to review it.
- They asked the organization to commit funds of \$13,000 (approved) to education and put together a plan for using the funds.
- They want to target front-line staff around education and to further develop committee members.
- The committee is working with PHEN to develop a tailored distance education course and ongoing workshops.
- They have monthly meetings and they intend to develop an annual work plan with concrete goals and objectives.
- The plan is to review regional policies and focus on education and then look at utilizing a framework for consultation.

*Thaine Olsen – Chinook Health Region Ethics Committee*

- They have lost some high profile members and currently have some new members.
- In the past, all research conducted in the region had to be reviewed by the committee but in the last 2 years they split their committee and now they do only clinical consults.
- The committee has good support from physicians.
- They developed a web space on Chinook website.
- The committee is looking to work on a program of self-education.
- The region's new vice president has just been assigned to their ethics committee.

*Sheila Toews – Winnipeg Regional Health Authority Ethics Services*

- This is a large region with a range of facilities and services
- They have found it important to have board and senior management involved
- The region identified 5 regional priorities for the ethics program from a regional survey
- They are working on organizational ethics, and are strengthening their regional ethics and education strategy.
- The Ethics Services is trying to help people see the value of ethics in their everyday work

*Dr. Allan Nicholson – Northern Lights Region Ethics Committee*

- The region is geographically separated, thus relies on videoconferencing for many meetings
- Received initial help from PHEN and are now beginning to do consults.
- They have developed a brochure and are anticipating using PHEN as a consultant for the first few cases.

*Marcia Fried – Peace Country Health Regional Ethics Committee*

- The committee meets once a month and uses teleconferencing.
- They are starting to do clinical consultations and have found that some PHEN video resources have been helpful in resolving the issues.
- The committee has developed a terms of reference, a consultation flow chart, and a brochure.
- They have had a recent presentation from PHEN, and the committee gave a talk during Bioethics Week.
- Challenges continue to be legal representation, and lack of consults coming forward.

*Catherine Chabot – Health Canada, Centre for Workplace Ethics*

- They have core workshops that they deliver to staff across the country.
- The Canadian Nurses Association has developed a paper on ethical distress for nurses and Health Canada finds it applies to all health care workers.
- They primarily concentrate on organizational workplace ethics

*Brian Farewell – Calgary Health Region Regional Ethics Service*

- The service has been in operation for 2 years
- The region has several groups preparing to become committees that can do consults; the Tom Baker Cancer Centre is committed to planning a full ethics committee and will become a full committee over the next 6 months.
- They will be having Bashir Jiwani come to the region and help develop a model for policy consults.

*Gary Goldsand – Capital Health*

- He indicated that a lot of the ethics in the Region is being done is through the Royal Alexandra and University of Alberta hospitals.
- The Capital Health Ethics Coordinating Council, which looks at regional ethics issues, has recently been resurrected

*Bashir Jiwani – Providence Health Care Center (Vancouver)*

- The Providence Center is attempting to identify individuals in the local area who could provide ethics support.
- There is a belief that education is imperative and some of the individuals may not have the training or support they need to do a good job.
- Vancouver Coastal Region has a number of ethics committees at various institutions and they are reflecting on the most appropriate ethics committee structure.
- BC Cancer has a clinical ethics committee that is not fully operational and the Fraser Health Region is seriously thinking about the development of ethics resources.

*Dawn Friesen – Alberta Health and Wellness*

- Dawn commended the PHEN board and staff for their excellent work and applauded the breadth and depth of positive changes seen over the years through the work of PHEN and others.
- Alberta Health and Wellness was involved with and supported PHEN's 10 year anniversary celebration.

**Ethics Resources and Support for Health Organizations: What's Needed?**

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- Money!
- Financial support to enable PHEN to provide more support, particularly to the rural areas that do not have the same resources as the urban centers.
- Resources for staff to attend educational activities/programs
- Culture change – the commitment of all levels of all regions to engage in ethics and ethics education. Consciousness raising, education and dealing with underlying obstacles that block ethical deliberations.
- The ability to access a clinical ethicist as required.
- A second contact in PHEN to lighten workload of existing staff
- A chat room on the PHEN website to facilitate long-distance discussions
- Training for regional boards and administration along with the various ethics committees in the region
- Access to ethics supports for rural institutions.
- Specific examples of case consultations that are accessible via the internet

*Resources Available*

- The John Dossetor Health Ethics Centre at the University of Alberta, the Office of Medical Bioethics at the University of Calgary, and the Alberta Catholic Health Corporation also provide ethics services within the province.
- PHEN is publishing a *Clinical Ethics Committee Member Manual*
  - The idea came from the fact that there were several ethics committees in the province that were developing an orientation manual for their members.
  - PHEN is nearing completion on it and it will be ready in 4-6 weeks.
  - The member manual will be available to regional ethics committees at a cost of \$150 which includes a manual for each committee member
  - Institutional ethics committees can purchase it at a cost of \$35 per manual.

**Ethics Committees and Liability: Necessary Precautions**

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*Glenys Godlovitch, Office of Medical Bioethics, University of Calgary*

It is important to consider issues of liability and risk management in regards to ethics committees. Ethics committees work under the umbrella organization; the patient can potentially sue the physician, the medical professionals, the institution and the ethics committee. It is possible that ethics committee members might be included in a legal action against the health care providers involved in a situation with respect to which the ethics committee has made recommendations. It is therefore important to ensure that they

are covered by the policy of the institution within which they work. There is potential for liability if there is evidence of the ethics committee showing negligence, failure to act appropriately, misrepresentation, or failure to give appropriate information to individuals. The best way to prevent litigation is to pay attention to standards (due diligence) and to ensure that committee members have the requisite skills when they start. It is also important that the committee is accredited when possible. It is best to be prepared!

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### **Alberta Research Ethics Community Consensus Initiative (ARECCI)**

*Michael Stingl, Associate Professor, University of Lethbridge*

*Sandy Doze, Manager, Information Management, David Thompson Health Region*

ARECCI is an ad hoc group that was formed partially as a result of the push towards, and increased activity surrounding, evidence-based research. The initiative seeks to explore what type of ethical oversight is required for knowledge-generating projects in health in Alberta including research, quality improvement and program evaluation. It is a joint initiative of the Alberta Heritage Foundation for Medical Research, the Research Ethics Boards in the province, regional health authorities and Alberta Health and Wellness. The questions being asked were: 1) Do all studies, including internal quality assurance and review, need to be reviewed by a research ethics board (REB) and 2) If not, what kinds of studies should be vetted by the health regions themselves and what should go to the recognized REBs in the province? It was decided that the answer to the first question was *no*. In regards to the second, a decision about what should go to an REB must be based on whether the project is considered to be research (generalizable knowledge/contribution to science) or not. ARECCI has produced draft tools and developed risk tables to help sort through these issues. There are 7 RHAs piloting these tools in their regions. The pilots started in January 2005 and will be completed in June 2005.

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### **The Challenge of Providing Ethics Support in Rural Healthcare Ethics and Medical Errors: Alice's Guide to Patient Safety.**

*Ann Cook, Director, National Rural Bioethics Project, Montana*

*Helena Hoas, Research Director, National Rural Bioethics Project, Montana*

Dr. Cook and Dr. Hoas note that they come from a system that is systematically unethical; one that appears to believe that health care is a privilege not a right, and has a foundation based on profit. They suggest that different healthcare providers see ethics differently; for physicians, ethics is at the bedside; for nurses, ethics is organizational; and for administrators, it is global. Existing ethics committees have limited roles and overwhelmingly, rural physicians, at least initially, have been skeptical of involving ethics committees in decision-making processes. Through their research in 30 hospitals, the presenters found that the hospitals were concerned with patient safety and there were positive experiences of reporting errors. However, few of the participants had been involved in error analysis and had not reported anything. The data was influenced by what the participants considered constituted an error. When the questions were changed from "Does this error occur?" to "Has this happened in your hospital?" answers were very different. Error is not a well-liked word and people avoided using it expressly. Generally they found that everyone agreed that nurses are primarily responsible for

patient safety. As a result, many nurses ignore physician errors, as they themselves will end up being blamed.

**Appendix**  
**Speakers' Powerpoint Presentations**

## **The Evolution of Demand for Ethics Services at the Royal Alexandra Hospital**

**Gary Goldsand**

Coordinator, Clinical Ethics Services, RAH

**Marie Edwards**

Resident in Clinical Ethics, RAH.

## **Clinical Ethics Services at RAH**

- Clinical Ethics Residency Established in 2000
- Clinical Ethics Program in 2001
- Activities:
  - Consultations
  - Education
  - Policy Review and Development
  - Ethics Committee and subcommittees

## **Ethicist as Team Member or External Consultant?**

- Various Models of Ethics Consultation
- Advantages of Familiarity (Trust)
- Benefits of pre-crisis ethics consultation

## **Interdisciplinary Rounds**

- Key time of Team interactions
- Opportunity for learning
- Opportunity for informal exchange of information.
- Opportunity to build critical relationships

## **The Strange Nature of Demand**

- Demand – Active and Latent
- Gauging success and failure in the clinic
- Managing latent demand
- Controlling growth rates
- Beware of success
- Empowering and Educating while consulting

## **Observations of a Clinical Ethics Resident**

- Common Themes
- Value of Visibility
- Moral Space

## Questions?

➤ Thank-you.

➤ **Gary Goldsand**

- Coordinator, Clinical Ethics Services, RAH.
- Email: [garygoldsand@cha.ab.ca](mailto:garygoldsand@cha.ab.ca)



➤ **Marie Edwards**

- Resident in Clinical Ethics, RAH.
- Email: [Marieedwards@cha.ab.ca](mailto:Marieedwards@cha.ab.ca)


**ETHICS**

**MOVING FORWARD**


in  
David Thompson Health Region


**Challenges**




- Time
- Money
- Travel
- Resources
- Culture



**Build on Platforms**

- Strategic Directions/ Vision
- CCHSA Survey supported findings
- Needs assessment of health care providers



**Think Big: but take small steps**


- **Time:** Lobbied Dept Directors to support staff involvement based on platforms
- **Money:** Lobbied Senior Mgmt for small budget (\$5000/year)
- **Travel:** Optimized travel time by meeting for full day/q2 mos.
- **Resources:** Invested in development of committee members → Mgmt/Staff
- **Culture:** Marketing, Education, Support, Accessibility, Approachability, Communication of successes.



**Capitalize on Strengths**

**PEOPLE**

- Passionate Believers
- Confident Leaders
- Willing Learners
- Accepting Supporters
- Daring to Commit





## Build your team!

- Members must be interested not assigned
- Only prerequisite: Consistent commitment
- Representation across disciplines and region
  - No hierarchy
  - Learn about one another
  - Learn from one another
  - Share the workload

*Don't try to be something that you are not!*

## Terms of Reference

- Purpose:
  - Resource
  - Assistance to examine issues
- Roles and Functions:
  - Education
  - Support
  - Dialogue
  - Reflection
  - Connections



## Operational Plan:

- **Marketing of Committee:** Brochure, Workshops, Newsletters, Posters, Orientation
- **Education:** committee, (orientation manual, PHEN membership, conferences, guest speakers, role plays, debriefing)
- **Policy resource:** Guiding questions
- **Sustainability:** safe environment, share workload



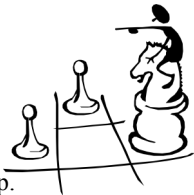
## Accomplishments

- **Web Page, 1-800 # for easy access**
- **Requests:** (23 last year, 11 already this year)
  - Education (13)
  - Clinical Consultations/Case review (12)
  - Policy review & recommendation (3)
  - Way Finding (2) Practice (4)



## Our ongoing plan:

- Set achievable goals each year: Don't tackle too much.
- Build Knowledge.
- Build Relationships.
- Market the framework.
- Be Visible. Be accessible.
- Advertise success. Talk it up.



**Recognize small steps...**

**To be successful, progress must be slow but steady**

**Reviewing the Review:  
Reflections on an Ad Hoc  
National Ethics Committee  
Process**

**Gerrit Clements  
Bashir Jiwani**

***The overall series of events***

- ◆ Complicated issue arose in Alberta
- ◆ Went to an ethics committee
- ◆ Committee undertook a consultation
- ◆ Because of gravity and controversy of issue, committee, institution & region requested broader ethics consultation
- ◆ Members of PHEN board and staff reflected on appropriateness of PHEN's role in meeting request
- ◆ Decided appropriate, asked ethicist to strike ad hoc national ethics committee

***The overall series of events***

- ◆ Discussions held about
  - ◆ appropriate representation on committee
- ◆ Process concerns:
  - ◆ Time line
  - ◆ Information gathering
  - ◆ Confidentiality
  - ◆ Deliberation process
- ◆ Potential committee members identified
- ◆ Potential committee members contacted
- ◆ Those agreeable sent background info & confidentiality agreement

***The overall series of events***

- ◆ Teleconference held:
  - ◆ HCP & local ethics committee chair joined first half to answer questions
  - ◆ Followed by deliberation
- ◆ Report drafted:
  - ◆ Summary
  - ◆ Individual committee member comments

## Regional Ethics Representatives' Forum

May 10<sup>th</sup> 2005  
Red Deer

## Legal risk management for Ethics Committees

Glenys Godlovitch  
Barrister and Solicitor  
Associate Professor of Bioethics  
University of Calgary

PHEN Education Resource Person

## Background

Ethics committees increasing in:

- Number of committees
- Diversity of membership
- Scope of work
- Number of consultations

## Two main kinds of committee

- (A) Research Ethics
- (B) Clinical Ethics

Plus: Policy advice and guidance

## Work and workloads I Research ethics committees

- Review capacity:
  - Proposed health research
  - Modifications and amendments
  - Annual renewals
  - Cancellation of approval at any time
- Decision capacity
  - Approval, refusal, withdrawal of approval of research
- Advisory capacity
  - National, regional and local policy review, input and guidance
  - Local researchers
- Membership
  - Clinicians, researchers, educators, lawyers, ethicists, community members

## Work and workloads II Clinical Ethics committees

- Consultation
  - Institutional clinical ethics consultation
  - Policy advice and guidance
- No decision-making authority
- Education
  - Institutional, regional educational role
- Membership
  - Clinicians, health practitioners, community members, academics, ethicists, lawyers

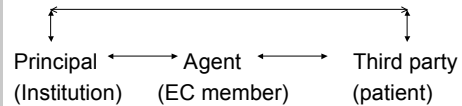
## Legal Status of Ethics Committees

### ECs

- Are not legal bodies
- Are aggregates of individuals
  - Often employees
  - Sometimes community members
  - Volunteers
- Individual legal liability
- Vicarious institutional liability

## Agency liability

- Agent is personally liable for own actions
- The governing body is vicariously liable for what is done by its agents in its name.



## Applicable law - examples

- Statutory health law
- Employment
- Agency
- Trust
- Tort negligence
- Tort defamation
- Contract
- Criminal

## Grounds for suing

- Tort – negligence
- Tort – breach of fiduciary duty
- Tort – misrepresentation/fraud
- Tort – defamation
- Tort – assault/battery
- Contract – negligence/employment contract

## Possible scenarios for ECs

- Discontinuance of feeding to a child/adult
- (Non) Intubation contrary to a personal directive
- DNR code status
- Use of contaminated therapeutic goods (e.g. colposcopy tubes) in procedure approved by EC
- Improper disclosure/nondisclosure of information
- Clinicians alleging legal immunity because they relied on EC consultation

## Membership of Ethics Committees

- Mostly volunteers
- No formal accreditation requirements
- Employees might be covered by employment contract,
  - but watch out for non-indemnification clauses in insurance
  - Community members not covered
- No "good Samaritan" rule

## Case law - liability

Ethics committees liable in

- Bouvia (US) clinical ethics
- Weiss v Solomon (Canada) research ethics

## Is it really that bleak?

Not if attention to due diligence

- ☞ Duty of care/standard of care
- ☞ Compliance with standard (may not be enough)
- ☞ Attempt to exceed standard
- ☞ Appropriate records and monitoring
  - Intra-institutional
  - Inter-institutional
- ☞ Ongoing educational upskilling

## Tools

- Planning strategies for risks
- Accreditation
- Certification
- Continuing education
- Audit
- Review
- Insurance

## Conclusions

While

- We cannot make ourselves litigation-proof
- We can (almost) make ourselves judgment-proof, by
- managing risks appropriately at the institutional and individual levels.

## ALICE'S GUIDE TO PATIENT SAFETY

.....with apologies to Lewis Carroll

Alice: "Would you tell me please which way I ought to go from here?"

"That depends a good deal on where you want to get to" said the Cat.

"I don't much care where" said Alice.

"Then it doesn't matter which way you go" said the Cat

So long as I get somewhere" said Alice.

"Oh, you're sure to do that" said the Cat, "if you only walk long enough."

"I wonder what Latitude or Longitude I've got to?"

### **The scene, the players:**

- Interdisciplinary teams of physicians, nurses, pharmacists, and administrators
- 30 Rural healthcare settings in a 9-state area
- American Indian Health Services settings

"How queer everything is today and yesterday went on just as usual....."

### **Methodology Included:**

- Baseline Survey
- VA Culture Survey
- Error Description Tool
- Quarterly Phone Interviews
- Ongoing Questionnaires
- Survey of Hospital Staff
- Analysis of Case Studies

"She generally gave herself very good advice (though she very seldom followed it)."

### **Findings from Surveys - Beliefs:**

- Hospitals concerned about patient safety
- Positive experiences when reporting
- Personal influence on increasing safety
- Learn from mistakes of others
- Comfortable talking about errors

"Would **you** like cats if you were me?"

### **But the other studies show *limited*:**

- Recognition of errors
- Reporting of errors
- Participation in *any* error reporting processes
- Agreement of definitions of errors *or* response when errors occur
- Enthusiasm for talking across disciplines
- Awareness of hospital data on errors

“Sh! Sh! If you can’t be civil you’d better finish the story for yourself”

*Healthcare providers acknowledge that:*

- Understanding of error is heavily conditioned by *preconceived* notions of what constitutes an error & professional roles
- Hospital data on errors are inaccurate

“It was much pleasanter at home when one wasn’t being ordered about by mice and rabbits.”

**Repercussions:**

- Errors are attributed to nursing and usually involve medication errors or patient falls.
- Responsibility for patient safety is attributed to nursing.
- Nurses fear & experience blame & shame.
- System inhibits corrective action.

“Curiouser and curiouser” cried Alice, so much surprised she forgot how to speak good English

**How do you handle diagnosis and treatment errors?**

- Nurse: “We haven’t gone there yet.”
- Administrator: “We don’t have to worry – they [docs] take care of that.”
- Physicians: “We don’t look over each other’s shoulders.”
- Pharmacist: “They [docs] don’t see that as an error.”

“I know what “it” means well enough when I find such a thing.”

**Responses to D&T issues in case studies & interviews:**  
*“It’s not an error, it’s...”*

- “Clinical judgment”
- “Sub-optimal outcome”
- “Practice variance”
- “Really not my role...”
- “Not an error, period.”
- “Can’t be an error if there is any clinical uncertainty.”
- “Not something you report”

“The last time she saw them, they were trying to put the Dormouse into the teapot”

**Scenarios in Staff Survey:**

- one depicting a medication error (nurse)
- and one a D&T error (physician).

**3 questions were asked:**

- Is it error?
- Would it be reported?
- Would the patient be told?

“We put a white one in by mistake and if the queen was to find out, we’d all have our heads cut off, you know.”

**Key Findings**

- Disagreement over definitions & statistics
- Diffusion of responsibility
- Unwillingness to take action/fear of risks
- Rationalization: “It’s *substandard* care, but *not* an error.”
- Minimize severity of patient the safety problem

“I was going to say that the best thing to get us dry would be a Caucus-Race.”

**Change the Question:** *From is this an error to does this happen in your hospital?*

**Examples**

- Delays in diagnosis
- Failure to employ needed tests & treatment
- Use of outmoded therapy
- Errors in dose, treatment, or diagnosis
- Inappropriate care process

“*Will you, won't you, will you, won't you, won't you join the dance?*”

**Beliefs are influenced by the perceived need to:**

- Maintain professional and personal relationships
- Accommodate economic factors
- Adhere to community norms & values
- Accommodate the perceived role & scope of one's *discipline*.
- Balance quality & burden

**Willingness to Take Action Influenced by:**

- Perception or belief that change is possible
- Perception that one can handle the repercussions associated with actions
- Sufficient time
- Authoritative information that supports proposed change or plan of action
- Organizational management of retribution

“That’s the reason they’re called lessons – because they lessen from day to day.”

**Need Resources & Models**

- Relevant, interdisciplinary & affordable
- *Time sensitive*
- Easily disseminated
- Reinforcing & engaging
- Organizationally sensitive & internally driven
- Proactive – show *how* to solve a problem
- Manage retribution
- Make a difference

‘*ARE you to get in at all?*’ said the Footman. ‘*That's the first question, you know.*’

**Case-based summary offers a way to link cognition & behavior:**

- Topic
- Issues
- Learning Points
- Clinical guides
- Steps for Improvement

Alice caught the baby with some difficulty

**Logistics:**

- How should such information be provided?
- Who should receive this kind of information?
- How often?
- How can discussion be facilitated?
- Where do you find information?
- What happens when you're wrong?
- What is the institutional responsibility for facilitating discussion & implementing change?

“There’s more evidence to come yet, please your Majesty”

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## The Challenge of Providing Ethics Support in Rural Healthcare

Who Does What to Whom and How?

## What is Bioethics?

### Traditional definition of bioethics:

- “*Systematic* study of the *moral* dimensions of the life sciences.” (Albert Jonsen)
- *Moral* dimensions refers to shared beliefs & obligations
- Focus on visible “*problematic instance*” & ethical obligations of clinicians to prevent and respond to specific moral problems.

### Traditional approach to bioethics

- Examination of ethical theories (Mill, Kant, Ross, Rawls, moral theology)
- Study & application of major moral principles (nonmaleficence, beneficence, autonomy & justice).
- Use of ethics committees and case consultation to support *reflection* & *deliberation* of identified problems.

## What do Rural Healthcare Providers Encounter?

- Personal issues – discerning the right course of action at the bedside
- Professional issues – role and scope of work
- Clinical Issues – kind of health care that is provided
- Organizational issues (e.g., association between accidents/harm & factors like work pressures or communication problems)

## Overview of Studies

- A 6-State survey of rural hospital administrators
- 2 Surveys of rural nurses
- 3-state survey of physicians in rural west
- Interviews with DONs in 21 rural hospitals
- Focus groups & interviews with healthcare providers, patients, families & community leaders in 7 states
- Multi-region studies of physicians & nurses
- Multi-state studies among healthcare professionals

## Ethics-Related Issues Identified by Administrators

### *Global Issues*

- Patient autonomy
- Patient competency
- Patient/clinician communication and relationships
- End of life care, advance directives & DNR orders
- Few formal ethics services

## Ethics-Related Issues Encountered by Physicians

### *Practical Clinical issues:*

- Patients frequently fail to understand diagnosis
- Patients fail to understand treatment;
- Patients lack resources that are needed to obtain treatments & follow recommendations;
- These issues are frequent, problematic & not typically discussed by any formal processes.

## Ethics-Issues Experienced by Nurses

### **Organizational issues:**

- Orders for patients are unclear or confusing;
- Lines of responsibility for patient care decision-making are unclear;
- Role as member on Pt. care decisionmaking team is unclear;
- Medical errors are not usually reported;
- Concerns about quality, competency & access to resources.

## Areas of Disagreement

- Who is a member of the patient care decision-making team?
- What are ethics-related issues & how should they be resolved?
- Does honest reporting of errors increase trust in the local hospital?
- Who is primarily responsible for patient safety?
- Are lines of communication adequate?

## Current Status

### **Rural settings report:**

- Few formal mechanisms for identifying & solving ethics-related problems
- Most rural healthcare providers have not received training in ethics
- Most rural healthcare providers have never served on, or referred cases to ethics committees
- Existing ethics committees have limited roles
- Skeptical of benefits of ethics committees & case consultation

## Perceptions of Need

- Most healthcare providers want to receive resource that address: dual relationships, mutuality, difficulty of limiting care, involvement in the community, support of community “rules”
- Most want resources that are inter-active, inclusive, practical, relevant, & non-academic
- Practical – identify the “right thing to do”

## Typical Bedside Issues

- Pain relief during labor and delivery
- Care provided after MI
- Pharmacist who corrects a prescription
- Physician who refuses to talk to nurses

## Building a Foundation for Rural Bioethics

### **Questions to ask:**

- Where/how patients & families wait for care & treatment?
- Where, how and by whom are families & patients given bad news?
- What are the hospital's billing practices?
- How are families asked to make difficult or complex decisions? Example: organ donation

## Foundation, contd.

- Who is involved in patient care decision-making?
- How is privacy enhanced?
- How are power issues among various healthcare providers and patients managed, balanced & resolved?
- What are the relationships among staff?
- Are processes of care appropriate and safe?

## The Context of Care

- Shapes the willingness of healthcare providers to recognize/act when encountering ethics-related issues
- Influences the patient's willingness to: trust healthcare providers, accept recommendations, use services, and offer forgiveness when problems occur.
- Influences incidence of medical errors/events

## Areas to Examine

- Communication (flow on information & availability of information)
- Training & skill
- Fatigue/scheduling (stress, scheduling, staffing)
- Environment & equipment
- Rules, policies, & procedures
- Barriers/controls that protect people/property from adverse events

## Examples of Resources

### *Moving beyond committees:*

- Case studies
- Readers theater
- Map/grid for ethical decision-making
- Critical thinking tools
- Bookmarks
- Scenario-based Patient/family chart form
- Internet\*
- CME/CE activities

### *Keys:*

- *Permission to ask questions*
- *Not for experts only*

## FOR MORE INFORMATION

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