

Developing a Regional Ethics Service

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Outline

- Pre-existing Situation
- Decisions/Priority Setting
- Underlying Assumptions
- Accomplishments
- Next Steps
- Lessons Learned

Services in Region 3

- Existing committees in 2002: 2 hospitals, 4 LTC, 2 rural
- Potential for committees: double the number.
- Calgary resources: PHEN, U of C (OMB)
- Regional service funded spring 2002, Dr. Maureen O'Brien, Medical Director
- Coordinator hired May 2003.

Decisions/ Priority Setting: Calgary

- Committee training and education
- Financial support to committees
- Standardize consultation process
- Resource for programs/sites without ethics resources

Decisions/Priority Setting:Winnipeg

- Ethics education for all staff: 46 %
 - Develop ethics committees: 36%
 - Policy review: 36%
 - Ethics Consultation: 36%
 - Committee education: 18%
 - Research ethics review: 9%
 - Board education: 9%
- Source: Sheila Toews, Ethics Service, WRHA

Underlying Assumptions

- First Priority is Clinical Ethics not policy, research or organizational ethics
Why: Depends who you ask
Depends on your own history
- Best delivery of ethics services is through site based committees Vs central experts
Why? Buy-in, trust, relevant issues, history, building leadership, capacity

Accomplishments To Date:

(1)

- 3 new committees, 2 rejuvenated
- Leadership development: PHEN course, new member orientation, consult role
- Clinical consultation: clinical model, process guidelines, forms
- Committee education: first on meeting agenda, annual retreat
- Staff; one full time coordinator

Accomplishments to Date

(2)

- Staff education: education committees, shared presentations, ethics week, Telehealth, journals/books
- Visibility: funding for brochures, web page
- Policy review: upon request or committee driven, involvement of policy planner, volunteer work groups

Future Directions

- Ethicist on staff? Ethics internship?
- Organizational ethics: assume leadership or wait for commitment from the top?
- A systematic approach/model designed to influence policy.
- Bringing ethics to outpatient programs.

Lessons Learned (1)

- Clinical ethics brings high credibility but low visibility: try policy or organizational ethics
- Don't underestimate staff interest in ethics
- Respect pre-existing culture
- Essential central standards only
- The role of "referral facilitator" is key to Ethics Consultations

Lessons Learned (2)

- Committee members require education and practice to feel comfortable in consults
- Leadership: physician membership is vital. Administrative membership or clear buy-in is essential
- Outside membership is important but a tough sell
