A Participatory, Mixed-Methods Assessment of Clinical Ethics Committees: How Might They Support Clinicians and Positively Impact Care?

Dissertation

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

Kathleen Keefe Raffel, MSW, MBA

Graduate Program in Social Work

The Ohio State University

2013

Dissertation Committee:

Mo Yee Lee, Advisor

Keith Anderson

Tamara S. Davis

Pedro Weisleder
Copyrighted by
Kathleen Keefe Raffel
2013
Abstract

The primary purpose of this exploratory study to learn how clinical ethics committees in one healthcare system might be more effective in supporting clinicians and their work in critical care settings. This study also attempted to address several issues in previous research. First, committees frequently lack information on what they could do to meet the needs of clinicians facing moral dilemmas, making it challenging for committees to be proactive, purposefully choose committee members and determine their training needs, and plan and support relevant services. Second, most needs assessments have solicited a top-down, management perspective rather than the views of constituent stakeholders. Third, ethics committees activities are often inadequately operationalized and difficult to evaluate. Finally, few studies have examined how different committee activities might potentially impact care.

This research was done in partnership with a large healthcare organization in central Ohio. The community partner wanted data that would drive strategic planning, program development, and evaluation for the seven ethics committees in its system. This study used a structured, mixed methodology, concept mapping, which is specifically designed to analyze and integrate the perspectives of multiple stakeholders. Data was collected from both ethics committee members and a diverse, multi-disciplinary sample of critical care clinicians to generate an inventory of 95 potential committee functions which might support the critical care units. Participants
rated each suggestion on two dimensions: potential to positively impact care and perceived current performance by the ethics committees. Rigorous statistical analyses were used to integrate and analyze the data collected. The “concept maps” produced after data analysis graphically displayed multiple dimensions of ethics committee work and performance.

Non committee members organized the suggested committee activities into seven different categories: staff development, guidance, outreach and accessibility, visibility, liaison with system, liaison with patients and families, and ethical and moral support. Individual ideas within each group help operationalize these broader functions and point to potential committee activities beyond the three traditional roles of education, policy development and consultation. Broadly speaking, the participants unaffiliated with ethics committees thought the suggested activities could have more positive impact on patient care than committee members did. Conversely, committee members rated their performance higher than non committee members did. Views about potential impact and perceived current performance varied among the hospitals participating in the rating activity. Within the same hospital, ratings varied among critical care units. A number of other variables - profession, years in healthcare, involvement with ethics committee consults, and use of the ethics committee as the first resource when questions about an ethical dilemma arise – also seemed to influence how ideas were rated. The findings suggest that ethics committees could have a positive impact on care by being more visible and accessible and working directly and proactively with families, particularly around end-of-life dilemmas. Participants also identified a need for interventions which provide staff with moral
and ethical support. Social work opportunities for working with ethics committees to address moral and ethical issues, supporting staff emotional needs, and improving communication with families are presented.
Dedication

To Corey, my partner, best friend and love of my life. Thank you for understanding how important this work was to me. I look forward to our next adventures.

To Forrest and Colin, my sons and fellow doctoral students. Thank you for inspiring me and offering support whenever it was needed. I am proud to be your Mom.

To my father. Thank you for showing me, with your own example, how to take risks, keep promises and work hard. I think you would have been pleased with this dissertation.

To my mother. Thank you for your love and wisdom and being the perfect Mom for me. I miss you.
Acknowledgments

I received my Masters in Social Work in 1977. In the intervening years, I have been taught, mentored, lead, and inspired by countless individuals. Although I do not mention them by name, I am always aware of their role in making me a better professional.

Since deciding to return to school, I have been helped by many people. While completing my Graduate Certificate in Alternative Dispute Resolution at Capital Law School, Terry Wheeler and Scot DeWhirst encouraged my interest in approaches to resolving ethical conflicts. Doug Cluxton, at Ohio Hospice and Palliative Care, shared his wisdom about the challenges of end-of-life decision-making. This work triggered my interest in how social workers might be more proactively involved in helping families address end-of-life issues more effectively.

At the College of Social Work, I would like to thank Dr. Theresa Early for accepting me into the doctoral program well after the application deadline; I hope I have met her expectations. Since day one, I have appreciated Jennifer Nakayama for her endless patience with my questions. I am so glad that Dr. Keith Anderson was willing to work with me in an independent study project which led to my discovery of the problem of moral distress. I thank Dr. Holly Dabelko-Schoeny for asking me to teach the class on family caregivers, re-invigorating my career long interest in supporting this population. I particularly appreciate that Dr. Rebecca Kim invited me to be part of the Macro Practice Planning Committee and gave me encouragement to develop a course on social work approaches to conflict resolution. Teaching that course has been one of the most rewarding (and unexpected) aspects of my doctoral experience. While I have not gotten to know all of the faculty at the College, many
others have inspired and supported me; a few kind words of encouragement go a long way when you are trying to complete a doctorate.

I would particularly like to thank the members of my dissertation committee. My advisor, Dr. Mo Yee Lee, taught me about qualitative research and provided calm, wise guidance. Her feedback was always right on the mark and made me rethink and dig deeper. Dr. Tamara Davis brought the concept mapping process alive by allowing me to join her in an ambitious research project at Ohio State exploring the needs of gay, lesbian, bisexual and transgender students. It would have been impossible to do my own research if I had not been able to learn by her side. Dr. Pedro Weisleder provided insight from his own work on ethics committees and provided friendship and emotional support at key moments.

My dissertation was a participatory research project; it could not have been done without the active involvement of partners from OhioHealth. I would like to thank the members of my research team, Robin Walton, Dr. Darrell Spurlock, and Kristi Marshall, for helping to plan this study. Krista Clouser contributed invaluable assistance by setting up meetings, assembling mailing lists, gathering data on the hospitals and answering my endless questions. I want to particularly thank my co-investigator, Corey Perry. Corey is smart, kind, funny, and dedicated to improving practice. I could not have asked for a better partner in this project. I hope that the results of this research help support all of the changes that he envisions.

I would like to thank all of my friends from around the country who have supported me and my husband these last few years. I look forward to reconnecting with all of them as I move on to my next adventures in San Francisco. DeAnna Duvall helped immensely by proof reading this document. I want to thank Bonnie for calling, listening, and calling again. She is a great friend. I want to acknowledge Francine for being one of the most caring, generous, and understanding friends a person could want. And, finally, I need to thank Gina for reminding me when it was time to put aside the computer and take a walk.
Vita

1974 ................................................. B.A. Psychology, Wellesley College
1977 ................................................. M.S.W. Healthcare and Community Practice, San Diego State University
1986 ................................................. M.B.A. Management, University of San Francisco
2009 ................................................. Graduate Certificate, Alternative Dispute Resolution, Capital University Law School

Publications


Major Field: Social Work
Specialization: Dynamics of organizational decision-making
Table of Contents

Abstract .................................................................ii
Dedication .............................................................v
Acknowledgements .....................................................vi
Vita ..............................................................................viii
List of Tables ..................................................................xi
List of Figures .............................................................xv
Chapter 1: Introduction......................................................1
   Statement of the Problems ........................................2
   Purposes of the Study ..............................................5
   Research Questions ................................................8
   Organization of the Dissertation ................................9
Chapter 2: Literature Review .............................................10
   History of the Clinical Ethics Committee ......................10
   Ethics Committee Structure and Functions ...................12
   Ethical Climate Theory ..............................................16
   Factors Contributing to the Ethical Climate in the Critical Care Setting .............................................................................18
   Application of Ethical Climate Theory in Healthcare Practice Research .................................................................30
   Recommended Strategies for Creating a Positive Ethical Climate .................................................................34
Chapter 3: Methods ..........................................................37
   Participatory Research ..............................................37
   Concept Mapping, a Mixed Methodology for Representing Ideas
   Graphically ..............................................................38
   Research Design .......................................................41
   Concept Mapping Process Overview .............................41
List of Tables

Table 1. Brainstorming Response Rate by Profession…………………………..….. 74
Table 2. Rating Response Rate by Hospital and Profession………………………..77
Table 3. Impact Rating and Performance Rating, Response Rate by Profession……..78
Table 4. Racial Distribution, Raters……………………………………………….....81
Table 5. Frequency of Involvement in Patient Care Issues Brought to an EA ………82
Table 6. Frequency of Initiating a Request for an Ethics Consultation………………82
Table 7. Person You Consult First When You Have an Ethical Dilemma…………….82
Table 8. Statements, Numbered in the Order Presented to Participants During Rating and Sorting……………………………………………………………..84
Table 9. Cluster and Statement Bridging Values…………………………………….96
Table 10. Impact and Performance, Cluster Averages for Non EAC Staff and EAC Members…………………………………………………………………..104
Table 11. Cluster Averages for All Participants, Impact and Performance..........111
Table 12. Impact, Cluster Averages for Non EAC staff and EAC members…..….112
Table 13. Performance, Cluster Averages for Non EAC Staff and EAC Members ……………………………………………………………..…………….114
Table 14. Impact and Performance Ratings, Cluster Averages for EAC Members ………………………………………………………………….…..115
Table 15. Impact and Performance Ratings, Cluster Averages for Non EAC Staff ……………………………………………………………....………….113
Table 16. Performance, Cluster Averages by Hospital……………………………..123
Table 17. Impact, Cluster Averages for RMH 6 and RMH 4 ...........................125
Table 18. Performance, Cluster Averages for RMH 6 and RMH 4 ........................126
Table 19. Impact, Cluster Averages for H2 General Clinicians and H2 Critical Care Clinicians ..........................……………………………………………………………..128
Table 20. Performance, Cluster Averages for H2 General Clinicians and H2 Critical Care Clinicians ………………………………………………………………………………………………129
Table 21. Impact, Cluster Averages for Requested an Ethics Consult 7 or More Times and Requested a Ethics Consult Less Than 7 Times …………………131
Table 22. Performance, Cluster Averages for Requested an Ethics Consult More Than 7 Times and Requested a Consult Less Than 7 Times………………..128
Table 23. Impact, Cluster Averages for Requested an Ethics Consults and Never Requested an Ethics Consult ………………………………………………………………134
Table 24. Performance, Cluster Averages for Requested an Ethics Consults and Never Requested an Ethics Consult …………………………………………………….135
Table 25. Impact, Cluster Averages for Involved in Patient Care Issue Brought to EAC and Never Involved in a Patient Care Issue Brought to EAC………………137
Table 26. Performance, Cluster Averages for Involved in Patient Care Issue Brought to EAC and Never Involved in Patient Care Issue Brought to EAC………138
Table 27. Impact, Cluster Averages for Nurses, Attending Physicians, and House Staff ……………………………………………………………………………………142
Table 28. Performance, Cluster Averages for Nurses, Attending Physicians, and House Staff ……………………………………………………………………………………142
Table 29. Impact, Cluster Averages for Nurses and Allied Health Professionals….143
Table 30. Performance, Cluster Averages for Nurses and Allied Health Professionals …………………………………………………………………………………………..144
Table 31. Impact, Cluster Averages for Social Workers and Nurses…………………..145
Table 32. Impact, Cluster Averages for Social Workers and Non-nursing, Allied Health …………………………………………………………………………………………147
Table 33. Impact, Cluster Averages for Administrators and Staff Providing Patient Care……………………………………………………………………………………………..149
Table 34. Performance, Cluster Averages for Administrators and Staff Providing Care ………………………………………………………………………………………………..150
Table 35. Impact, Cluster Averages for Those Who Consult the EAC first and Those Who Use Other Resources First………………………………………………….152
Table 36. Performance, Cluster Averages for Those Who Consult the EAC first and Those Who Use Other Resources First .......................................................153
Table 37. Impact Ratings by Statement and Cluster for Non EAC Staff, EAC Members and All Participants .................................................................330
Table 38. Performance Ratings by Statement and Cluster for Non EAC Staff, EAC Members and All Participants .................................................................338
List of Figures

Figure 1. The Concept Mapping Process .......................................................... 41
Figure 2. Brainstorming, Recruited and Responded ........................................ 72
Figure 3. Recruited and successfully completed one or more rating surveys ...... 75
Figure 4. Recruited and successfully completed sorting activity ....................... 80
Figure 5. Point map, All Participants (Stress value = 0.25) ............................. 90
Figure 6. Point map, Non-EAC Staff Only (Stress value = 0.28) ....................... 90
Figure 7. Point Map, EAC Members Only (Stress value = 0.27) ....................... 91
Figure 8. 8 Cluster Map Based on All Participant Point Map ........................... 93
Figure 9. 7 Cluster Map Based on Non EAC Staff Only Point Map ................. 94
Figure 10. Impact Cluster Rating Map, Non EAC Raters ............................... 106
Figure 11. Impact Cluster Rating Map, EAC Member Raters ............................ 106
Figure 12. Performance Cluster Rating Map, Non EAC raters ......................... 108
Figure 13. Performance Cluster Rating Map, EAC Member Raters ................. 108
Figure 14. Pattern Match: Impact and Performance, All Rating Participants ...... 110
Figure 15. Pattern Match: Impact Rating, Non EAC staff and EAC Members .. 112
Figure 16. Pattern Match: Performance Rating, Non EAC staff and EAC members ................................................................. 114
Figure 17. Go-zone: Liaison With Patients & Families, All participants .......... 117
Figure 18. Go-zone: Liaison With Patients & Families, EAC members ............ 118
Figure 19. Go-zone: Liaison with Patients & Families, Non EAC Staff .......... 118
Figure 20. Pattern Match: Impact Rating, H1 and H2 (EAC members and Non EAC staff) ............................................................... 121
Figure 21. Pattern Match: Impact rating, H2 and H3 (EAC members and Non EAC staff) ............................................................... 122
Figure 22. Pattern Match: Impact rating, H1 and H3 (EAC members and Non EAC staff) .................................................................................................................................122
Figure 23. Pattern Match: Impact rating, RMH 6 and RMH 4 ................................125
Figure 24. Pattern Match: Performance Rating, RMH 6 versus RMH 4 ..........126
Figure 25. Pattern Match: Impact Rating, H2 General Clinicians and H2 critical care clinicians .................................................................128
Figure 26. Pattern Match: Performance Rating, H2 General Clinicians and H2 Critical Care Clinicians .................................................................129
Figure 27. Pattern Match: Impact Rating, Requested an Ethics Consult 7 or More Times and Those Who Have Requested a Consult Less Than 7 Times .............131
Figure 28. Pattern Match: Performance Rating, Requested an Ethics Consult 7 or More Times and Those Who Have Requested a Consult Less Than 7 Times ....132
Figure 29. Pattern Match: Impact Rating, Requested an Ethics Consult and Those Who Have Never Requested a Consult .........................................................134
Figure 30. Pattern Match: Performance Rating, Requested an Ethics Consult and Those Who Have Never Requested a Consult .........................................................135
Figure 31. Pattern Match: Impact ratings, Involved in Patient Care Issue Brought to EAC and Never Involved in a Patient Care Issue Brought to EAC ..................137
Figure 32. Pattern Match: Performance ratings, Involved in patient care issue brought to EAC and never involved in patient care issue brought to EAC .........138
Figure 33. Go-zone: Staff Development, Worked in Healthcare < 5 years ..........140
Figure 34. Go-zone: Staff Development, Worked in Healthcare 5 or More Years ..140
Figure 35. Pattern Match: Impact Rating, Social Workers and Nurses ..................145
Figure 36. Pattern Match: Impact Rating, Social Workers and Non-nursing Allied Health Professionals .................................................................147
Figure 37. Pattern Match: Impact Rating, Administrators and Staff Providing Care .................................................................149
Figure 38. Pattern Match: Performance Rating, Administrators and Staff Providing Care .................................................................150
Figure 39. Pattern Match: Impact Rating, Those Who Consult the EAC first
and Those Who Use Other Resources First .........................................................152
Figure 40. Pattern Match: Performance Rating, Those Who Consult the EAC
First and Those Who Use Other Resources First...............................................153
Figure 41. Go-Zone: Ethical & Moral Support Non EAC Staff ..............................154
Chapter 1: Introduction

A clinical ethics committee is an institutional forum for education, discussion and guidance regarding ethical decisions impacting the provision of optimal patient care. Over the past fifty years, the courts, the American Medical Association and the Joint Commission have supported the creation and use of clinical ethics committees to address the increasingly complex and sensitive ethical issues arising in healthcare. By 1998, Fox, Myers, and Pearlman (2007) found that 100% of surveyed hospitals with over 400 beds had a clinical ethics committee in place. Yet, there have never been any specific standards for these committees (Moeller et al., 2012). Consequently, the functions, membership, visibility, and perceived quality and usefulness of clinical ethics committees vary from institution to institution (McGee, Spanogle, Caplan, & Asch, 2001; Post, Blustein, & Dubler, 2007).

Over the past twenty-five years, multiple inventories have been made of the kinds of issues brought to clinical ethics committees for review. Consistent with the original conception of how these committees might support clinicians and families, these surveys have found that the majority of committee consultations are triggered by ethical challenges in end-of-life decision-making and issues in the critical care units (Hoffman, 1991; Lapetito & Thompson, 1993; La Puma et al., 1988; Swetz, Crowley, Hook, & Mueller, 2007). Care providers continue to struggle with difficult questions about withholding and withdrawing life sustaining treatments and patient autonomy issues. Patients, families and clinicians often disagree about whether care should continue when further treatment is deemed “futile.”

Consultation, education and hospital policy development are the three functions most commonly provided by clinical ethics committees. However, research has found that committees may also be asked to deal with a broad range of additional concerns such as organizational ethics or risk management (Gaudine, Thorne, LeFort,
& Lamb, 2010; Lappetito & Thompson, 1993). For example, in addition to their core responsibilities some committees may also:

- Provide emotional support to clinical staff (Fox et al., 2007; Helft, Bledsoe, Hancock, & Wocial, 2009) by providing a safe space for discussion of moral and ethical issues (Shale, 2008).

- Recommend steps for reducing exposure to legal liability (Caufield, 2007; Fox et al., 2007; Hoffman, 1993).

- Lead efforts to improve the ethical climate (Edelstein, De Renzo, Waetzig, Zeliger, & Mokwunye, 2009; Englehart, 1999).

- Mediate conflicts within families (Dubler, 2005; Feister, 2007; Kovach, 2000; Sims-Taylor, 1994).

- Tackle issues of access to care, cost containment and resource allocation (Caufield, 2007; McGee et al., 2001).

- Deal with strife between medical staff and allied health professionals (Edelstein et al., 2009; Reiser, 1994; Silva, Gibson, Sibbald, Connolly, & Singer, 2008).

- Initiate quality improvement projects (Agich, 2009; Nelson, Gardent, Shulman, & Splaine, 2010; Ross, 2000).

Increasing concerns about patient and family satisfaction, clinician retention, rapid changes in clinical practice, and the sometimes tumultuous transformation of the healthcare industry have added to the challenges of identifying which activities are the most important for individual clinical ethics committees.

**Statement of the Problems**

**Committees lack information about the needs of clinicians.** Without a mandate specifying how a clinical ethics committee should function, committees can vary considerably in size and composition. They may meet regularly or only in response to a consultation request. Members may have substantial training in bioethics or very little. Within an institution, the committee may be seen as a valuable resource by clinicians or an unwanted intrusion into clinical practice. Generally, ethics committees choose activities in response to leadership priorities,
committee interests or organizational requests (Bruce, Smith, Hizlan, & Sharp, 2011; Moeller et al., 2012) determined primarily from a top-down management perspective. If the ethics committee is primarily serving the needs of administration in a reactive fashion, then this approach may be adequate. But, if clinical ethics committees wish instead to be proactively responsive to the concerns of clinicians and ultimately patients, then committee work should also be based on the needs of these “customers.” Research is needed which specifically asks a full spectrum of healthcare professionals what they feel clinical ethics committees could do to support them and their work (Guo & Schick, 2003).

Committees lack empirical baseline data on performance. Many studies of clinical ethics committees have been primarily exploratory reporting on the most common issues brought to the committees for consultation (e.g., Duval, Sartorius, Clarridge, Gensler, & Danis, 2007) or the variation in committee functions (e.g., Fox et al., 2007). Because of evaluation challenges, research on ethics committee performance has often relied on approaches which have limitations, such as self-assessment by committee members (Gaudine, Lamb, LeFort, & Thorne, 2011; Guo & Schick, 2003; McGee, Spanogle, Caplan, Penny, & Asch 2002). For example, McGee et al. (2002) reported in a survey of clinical ethics committee chairs that about one third of respondents thought their committee’s most successful function was providing education while a similar percentage felt this was their committee’s least successful work. The researchers gathered data on what the educators thought of their programs but did not gather feedback from those attending the educational programming.

Another common approach used in evaluating clinical ethics committees is the satisfaction survey (Dorries, 2003; DuVal et al., 2004; La Puma, Stocking, Silverstein, Dimartini, & Siegler, 1988; McClung, Kamer, DeLuca, & Barber, 1996; Orr, Morton, deLeon, & Fals, 1996). Perceptions of ethics committee usefulness have been mixed. Hoffman (1991), in one of the few studies to survey the satisfaction of nurses and social workers as well as that of physicians, found that only 65% of respondents found the clinical ethics committee’s recommendations useful. Of note,
satisfaction was low when respondents found the committees’ functions unclear, input unhelpful and services ineffective in addressing clinician needs.

To learn why some committees receive hundreds of consultation requests each year and other committees receive no requests at all, some researchers have explored what clinicians perceive as barriers and facilitators to requesting an ethics consultation. DuVal, Gordon, Clarridge, Gensler, and Danis (2004) found that while almost three quarters of physicians thought consultations yielded information that would be useful in dealing with future ethical dilemmas, some hesitated to seek an ethics consultation because they believed it was too time consuming, might make the situation worse or that consultants were unqualified. In teaching hospitals, interns and residents play a significant role in clinical care. Glacki-Smith and Gordon (2005) found in their study that while three quarters of residents were aware that a clinical ethics committee existed, only 21% knew how to request a consultation. More importantly, almost half of the residents did not request consultations because they feared opposition from the attending physician or had negative impressions of the ethics committee. Despite these studies, a number of important gaps in knowledge remain.

**Problem 1.** Clinical ethics committees lack information on what they *could* do to meet the needs of clinicians who are facing ethical and moral dilemmas. Without this information, committees who wish to be proactive cannot effectively establish committee composition, determine requisite membership skills and training needs and plan and support relevant service offerings.

**Problem 2.** Research is needed which incorporates input from as many representatives of the healthcare team as possible (Guo & Schick, 2003). To date most research has reported the views of committee members, nurses and physicians. Few studies have purposefully included a multi-disciplinary perspective in either the planning of the research or in the study sample (Singer, Pellegrino, & Siegler, 2001; Tulsky & Fox, 1996). Without multi-disciplinary input, clinical ethics committees are less effective in understanding and meeting the needs of diverse constituents.
Problem 3. In addition to making planning challenging, the multiplicity of purposes and lack of standardization have made it difficult for clinical ethics committees to assess their own performance (Schick & Guo, 2001; Tulsky & Fox, 1996). The different functions committees may undertake require different forms of evaluation, and functions are not easily separated so that they can be evaluated in isolation (Griener & Storch, 1992). In research conducted in 2008 (Gaudine et al., 2010), over 50% of committees reported that they are ineffective in monitoring their own operations; consequently, most committees lack data to establish a baseline for evaluating their different activities (Agich, 2009; Bruce et al., 2011; Gordon, 2007; Guo & Schick, 2003).

Problem 4. Virtually none of the published research has looked at committee work from the perspective of what activities might have the most potential for impacting the provision of optimal patient care (Caulfield, 2007; Guo & Schick, 2003; Hoffman, 1993; McGee et al., 2002; Sims-Taylor, 1994). If ultimately clinical ethics committees are meant to support excellent patient care, then more information is needed on how the committees can support best practice.

Purposes of the Study

Clinical ethics committees demand a substantial commitment from volunteer participants and healthcare institutions (Gaudine et al., 2010; Hoffman, 1993). Research which can help ethics committees prioritize and refine their functions is important to administrators who support the time and effort invested in ethics committee work. Research is also important to the committees themselves if they wish to be as effective as possible in providing the traditional services of hospital policy making, education, and consultation. Finally, research is needed to determine if there are new committee activities which would better meet the needs of clinicians and ultimately patients and families. This study had three purposes. The first was very specific and pragmatic: to assist a healthcare system, which partnered in this study, gather data which would assist its ethics committees with planning and evaluation. The second was broader in scope: to add to the scholarly literature on clinical ethics
committees by addressing some of the existing gaps in the research. The third was more exploratory: to gather information that might point to opportunities for medical social workers to become more involved in supporting ethical practice, particularly at the end of life.

In a healthcare system, Institutional Review Boards may address ethical questions encountered in research, and compliance committees may investigate ethical concerns related to the business operations in a hospital. However, this study explored only the role of clinical ethics committees. All future references to ethics committees are only to those which are concerned with clinical practice.

A needs assessment for a specific healthcare system. The primary purpose of this study was to provide data that would enable a large regional healthcare system in central Ohio, OhioHealth, better understand how its clinical ethics committees might be more effective in supporting clinicians and the work they do in the critical care units. In this organization, ethics advisory committees (EACs) currently assist in developing policies, provide education, and offer consultation services to clinical staff. It was hoped that the study findings could be used to develop and justify a strategic plan for the seven clinical ethics committees in this system.

To develop a strategic plan, the health system wanted information which would give insight into two different concerns. First, the system wanted to learn from a broad range of stakeholders what specific activities clinical ethics committees could do or support to have a positive impact on care. Second, they wanted data, from all of the disciplines involved in providing care in the critical care setting, on the current performance of selected clinical ethics committees. The information was sought to help prioritize, modify, or refine committee functions and direct future planning and evaluation efforts.

It was conjectured that the study findings might be used by stakeholders in a number of ways. The data might 1) help justify the expansion of human resources for ethics consultation; 2) support the development of educational programs for both committee members and critical care staff based on learner-identified needs; 3) indicate material resources that might be needed by committee members and clinical
staff to better fulfill their roles and responsibilities; 4) identify additional services that EACs might provide to support the staff and work in the critical care units (Gordon, 2007); and 5) determine if the members of the ethics advisory committees have the requisite skills and perspectives to address the needs identified in the study (Post et al., 2007, p. 3). In sum, the primary purpose of this study was to provide data that would allow a specific healthcare system to assess the needs of key constituents, identify high priority action items and establish a baseline of performance data to use in future evaluation and research efforts.

**An addition to the scholarly work on ethics committees.** In addition to addressing the objectives of a specific healthcare system, this study was intended to address some of the existing gaps in the literature on the ethics-related needs arising in critical care units. In particular, the purpose was to add to the scholarly literature by offering the perspective of multi-disciplinary end users who have not been represented in previous studies and exploring how traditional committee functions align with clinician need. In addition, by focusing on what committees might do to have a positive impact on care, this study was intended to point to potential activities which might be the most beneficial to clinicians, patients, and families.

**A consideration of possible roles for medical social workers.** Social workers bring significant training in assessment, family counseling, and communication to their roles in the healthcare setting. Unfortunately, these advanced skills are often not fully recognized, appreciated or utilized by hospitals where the social worker may be perceived primarily as a discharge planner (Cowles & Lefcowtiz, 1992; Jansson & Dodd, 2002; Judd & Scheffield, 2010; Landau, 2000). The final purpose of this dissertation was to explore, based on the study results, whether there are opportunities for medical social workers to be used more effectively to support ethical practice, staff and families in the critical care units, and the work of the ethics committee.
**Research Questions**

To better understand how clinical ethics advisory committees at OhioHealth could support the staff and work performed in critical care units, this exploratory study used a participatory research approach. Because this was a participatory study, the research questions were developed by the author in partnership with an advisory committee drawn from the healthcare system. The primary research question was:

*How could clinical ethics committees support the staff and work in the critical care settings?*

This question was used as the foundation for a brainstorming prompt to generate suggestions from both ethics committee members and non-ethics committee members. The research team also developed three secondary questions to be posed about the ideas generated:

a. How much positive impact do ethics committee members and non-ethics committee member think suggested activities could have on care?

b. How well do ethics committee members and non-ethics committee members think the ethics committees are currently performing the suggested activities?

c. Do ethics committee members and non-ethics committee members rate potential positive impact of suggested activities and current performance of ethics committees differently?

To develop an even more refined understanding of the data and assist in strategic planning, additional questions were developed around how different disciplines, racial groups, hospitals and critical care units rate the potential positive impact of suggested activities and current performance of ethics committees. The research team was also interested in how years of experience in healthcare, interactions with the ethics committee and patterns of seeking ethical support affected the assessment of the committee’s potential impact and current performance.

To answer these questions, the study used a structured, mixed methodology, concept mapping, which is specifically designed to analyze and integrate the perspectives of multiple stakeholders. The “concept maps” produced after analysis of the data graphically displayed multiple dimensions of a problem at one time. The
results were expressed in the language of the participants, making them easier to understand and more relevant to those designing and evaluating ethics committee services. In addition, with concept mapping the researcher was able to generate various, tailored graphical output which could be used for strategic planning. This approach made it possible to compare and contrast the perceptions of committee members and non-committee members in ways which have not been done in previous studies.

**Organization of the Dissertation**

The literature review in next chapter presents a history of ethics committees and an overview of ethics committee structure and functions. Ethical climate theory is introduced followed by a review of the complex factors which contribute to the ethical climate in critical care settings. The literature review continues with a discussion of how ethical climate theory has been applied in healthcare practice research particularly around the issue of moral distress. The conclusion of the literature review provides a discussion of strategies which have been recommended to create a positive ethical environment in healthcare settings. Chapter 3 provides an in-depth description of the concept mapping methodology used in the study. Chapter 4 provides selected findings related to the research questions. In Chapter 5, the findings are discussed in light of their implications for the healthcare system which partnered in this research and for the field of bioethics. Following this discussion, Chapter 5 concludes with suggestions for ways in which medical social workers might become more actively engaged in supporting ethical practice in the critical care units, particularly at the end of life.
Chapter 2: Literature Review

Providing healthcare is an inherently moral endeavor. Decisions must be made about the allocation of scarce resources: Who will get treatment, where, and for how long? Do we have a right to healthcare? Decisions must be made that encompass the philosophical and religious domain: When does life begin and when and how shall it end?

Although clear, straightforward answers to ethical issues are desired, ethics is fundamentally a matter of questions, questions that require openness, deliberation, self-questioning, uncertainty, and contemplation. It is in asking good questions, not in having all the answers, where morality resides. Being ethical is never something one possesses. It is the recognition of the messy and expanding interdependence of decisions, interests, and persons. (Austin, 2007, p. 84)

It is within this complex realm of decision making that ethics committees strive to give guidance to hospitals, clinicians, and families.

History of the Clinical Ethics Committee

Clinical ethics committees have existed in various forms for over fifty years. In the early 1960s, before hemodialysis machines became widely available, patient selection committees were formed to make decisions about who would receive treatment. In the late 1960s, when the first heart transplant was performed, issues of organ donation and brain death were raised broadening the scope of ethical concerns (Csaiki & Chaitin, 2006). In 1976, the parents of Karen Ann Quinlan, who was in a persistent vegetative state and on a ventilator, requested that the ventilator be removed. When the long-term care facility refused this request, the father brought the issue before the courts. Ultimately, the Supreme Court of the state of New Jersey
granted the father’s request. In addition, the court recommended that hospitals form ethics committees to help physicians deal with difficult cases and to keep complex ethical choices in the hospital and out of the courtroom.

Between 1976 and 1985, the development of “infant care review committees,” which were formed to assist in determining appropriate life-saving interventions for handicapped infants, increased the presence of institutional ethics committees in hospital settings. During this same period, Catholic hospitals instituted medical morals committees to ensure that treatment was consistent with Catholic beliefs. In the late 1980s, a second pivotal case was brought before the courts. A car accident in 1983 left Nancy Cruzan in a persistent vegetative state. For many years, she lived in a nursing home and was kept alive with a feeding tube. In the late 1980s, Ms. Cruzan’s husband asked to discontinue this artificial hydration and nutrition based on his belief that his wife would not have wanted to be kept alive in such condition. When the nursing home refused the husband’s request, the issue was taken to the legal system and was ultimately decided by the U.S. Supreme Court. The Supreme Court’s ruling has had significant ramifications for end-of-life decision-making. The Court held that: a competent adult has the right to refuse any and all therapies, even if refusal results in death; an incompetent adult can retain and exercise rights through the use of a surrogate decision maker; and all medical therapies, including artificial nutrition and hydration, are considered the same under the law (Csaiki & Chaitin, 2006, p. 172). Following this ruling, legislation (the Patient Self-Determination Act of 1990, http://thomas.loc.gov/cgi-bin/query/z?c101:H.R.4449.IH:) established rights of individuals to create advance directives such as a living will and a healthcare proxy. While the Patient Self-Determination Act was intended to clarify and simplify end-of-life decision-making, other court cases (e.g., Terri Schiavo) quickly showed that family dynamics, conflicting values, and public opinion could make treatment provision quite complex, particularly when the issue was one of quality of life.

As technological advances have made it possible to sustain life, ethical dilemmas have gained increasing attention. In 1982, less than one percent of hospitals had ethics committees; three years later more than sixty percent had some form of
ethics committee available to address issues such as living wills and do-not-resuscitate orders (Csaiki & Chaikin, 2006; Sims-Taylor, 1994). In 1985, the American Medical Association’s Judicial Council (1985) suggested that hospitals have committees which were “voluntary, educational and advisory in purpose so as not to interfere with the primary responsibility and relationship between physicians and their patients” (p. 2698). In 1993, the Joint Commission required in its accreditation guidelines that hospitals establish a mechanism for resolving ethical dilemmas. Under the influence of these recommendations, by 1998 100% of hospitals with over 400 beds had ethics committees in place, although 22% of the committees surveyed did not actually perform any consults (Fox et al., 2007).

**Ethics Committee Structure and Functions**

While ethics committees have been strongly endorsed by multiple organizations, there are no standards for the membership of ethics committees, their functions or how they operate day-to-day. Ethics committees, on average, have 20 members and meet ten times per year (Guo & Schick, 2003). A small majority (57%) of committees are chaired by physicians, but nurses, administrators, social workers and ethicists also lead these groups (Schick & Guo, 2001). Committee membership is up to individual institutions and there is a substantial variability in composition. In a random sample of over 400 ethics committees, 94% use physicians, 91% use nurses, 71% use social workers, 70% use chaplains, 61% use administrators, 32% use attorneys, 25% use other healthcare providers and 23% use lay people (Fox et al., 2007). While a faith-based hospital may have a high percentage of chaplains, another institution may have multiple attorneys, perhaps reflecting that the clinical ethics committee is being used for risk management concerns as well as clinical ones (McGee et al., 2001). Multi-disciplinary, volunteer ethics advisory committees are the most common and were the focus of this research.

As noted in the Introduction, committees may undertake a number of functions depending upon the needs and interests of their institutions. However, generally, ethics committees are seen as having three broad roles: to review or write
hospital policy and procedures related to patient care; to advise and educate clinicians, patients and families about treatment options; and to provide education on ethics to committee members, hospital personnel, and the broader community (American Society of Bioethics and Humanities, 2011; Heitman, 1993; Post et al., 2007). McGee et al. (2001) reported in a survey of 356 hospitals that 100% of the committees surveyed spent at least some of their time formulating or evaluating hospital policy related to ethical clinical practice. Policies may be created, for example, on the treatment of terminally ill patients who demand care that clinical staff feel is medically unjustified. Generally, a committee writes or recommends policies which conform to federal and state requirements, accreditation standards, and the organization’s mission or philosophy (Heitman, 1993) with input from hospital counsel and risk management.

Ethics education for committee members is an ongoing activity as the volunteer membership fluctuates. Volunteer committee members may have little or no formal training in either ethics or conflict resolution (Aulisio & Arnold, 2008) and most of those who serve get their ethics training from more experienced committee mentors (Fox et al., 2007). Committees may provide education to other clinicians informally through consultation or through more structured activities such as annual continuing education workshops. Since the majority of ethical decisions are made in the course of day to day medical practice, without the formal input of an ethics committee, clinician education is considered by some to be the most important of the committee functions (Aulisio & Arnold, 2008, p.420).

The function most commonly associated with clinical ethics committees is consultation. In most settings, consultations can be requested by the physician, nurse, social worker, family or others, but in some institutions only physicians can request an ethics consult (McGee et al., 2001). Of note, research has shown that only between 4% (Bruce et al., 2011) and 9% (Swetz et al., 2007) of the requests for consultation come from patients or families. Even when committees have made efforts to increase family awareness of the ethics committee and its function, this has not increased family requests for ethics committee consults (Moeller et al., 2012). No studies have
provided a clear explanation for why families do not request ethics consults more often.

The most commonly cited reasons for ethics consultation across all studies in a review by Swetz et al. (2007) were:

1. The permissibility of withholding and withdrawing life sustaining treatments,
2. Patient and surrogate decision-making concerns,
3. Resuscitation issues,
4. Autonomy issues (e.g., informed consent and right to refuse treatments),
5. Professional responsibilities,
6. Appropriateness of treatment (i.e., futility vs. non-futility),
7. Inter-professional and family disagreements,
8. Advance directives,
9. Resource allocation,
10. End-of-life care,
11. Religious, cultural, and spiritual issues. (p. 690)

Often, assistance is required on more than one of these issues at a time (La Puma et al., 1988). Even when end-of-life issues are not a major focus of ethics consultations, they may provide a context for consultation about basic issues such as patient autonomy or the improvement of communication. Requests for ethics consultations can come from any of the clinical units. However, nationally the majority of requests come from the intensive care units (McGee et al., 2001) where decisions must often be made quickly on behalf of patients who have limited decision-making capacity at the time of the health care crisis. Moeller et al. (2012) reviewed 100 ethics consults and noted the recommendations made. In 30% of the cases, the committee recommended comfort care, the withdrawal of treatment, or the creation of a do not resuscitate order. In 20% of the cases, it was determined that an ethics consult was not necessary; in 37% the committee’s recommendation was that the patient and family needed emotional support.

Ethics consultation can be performed by committees, teams or individuals or a combination of these (Fox et al., 2007). The form of the consultation service is usually driven by organizational context and resources and the expertise available. In some settings, a bioethicist is assigned to a clinical unit and a committee is called into action only when more complex issues arise (Bruce et al., 2011; Helft et al., 2009; Richter, 2007). However, in most settings a sub-set of the full committee is called
upon to provide consultation after problems have been identified by clinical staff and brought to the committee's attention. In their national survey, Fox et al. (2007) found those performing ethics consultations were physicians (34%), nurses (31%), chaplains (18%), social workers (11%), and administrators (9%) with less than 4% being attorneys or lay-persons.

The ethics committee may render decisions, make a recommendation for a single best course of action, or describe a range of acceptable alternatives. Fox et al. (2007) found that 87% of the ethics committees surveyed "usually" or "always" gather information from chart reviews and 67% "usually" or "always" gather information by meeting with practitioners. In practice it is much less common to include patients and families in the fact-finding. Fox et al. (2007) reported that only 54% of committees "usually" or "always" examine the patient, 29% "usually" or "always" talk with the patient, and 48% "usually" or "always" meet with families. In most instances, the ethics committee is essentially an arbitration board. After conducting its investigation, the committee makes a non-binding recommendation offering a range of ethical options for resolving the conflict or uncertainty (Fox et al. 2007; Lappetito & Thompson, 1993). While 91% of the ethics consultants report their results back to the full ethics committee, only 36% present their results in writing to the patient and family (Fox et al., 2007).

There are a number of challenges which make it difficult for an ethics committee to serve in an advisory capacity. The ethics consultants, whether or not they are clinicians, are generally not part of the care team and are often considered “outsiders” (Aulisio & Arnold, 2008). This may make it difficult for members of the team to trust committee recommendations. And, some contend, even when a committee’s opinions are presented as only advisory, their institutional and psychological force may create the impression that suggestions are, in fact, mandates (Simms-Taylor, 1994). As such, clinicians, particularly physicians, may feel that the committee is an unwanted intrusion into their medical practice and patient-physician relationship (Kovach, 2000, p. 282). The committee's strong association with the healthcare facility also raises the possibility of conflict of interests (Brannack, 2001;
Kovach, 2000). While committees are purportedly acting on behalf of the patient, they also have a vested interest in the needs of the institution for which they serve (Pope, 2009). If a patient disagrees with a treatment plan, the ties between the ethics committee and the institution may result in increased pressure on the committee to focus on liability or financial considerations (Bierlein, 2007; Caufield, 2007; Pope, 2009).

Some have suggested broader functions for clinical ethics committees. In particular, some believe that ethics committees should play a central role in creating a positive ethical environment. Englehart (1999), for example, suggests that committees can create “a common institutional morality that can guide the institution's behavior” and can direct the application of this institutional morality toward new biomedical challenges (p. 87).

Nationally, ethics committees are not well utilized. The median number of ethics consults was three per year, and 22% of the committees did not conduct any consults in 2007 (Fox et al., 2007). Feister (2007) observes, "If we reflect on how many ethically-charged conflicts occur in hospitals each year, it is clear that there is a large, unmet need among patients and their families for help in navigating these conflicts: the ethics consultation system we have in place in the United States is not working" (p.32). One might also question whether ethics committees are meeting other commonly stated goals: protecting patient rights; improving the quality of patient care, and increasing patient/family satisfaction.

**Ethical Climate Theory**

Over the past sixty years, theorists and researchers in both the business and non-profit sectors have proposed that organizational culture and climate are useful constructs for explaining how organizations influence the behavior, attitudes and well-being of workers and why some organizations are more successful than others (Glisson & James, 2002). An organization’s culture is created by its institutionalized norms and shared behavioral expectations. An organization’s climate is a reflection of employee perceptions of the work environment, practices and procedures. Culture
and climate need not be uniform throughout a company. Multiple sub-cultures and climates can develop within an organization particularly when the organization is large and units work independently, under separate supervisors (Glisson & James, 2002).

The ethical climate is a particular kind of work climate which emerges from the moral implications of an organization’s procedures, policies and practices. Ethical climate is a shared perception of what constitutes right behavior; it influences which issues employees consider ethically significant or relevant as well as the criteria that are used to evaluate and resolve moral and ethical dilemmas in the workplace (Martin & Cullen, 2006). An ethical climate assumes that an individual arrives at the organization with a set of moral values but, after becoming an employee, decision-making is heavily influenced by organizational and other environmental factors (Jones & Ryan, 1997; Pastoriza, Arino, & Ricart, 2009).

Ethical climate theory was developed by Victor and Cullen (1988) in an effort to better understand which organizational and individual factors might influence employee decision-making and attitudes. This theory reflects the interaction between the individual’s moral values and social pressures, company rules, professional codes and legal standards. The theory is based on ethical philosophy, theories of moral development (particularly that of Kohlberg), and sociological theories of reference groups.

Originally, Victor and Cullen (1998) proposed a two dimensional typology with nine distinct ethical climates reflecting on one dimension individual ethical value systems (egoism, benevolence, and principle) and on the other a level of analysis (individual, local [work group] and cosmopolitan [external to the organization]). After empirical study, the three by three matrix was reduced to five distinct ethical climates:

1) Instrumental: “In this organization, people protect their own interest above all else.”
2) Caring: “In this organization, people look out for each other’s good.”
3) Independence: “In this organization, people are expected to follow their
own personal moral and ethical beliefs.”

4) Rules: “In this organization, everyone is expected to stick by organization rules and procedures.”

5) Law and Code: “In this organization, the first consideration is whether a decision violates any law.” (Victor & Cullen, 1988, p. 112)

The ethical climate in an organization reflects how decisions are made, particularly decisions with ethical implications. A number of factors can contribute to a perception of a more positive ethical climate: organizational practices that encourage an open, respectful discussion of ethical problems and differences of opinion; opportunities for inter-disciplinary collaboration; resources to help direct ethical decision-making; and support when decisions cause stress or uneasiness (Hamric & Blackhall, 2007). Conversely, if employees feel they are not entitled to ask questions or may face negative repercussions if they voice concerns about practice, then the ethical climate can become negative (Pugh, 2011). The nature of work responsibilities may also impact the ethical climate. For example, when there are many competing but valid concerns, decisions must be made under pressure, religious or cultural values make options less clear cut, and choices have significant consequences, the environment can become ethically stressful and may feel more negative even when supports are in place. Research in business, non-profit organizations and healthcare institutions has shown that one dominant ethical climate will emerge in a unit of the organization or in the organization as a whole (Martin & Cullen, 2006). However, staff with differing qualifications, experience, or assignments may perceive the ethical climate differently (Filipova, 2009) even within the same work area. Multiple factors can contribute to the ethical climate particularly when the work environment is complex.

**Factors Contributing to the Ethical Climate in the Critical Care Setting**

The nature of care provided in the critical care unit. The critical care unit is an intense environment in which choices, often made at a point of crisis, can
literally mean the difference between life and death. Care is complex and highly technical, requiring the expertise of many disciplines. In addition, inherently ethical and moral decisions must be made on a daily basis. For example, decisions must be made whether or not to resuscitate a patient, extubate a patient and allow the patient to die, or use medications which may bring comfort while hastening death. Staff may be faced with withholding or withdrawing “futile” treatment when the family is not in agreement that treatment should be discontinued (Nelson, 1997). Working in critical care is physically and emotionally exhausting, and burnout is common (Epp, 2012).

Decision-making in the critical care units is difficult and often fraught with conflict. Decisions must be made in the context of medical knowledge, standards of practice, ethical principles, legal constraints, financial worries, family dynamics, and personal and religious values. Good communication is not only more challenging but also more critical. However, in practice communication in the units frequently breaks down:

Take information that could be interpreted in different ways by different people, depending on their knowledge, values and life experiences. Exclude some important information, and distribute what is known to different people. Bring in events that could be viewed and interpreted in disparate and contradictory ways. Create uncertainty about options and outcomes. Sprinkle a dash of vagueness over the mix. The ambiguity itself would be inconsequential if it wasn't baked in the heat of requisite decisions and actions. (Marcus, Dorn, Kritek, Miller, & Wyatt, 1995, p.13)

Patients, their families, clinicians, and health care institutions each have their own needs and interests - and often these interests clash. Because of these variables, critical care units have their own sub-cultures and ethical climates which may differ from that of the main hospital. The stress of decision-making in the critical care units is persistent and intense and can contribute to feelings of stress; this, in turn, can lead to a sense of a more negative ethical environment.
**Patient variables and ethical climate.** By law, a competent adult has the right to accept or refuse medical care. Patient "self-determination" also includes the right to withhold or withdraw life-sustaining treatment. Many variables impact how, or even whether, an individual fully exercises this right. Patients often avoid end-of-life conversations because of the stigma and embarrassment associated with death and dying. Shyness, confusion, fear of death, and cultural prohibitions may also block meaningful discussion of end-of-life wishes (Larson & Tobin, 2000). When adults know or suspect that family members may not support their end-of-life wishes, they may downplay, disregard or deny the conflict to keep others happy (Parsons & Cox, 1989). A patient who sees herself as a financial or emotional burden on her family may also not voice her own desires.

Unfortunately, while initiating planning discussions about end-of-life care may be uncomfortable, most individuals desire and expect it (Hammes & Briggs, 2004) with both significant others and their healthcare team. Most patients do not want physicians to defer end-of-life care planning until the disease has progressed so far that they can no longer participate in future decision-making.

A patient's trust in the assistance of physicians in end-of-life treatment decision-making encompasses not only choices among various methods of curing an illness, but also the far more consequential choice of whether to stop fighting an illness and accept the inevitability of death. (Gatter, 1999, p. 1102)

The patient works with the presumptive trust that the medical team is committed to his wellbeing. And yet, when patients do not agree with treatment recommendations, they may fear that if they make decisions at odds with the person controlling treatment or express a desire to die, their care might be abandoned (Cooley, 2006). If, because of gender or socio-economic differences, the patient feels uncomfortable confronting the physician, a true exchange of information may never take place.

The patient's medical condition and mental status may also complicate decision-making. Many variables affect a person's ability to participate fully in making treatment choices. External factors such as pressure from family and friends
or being in the alien health care environment; internal factors such as pain, medications, stress, intelligence, and the disease process; communication barriers such as language, literacy level, and hearing and vision difficulties; and the nature of the decision being reached can all impact an individual's decision-making capacity (Hammes & Briggs, 2004). In practice, a person may have the capacity to make some decisions but not others, and capacity may fluctuate over time making decision-making and the full exercise of self-determination that much more difficult (Hafemeister, 1999).

Unless a patient has been adjudicated incompetent in a court of law, the health care team should make every effort to include a patient in decision-making. However patients “may not want to exercise autonomy. Even fully competent patients find it difficult to make voluntary, un-coerced and knowledgeable choices as to whether to withdraw life sustaining support" (Cooley, 2006, p.235) or attempt extensive, invasive or painful procedures. Many are content or even anxious to delegate decision-making authority to their families or the healthcare team. In studies, over 70% wanted to leave the final resuscitation decision to their family and their doctors rather than having their own preferences expressly followed (Fagerlin & Schneider, 2004; Hafemeister, 1999). So, while in principle patients should be actively involved in making informed decisions, healthcare providers still continue to dominate the process. These patient-related factors can create multiple ethical dilemmas for healthcare providers who may wish to respect patient self-determination but are not clear on the best way to do so. Uncertainty and conflicting opinions can contribute to a negative ethical climate. Patient autonomy and capacity issues are some of the most frequently cited reasons for ethics consultation requests (Lappetito & Johnson, 1993; Moeller et al., 2012; Swetz et al., 2007) as staff look for support in addressing these ethical concerns.

**Family variables and ethical climate.** While including families in medical treatment decision-making is often “wise and appropriate" (Gentry, 1995, p.118), it is not uncommon for well-intentioned family members and friends, who mistake declining physical condition with decreased ability to make decisions, to try to make
treatment choices for the patient. Unfortunately, this undermines both the patient's autonomy and right to self-determination (Csikai, 2004) and makes clinical care more difficult. Sometimes, to avoid the strain of conflict or for fear of litigation, healthcare providers consciously allow family member feelings to trump those of the patient: they share information with the family rather than the patient or even let family wishes override those of the patient (Cooley, 2006). Some members of the healthcare team may find this approach appropriate while others find it ethically challenging creating different perceptions of the ethical climate.

As family members become more involved in the crisis driven decision-making in the critical care unit, dormant, unresolved family issues may surface. Long standing patterns of leadership may no longer feel appropriate if some family members have been more involved in the patient's life than others. For example, women often shoulder the primary burden of caregiving but during end-of-life decision-making are often considered less critical than male family members (Parsons & Cox, 1989). The heterogeneity of families can also create challenges. Family members may have unequal abilities to understand medical concepts and different views about the trustworthiness of the healthcare institution (Arnold, Artin, Griffith, Person & Graham, 2006). It is not uncommon for family members to have conflicting interpretations of a patient's remarks about what treatments are wanted or not wanted and divergent views on the benefits and burdens of recommended treatments and quality of life (Hoffman, 1994). Misunderstandings about who will bear the cost and burden of ongoing care can also fuel family conflict. For example, family members who may otherwise be quite close can hold disparate and often highly tenacious views on the importance of sustaining life at all costs. At a time of crisis when individuals are least able to make important decisions, family dynamics may help, but more often hinder, smooth decision-making, particularly in the critical care setting. Family conflicts frequently trigger ethical dilemmas for clinicians and challenges in providing timely, appropriate care. Frequent confrontations with family members about what is right for the patient create a negative ethical environment in the critical care unit. Consequently, family conflicts in the intensive care unit are seen
as disruptive by staff and frequently trigger requests for ethics consultation (Fox et al., 2007; Kovach, 2000; Lappetito & Thompson, 1993; Ramsauer & Frewer, 2009; Swetz et al., 2007).

**Surrogate decision-maker variables and ethical climate.** Through a power of attorney for healthcare, an individual can appoint another person to make healthcare decisions. The healthcare agent, or surrogate, cannot make financial or business decisions and can only make healthcare decisions when a physician has declared that the individual is incapable of making these decisions for herself or himself. Appointment of a healthcare surrogate is intended to make healthcare decision making easier and less contentious. In practice, the designation of the surrogate may not help the decision-making process.

In Ohio, the law is set up to allow one surrogate (Ohio Revised Code 1337.11 to 1337.17). But, others often want (and sometimes demand) to play a role even when they are not the designated proxy decision maker. "Having one family member make decisions may result in disagreements among family members and/or caregivers, accentuating conflicting, deeply entrenched positions - positions that might not even be what the patient would have wanted" (Cooley, 2006, p. 239). If the chosen surrogate is not a family member, family members may try to wrest away decision-making authority. Healthcare providers, particularly physicians, may also pressure the surrogate to make decisions that do not really reflect the patient's wishes (Hafemeister, 1999). Although surrogates are expected to follow particular standards, in practice they are often guided by either their own treatment preferences or, if the patient is dying, an urgent desire to keep their loved one alive (Fagerlin & Schneider, 2004). With all the pressures surrogates face, it is perhaps not surprising they have a tendency to over predict the amount of care desired (Cooley, 2006). Current health care decisions law gives surrogates disproportionate power, and many providers feel they must back down and provide the treatment surrogates want even if this does not reflect what they feel is the best care for the patient (Pope & Waldman, 2007, p.149). Because they can become so frustrating and contentious, issues involving surrogate
decision-making are often particularly challenging for ICU staff. Consequently these disputes are often brought before the clinical ethics committee (Swetz et al., 2007).

**Advance directives and ethical climate.** In the early 1990s, living wills were advocated as an advance directive that could help patients communicate end-of-life wishes making it easier for surrogates to make healthcare decisions. Unfortunately, advance directives have not helped with end-of-life communication as much as hoped. Researchers estimate that only about 18% of patients have living wills (Fagerlin & Schneider, 2004). There are many common misunderstandings from both the public and healthcare providers about advance directives. Healthcare providers may mistakenly have the idea that advance directive forms must be in writing and on specific forms to be enforceable and that comfort measures which hasten death are illegal (Hammes & Briggs, 2004). Or, based on their own moral values, practitioners may believe withholding or withdrawing of life sustaining treatment is the same as suicide or murder regardless of the patient’s wishes. Socio-economic and cultural differences also pose a barrier to the completion of advance directives. Ethnic minorities who fear not receiving necessary care are often reluctant to complete these documents (Hammes & Briggs, 2004). To add to these challenges, 62% of those who have advance directives fail to share them with their doctors (Fagerlin & Schneider, 2004) or surrogate. Finally, invoking the advance directive signals that the patient is hopelessly ill so all parties are reluctant to call it into use (Fagerlin & Schneider, 2004). It is not surprising that surrogates may feel overwhelmed by having to exercise singular, final authority particularly with so little guidance from the advance directive (Hafemeister, 1999). Consequently even when the documents are available, surrogates, family members, and providers often take advantage of the imprecise language (Huff, Weisenfluh, & Murphy, 2008) to interpret them using their own preferences creating conflict as well as ethical dilemmas. When high stakes decision making becomes muddied this can lead to a more negative ethical climate. Conflicting interpretations of advance directives are often brought to ethics advisory committees for discussion (Lappetito & Thompson, 1993; Moeller et al., 2012; Swetz et al., 2007).
Communication challenges and ethical climate. Multiple studies have shown that the most important need of families of ICU patients is good communication: they want their questions answered honestly; they want to understand the diagnosis and prognosis; and they want the information explained in understandable terms (Way, Back, & Curtis, 2002). Families trust that doctors will ask the right questions, give the right information, and make sure that the risks and benefits of treatment are understandable so that patient consent can be truly informed (Gatter, 1999). Unfortunately, the most common causes of bioethical disputes are dysfunctional or inadequate communication and conflicting interpretation of facts and data (Fox et al., 2007; Penn Center for Bioethics Mediation Service, 2008; Swetz et al. 2007).

Many factors contribute to ineffective communication between patients, families and the healthcare team. Despite the recent movement to promote “patient-centered care,” many patients continue to see doctors as miracle workers, and physicians often adopt a manner of certitude that helps them maintain professional power and control over the medical decision-making. In fact, patients and family members are often expected to defer to the opinion of the doctor (Kellett, 1987), and questions or challenges may be actively discouraged (Kovach, 2000). When they answer questions, healthcare providers often use acronyms, medical jargon and technical terms. Even highly educated patients may be at a loss in the alien world of healthcare; individuals who have limited literacy skills, speak another language or have hearing impairments have more serious challenges in processing medical information. The stress of the high stakes decision-making process may also undermine an individual's ability to process complex facts and data. Many have likened dialogues in the healthcare setting to cross-cultural communication: patients and providers are frequently "not speaking the same language" (Lebed & McCauley, 2004-2005).

Providers can consciously or unconsciously influence a patient's preferences for treatment. For example, factors such as whether success or failure rates are used or short term or long term consequences are presented first can impact treatment
choices (Fagerlin & Schneider, 2004). While practitioners need to openly acknowledge that treatment may fail, they often neglect to do so as it is difficult to share bad news (Stoller, 2008). At times, the medical team may altruistically believe it is in the best position to make decisions and may be reluctant to involve patients and families in the process of joint decision-making. However, without accurate information, families and patients can understandably develop unrealistic expectations (Workman, 2007) which can lead to misunderstanding and conflict. In addition, when patients and families are excluded from the decision-making, even if the actual choices are acceptable, they may feel ignored, demeaned and resentful (Kellett, 1987).

With so many specialists involved it is often unclear who is responsible for initiating and documenting end-of-life discussions (Larson & Tobin, 2000). In addition, while healthcare practitioners may develop a united plan of care to present to the patient and family, it is not unusual for members of the treatment team to be in disagreement about end-of-life treatment. For example, a physician may favor more aggressive treatment while nursing staff may want to shift the focus of care to palliation. When this happens, resentment may build in the healthcare team and the providers may present mixed messages about prognosis and appropriate next steps (Gerardi, 2007-2008). Too often, the problem is made worse by the fact that decisions are frequently made in the hospital corridor at a time of great stress for both the family and healthcare team (Cooley, 2006). With multiple disciplines involved in care, residents rotating on and off service, and allied health staff changing on a daily basis, it is not surprising that there are often breakdowns in communication among providers and between providers and patients. Many end-of-life conflicts which occur in the critical care unit may be based on a failure of communication and subsequent discordance in expectations (Cohn, Goodman-Crew, Rudman, Schneiderman, & Waldman, 2007; Hoffman, 1994) rather than on a real disagreement about the goals of care. Regardless, these problems in communication create a stressful and negative ethical environment.
One strategy that has been recommended for improving communication with relatives of critically ill patients and easing the decision-making burden that weighs on families is the family conference (Azoulay, 2005). Family conferences are intended to: provide early, effective and intense communication with a patient's relatives; empower family members by helping them understand the patient's situation; reduce anxiety; and increase the family's ability to act as surrogates and work collaboratively to make decisions about the patient should they wish to do so (Azoulay, 2005). Unfortunately, despite research supporting the use of end-of-life conferences, these structured discussions are not a routine part of care as there is rarely compensation for these time intensive meetings (Larson & Tobin, 2000).

In over 70% of malpractice suits, relationship and communication issues have been cited as a key reason for litigation. These issues include: the physician's failure to be available, the health care team's devaluing of the patient's and family's views, the dysfunctional delivery of information, and the failure to solicit or hear a patient's request for information, opinions, or expressions of discomfort (Currie, 1998). In contrast, Heyland, Cook, Rocker, et al. (2003) found that when surrogate decision makers are involved in and satisfied with the decision-making process, they are more likely to be satisfied with the care overall. This satisfaction was not influenced by whether or not the patient died while in the critical care unit. Kaufer, Murphy, Barker and Mosenthal (2008) found a similar correlation between family inclusion in the decision-making process and overall satisfaction with care. In sum, poor communication between the healthcare team, the patient and the family can lead to dissatisfaction, tension, and even litigation, while good communication is a critical ingredient for patient empowerment, family satisfaction and a more positive ethical environment in the critical care unit.

**Financial and systemic pressures and ethical climate.** Healthcare providers who play a pivotal role in critical care and end-of-life decision-making also face both external and internal pressures that can impact how they participate in the process. Providing care to patients in their final months of life can be expensive. According to Department of Health and Human Services research: "In the last month of life,
Medicare expenditures are twenty times as high as average monthly expenditures for beneficiaries who are not in their last year of life" (Centers for Medicare and Medicaid Services, 2003). Expenses not covered by insurance are often absorbed by the hospital if the patient or family cannot pay. So, physicians may face pressure from the hospital to discontinue medically ineffective patient care, particularly expensive ICU services. However, they may also feel pressured to surrender to demands for ineffective treatments from aggressive patients and families. Unfortunately, physicians often feel compelled to practice "defensive medicine," ordering tests and procedures primarily to avoid liability and malpractice claims. Defensive medicine is reflective of an “instrumental,” more negative ethical climate (Victor & Cullen, 1988). Fear of protracted, expensive court proceedings undermine the therapeutic relationship, drain resources, and polarize the patient, family and healthcare team (Buchanan, Desrochers, Henry, Thomasson, & Barrett, 2002). Legal myths and misunderstandings can also undermine good care and ethical decision-making (Meisel, Snyder, & Quill, 2000). It is not surprising that critical care decision-making can be fraught with financial as well as legal and ethical concerns. At times these complicated issues are brought to a multi-disciplinary ethics committee where administrators and lawyers as well as clinicians can weigh in on the discussion (Moeller et al., 2012; Swetz et al., 2007).

**The healthcare team and ethical climate.** Emotions play a significant role for healthcare providers as well as for patients and families. Many members of the healthcare team, particularly physicians, equate "success" with the survival of the patient. If the dominant "narrative" is that of rescue, this serves to organize a set of beliefs that medicine is infallible and that illness is unnatural; it sets up the physician as the hero/warrior. This narrative limits the perspective of the entire healthcare team and makes it harder to deal with terminal illness when a rescue (cure) is no longer possible (Barton, 2008). If members of the healthcare team feel they have "failed" in the face of death, then end-of-life discussions can be complicated with the providers’ feelings of Helplessness, failure, and denial. In addition, healthcare providers who spend months or even years caring for an individual may feel significant loss when
the patient becomes terminal. This grief has the potential to cloud their professional decision-making ability. Emotional struggles of healthcare providers around end-of-life discussions (Csikai & Bass, 2000) impact the climate in the critical care unit.

While the primary physician is the key decision maker within the healthcare setting, other professionals are critical to providing care in the ICU. Yet, to use the term “healthcare team” may give a false impression of how providers work and interact. In fact, providers rarely work as a "team" and turf battles are common (Marcus et al., 1995). Team members may have conflicting opinions about pain management, error disclosure, necessary level of care, interpretation of living wills, and medical futility (Hayes, Hetzler, Morrison, & Gerardi, 2003; Nelson, 1997; Shwenzer & Wang, 2006). In addition, differences in knowledge level, experience and professional status can impact how providers share information leading to a more negative “instrumental” ethical climate (Filipova, 2011). Disciplines tend to work in isolation and there may be few opportunities for group conversations. Providers may find themselves struggling to do the right thing within the frameworks of their professional expertise, code of ethics and personal value system without the opportunity to hear the whole story (Gerardi, 2003). This can lead to an “independent” ethical climate which also tends to be more negative. When professionals feel powerless to influence the course of care, they may feel guilt, tension and distress that can undermine teamwork and morale on the unit (Ulrich, Hamric, & Grady, 2010). The complexity of the healthcare system means that misunderstandings and conflict can occur at multiple levels at the same time (Marshall & Robson, 2003) making it difficult to create a “caring,” positive ethical environment.

**Social workers and ethical climate.** Social workers can play an important role in the intensive care units. While other critical care staff are focused on providing clinical care for the patient, social workers often focus their interventions on the family. An ICU admission often triggers a crisis in family members who enter an alien environment at a time when a loved one is gravely ill. Consequently, one of the first roles of an ICU social worker is to provide rapid assessment, clear
information, emotional support and crisis intervention (Epperson, 1977; Foster, 1980; Hartman-Shea, Hahn, Kraus, Cordts, & Sevransky, 2011; Rose & Shelton, 2006; Williams & Rice, 1977). As part of the assessment process, the social worker may also identify the existence of advance directives and healthcare surrogates and explore family concerns about end-of-life decision-making (Hartman-Shea et al., 2011). During this assessment, the social worker may uncover and address potentially disruptive family conflicts (Rose & Shelton, 2006) which must be resolved before a care plan can be finalized.

Another important role of the social worker is to talk with the family, and then subsequently with the other staff in the ICU, about spiritual needs and cultural values that may be affecting treatment decision-making (McCormick, 2010). Often, the social worker is responsible for organizing meetings between the family and the treatment team (Hartman-Shea et al., 2011). At these sessions, the social worker often acts as a patient/family advocate, clarifying misperceptions and miscommunications (Foster & McLellan, 2002; Williams & Rice, 1977). In addition the social worker can help model for doctors how to pose the tough questions and address concerns raised by patients and families (Larson & Tobin, 2000). These meetings with the social worker have been reported to improve family satisfaction with care in the ICU (Sundararajan, Sullivan, & Chapman, 2012) and ease the work of clinicians by making their work flow more smoothly (Joseph, Berzoff, & Dobbie, 2009). Based on their involvement with the families in the ICU, social workers often initiate requests for multi-disciplinary ethics discussions or formal ethics consultation when ethical dilemmas arise (Jansson & Dodd, 2002). In addition, social workers may have the potential to improve the ethical climate in a unit if, by helping to address family concerns, they can make work easier for the other members of the healthcare team.

**Application of Ethical Climate Theory in Healthcare Practice Research**

In healthcare, studies have explored the relationship between the ethical climate, employee retention and job satisfaction. Joseph and Deshpande (1997)
reported that nurses who worked in a hospital where they believed there was a caring ethical climate were more likely to be satisfied with their work. Research by Filipova (2011) and Joseph and Desphande (1997) found similar results: a caring climate significantly and positively influenced job satisfaction and commitment but an instrumental ethical climate was negatively associated with commitment. Hart (2005) in a study of 463 registered nurses, found that a perceived, negative, hospital ethical climate was the most important factor in explaining participants intention to change jobs or place of employment.

**Ethical climate and moral distress.** A number of studies have examined the relationship between the perceived ethical climate of the organization and levels of moral distress (McAuliffe, 2005; O'Donnell et al., 2008; Pauly, Varcoe, & Newton, 2009; Sporrong, Hoglund, & Arnetz, 2006; Ulrich et al., 2007). Moral distress (also referred to as ethical stress) has been described as “an occupational stress that occurs when one knows the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action” (Kalvemark, Hoglund, Hansson, Westerholm, & Arnetz, 2004, p. 1076). Healthcare professionals who feel ethical stress may suffer from physical symptoms, anger, guilt, depression, anxiety and frustration (Bell & Breslin, 2008; McAuliffe, 2005; Ulrich et al., 2007). In addition, unresolved moral distress may lead to inter-personal conflict, a diminished capacity for caring, the provision of poorer quality of care, and an avoidance of patient and family contact (Guttierez, 2005; Lang, 2008; Rathert & Fleming, 2008). Multiple studies (O'Donnell et al. 2008; Pauly et al., 2009; Ulrich et al., 2007) have shown a significant negative relationship between ethical climate and moral distress. In other words, when the work environment was seen as ethical and supportive (“caring”), ethical stress was less. The concept of moral distress was developed in the nursing field and most of the research has been conducted with this population. A few recent studies of social workers (Doyle, Miller, & Mirza, 2009; Grady et al., 2008; McAuliffe, 2005; O'Donnell et al., 2008; Ulrich et al., 2007) and other members of the healthcare team (Kalvemark, et al., 2004) have had findings similar to those in nursing.
Moral distress and work satisfaction. A number of studies have been conducted to determine if there is a relationship between a health care provider’s level of moral distress and job satisfaction. O’Donnell et al. (2008) found that as ethical stress increased, work satisfaction decreased. In fact, if serious enough, moral distress may lead some social workers and nurses to quit their jobs or even abandon their profession all together (Corley, 1995; Corley, Elswick, Gorman, & Clor, 2001; Elpern, Covert, & Kleinpell, 2005; McAuliffe, 2005; O'Donnell et al., 2008; Ulrich et al., 2007). In all these studies, researchers found that when workers do not have the training, skills and support to resolve ethical issues they are more likely to experience more moral distress and leave their place of employment. Some of the costs of high employee turnover include lower staff morale, inferior quality of care, and expensive retraining to replace staff with highly specialized skills (Bell & Breslin, 2008). On the other hand, Vicentia (1989) found that social workers who felt they had an influence on ethical decision-making were more satisfied with work.

Interpersonal dynamics in the workplace were also found to contribute to or militate against moral distress. In several studies (Malloy et al., 2009; Vicentia, 1989; Ulrich et al., 2007), workers reported less stress when they felt like respected members of the treatment team. On the other hand, a number of researchers (Eizenberg, Desivilya, & Hirsch, 2009; Kalvemark et al., 2004; Lutzen, Conqvist, Magnusson, & Andersson, 2003) have reported that conflicts with other staff were a commonly cited source of ethical distress. For example, a professional might feel distress because she is required to follow the wishes of a superior against her own moral beliefs (Malloy et al. 2009). Or, she might feel stress because she must choose between meeting the needs of a patient she sees for a brief visit, the desires of a team member with whom she works every day, or the financial well-being of her place of employment (Cesta, 2011; Shale, 2008). More ethical distress was reported when respondents were reluctant to dissent with others (McAuliffe, 2005; Vicentia, 1989) or when issues of power and authority made it impossible, or seem impossible, to do what was right (Malloy et al., 2009; McAuliffe, 2005; Lutzen et al., 2003; Vicentia, 1989).
Moral distress and the critical care unit. Within the critical care unit, clinicians report that end-of-life issues, particularly around medical futility, create the most moral distress (Shwenzer & Wang, 2006; Wiegand & Funk, 2012). In particular, staff may be troubled by patient suffering, prolonged or undignified dying, and what they see as inappropriate care (Wiegand & Funk, 2012). Family distress, expressed as grief, guilt, and anger, can also prompt feelings of moral distress (Wiegand & Funk, 2012) particularly when family members push to continue life support even when this is not in the best interests of the patient (Nelson & Merighi, 2003; Zuzelo, 2007).

Moral distress, policies and access to support. McAuliffe (2005) noted that a lack of clear policies and guidelines contributed to an ethically stressful environment. On the other hand, climates that foster adherence to policies that are considered fair tend to foster positive employee attitudes and reduce employee intentions to quit (Filipova, 2011). Kalvemark et al. (2004) found greater levels of ethical stress when staff could not reach agreement on what constitutes a moral issue or when professional values conflicted with administrative routines.

Access to support and advice on how to address ethical concerns was found to be a critical component of an ethical environment and levels of moral distress (Grady et al., 2008; Helft et al., 2009; McAuliffe, 2005; O'Donnell et al., 2008; Olson, 1998; Pauly et al., 2009; Ulrich et al., 2007; Vicentia, 1989). This seemed particularly important in settings in which staff have different priorities among moral values. For example, nurses may feel moral distress when they place priority on patient dignity but feel that doctors put more value on patient survival (Eizenberg et al., 2009; Malloy et al., 2009). Support was also important when staff had concerns about their own competency to do what was requested or when concerned about the competency of others (Pauly et al., 2009). Meltzer and Huckabay (2004) found that when nurses had access to an ethics committee and were involved in developing policies on futility, they were less likely to suffer burnout.
Recommended Strategies for Creating a Positive Ethical Climate

**Ethics education.** While known strategies for improving ethical climate are limited, researchers have suggested a number of approaches for creating positive ethical environments. Respondent level of education has not been found to be a significant predictor of level of moral distress or of discrepancies in moral decision-making (Doyle et al., 2009; O'Donnell et al., 2008; Pauly et al., 2009). However, researchers have found a relationship between the amount and kind of ethics education a respondent has received and moral distress level. Vincentia (1989) found that respondents felt better prepared to discuss ethical conflicts after attending a course and therefore felt less distress. Grady et al. (2008) found those with ethics training were significantly more likely than those without ethics training to take “moral action.” Boland (2006) found that prior ethics training was the only significant predictor of using an ethical decision-making process when hospital social workers faced ethical dilemmas. Doyle et al.’s (2009) research found that those with formal ethical training had fewer discrepancies in what they felt they should and would do. Unfortunately, Ulrich et al. (2007) found in their study that social workers and nurses who had some knowledge and skills in ethics – but no access to other resources – were more likely to feel frustration, dissatisfaction and moral distress.

Healthcare providers may receive ethics education from different sources: while in school, through continuing education or during supervision. Providing ethics education to staff has also been one of the traditional roles of clinical ethics committees. Ethics education has the potential to help healthcare providers identify ethical issues, clarify personal and professional values and, as noted in an earlier section, feel less moral distress as they support patients while meeting institutional demands (Jotkowitz & Gesundheit, 2008). In addition, information and education can help staff identify resources in the institution – such as the ethics committee – which can assist in resolving ethical dilemmas. Further information is needed on whether staff believe that ethics education provided by a clinical ethics committee makes a positive difference in the care provided in the critical care units.
**Ethics consultation.** Gordon and Hamric (2006) reported that nurses who took action and requested an ethics consultation reported significantly less regret in their decision than the nurses who desired to, but did not, make a request. Those who did not request a consultation reported feelings of moral distress from not being able to advocate for their patients or to influence ethical decision making (Gordon & Hamric, 2006; Malloy et al., 2009). Suhonen, Stolt, Virtanen, and Leino-Kilpo (2011) in their literature review report that consultation about ethical issues was found to enhance clinical work, and Ulrich et al. (2007) report that nurses and social workers who have support and resources available when they have ethical concerns are better able to tolerate ethical stress.

In a study of nurses, Olson (1998) reported that perceptions of the ethical climate were based on how patient care problems with ethical implications were discussed and decided. For example when a manager listens and is supportive or hospital policies facilitate decision-making, this contributed to a positive ethical climate. If the nurses felt that patients’ wishes were not respected or conflict was not dealt with openly, this contributed to a negative ethical climate. Clinicians looking for both clarification of ethical issues and emotional support may request assistance from an institutional ethics committee. Ethics consultations have been suggested as a means of preventing unilateral decision making about patient care and enabling multi-disciplinary discussions and shared values which can in turn promote a more caring ethical climate (Filipova, 2009; Pastoriza et al., 2009; Schluter, Winch, Holzhauser, & Henderson, 2008; Slowther, Johnston, Goodall, & Hope, 2004). In addition, ethics consultations may, by clarifying patient wishes, uphold patient autonomy which in turn can promote non-maleficence, a better use of limited resources (Skeel & Self, 1989) and a more positive ethical climate. Unfortunately, Ulrich et al. (2007) found that almost 40% of the nurses and social workers in their study reported having no organizational resource to assist them with their ethical concerns. In another study of ethical climate in managed care (Bell, 2003), 91% of the respondents did not know whether their employers had an ethics committee and 92% did not know whether their company had a process for deciding ethical issues. Gacki-Smith and Gordon
(2005) reported that while 76% of medical residents were aware of the ethics consultation service, only 21% knew how to request a consult. Ten percent of the residents indicated they wanted to request a consultation but did not do so often fearing opposition from the attending physician. O’Donnell et al. (2008, p. 33) found that allied health professionals, including social workers, use ethics consultation services less frequently than physicians because of perceptions of powerlessness, communication failures, distrust among professionals of different disciplines and lack of knowledge about ethics. This finding was supported in another study by Jansson and Dodd (2002) which found that less than half of the social workers surveyed felt that they were frequently or always treated as equals in ethical deliberations. Even when a clinical ethics committee exists, members of the healthcare team may not use the service because of lack of information or perceived or real barriers to access.
Chapter 3: Methods

This exploratory study was a collaboration between the researcher and a large healthcare system, OhioHealth. The primary purpose of the study was to gather information which might help the system’s ethics committees become more effective in supporting clinicians and the work they do in the critical care settings. The research questions emerged based on the needs identified by the research partner. Specifically, the system wanted to learn from a broad range of internal stakeholders what specific activities the ethics committees could do or support to have a positive impact on care. The system also wanted data, from all of the disciplines involved in providing care in the critical care setting, on the current performance of selected committees.

Chapter 3 begins with a short introduction describing the participatory research perspective that guided this dissertation. The next section provides an overview of the specific methodology, concept mapping, which was used for this research with examples of how the approach has been applied in other studies. The rest of this chapter provides a detailed description of each phase of data collection and analysis.

Participatory Research

This study used a participatory research (PR) approach. Participatory research is based on a mutually respectful collaboration between researchers and community partners in all stages of the research process from formulating the questions, conducting the study, and analyzing the data to disseminating the results (Jones & Wells, 2007; Macaulay, et al. 1999). When a partnership is formed, responsibilities, costs and benefits are all shared. In this context, the researcher is no longer the only expert but rather a partner in the process with knowledge and skills that complement those of other stakeholders. In participatory research, a community is defined as
“those affected by issues under study or who are in positions to act on the knowledge generated by the research” (Jagosh, et al., 2011). PR embodies the language of the community not the academy (Wallerstein, 2010) and assists the researcher and the participants in negotiating the meaning of the information they have generated together (Kindon, Pain, & Kesby, 2007). PR investigates actual, specific practices or issues. By focusing on the particular rather than the abstract, the approach facilitates reflection, discussion, and recommendations grounded in real life experiences (Kemmis & McTaggart, 2008, pp. 279). Diverse community perspectives are believed to enrich the process and enhance the external validity of study findings. Ultimately, the goal of PR is to produce findings that have practical value and relevance to those who deliver services.

In order to function most effectively, an ethics committee must fulfill multiple functions and serve the needs of diverse stakeholders. Consequently, using a participatory approach provided an important perspective on optimizing the ethics consultation process. In particular, this study gave voice to clinical staff who have not been included in previous studies. For this study, the researcher - who had an established relationship with the healthcare system through four years of volunteer service on the Ethics Advisory Committee for Community Based Services - worked in partnership with the System Director of Clinical Ethics and clinical staff of his choosing. True to a PR model, the researcher helped the participants frame the questions, develop hypotheses, and make choices about how the data were collected (Jones & Wells, 2007). The researcher orchestrated the study design and data collection and interpretation, but overall this study was driven by the needs of the healthcare system and guided by the questions and observations of the co-investigators.

**Concept Mapping, a Mixed Methodology for Representing Ideas Graphically**

For this study, the researcher used a specific, participatory research, mixed methods approach: concept mapping. A concept is “a perceived regularity in events or objects designated by a label” (Novak & Canas, 2008, p. 1). A concept map is a
schematic representation showing relationships among ideas. These maps are usually constructed in response to a focus question or prompt, which gives context to the constructs and their relationships (Novak & Canas, 2008). Through this graphical approach, individuals are able to manage, construct and share their own understanding of experiences (De Simone, 2007).

Concept mapping was first developed at Cornell University in the 1970’s by Joseph Novak as a means of exploring how students learn science. As an educational tool, concept maps have helped students improve logical thinking skills by linking ideas and seeing their relationship to each other. Over time, others have seen the usefulness of this approach for different applications such as instructional design and planning efforts.

Over the past twenty years, William Trochim has become the acknowledged leader in the promotion and refinement of a particular concept mapping approach for use in social science research. As developed by Trochim, this structured, multi-stage, mixed methodology combines qualitative “input from multiple sources with differing content expertise and interest” (Trochim & Kane, 2005, p.187) with sophisticated statistical analyses to create multiple graphical displays or “concept maps.” Through this research approach, individuals are able to manage, construct and share their own understanding of experiences (De Simone, 2007).

This mixed methodology is appealing to participatory researchers because it balances the power among participants and between the participants and the researcher (Linton, 1989). In addition, this methodology provides graphical output (maps) which can facilitate discussion among stakeholders and point to areas for future action. Trochim’s concept mapping research procedure, described in greater detail below, was chosen for this study because it is participatory, cost efficient, and flexible enough to accommodate input from a variety of stakeholders in different locations. For the remainder of this paper, concept mapping (CM) will refer specifically to Trochim’s methodology.
Concept mapping has been used extensively for program planning and evaluation. The concept mapping approach has been used in a variety of settings to produce practical direction for program improvement. Petrucci and Quinlan (2007) conducted a study to determine what benefits counselors need to know and do to be effective at their jobs. Sutherland and Katz (2005) used CM to integrate the perspectives of students and teachers in developing definitions of “student engagement” which could be used for planning, program development and evaluation. CM has helped assess community readiness to implement a system of care (Behar & Hydaker, 2009); identify what is needed to get an in-home family based treatment model operating (Mannes, 1989); uncover barriers to the adoption of electronic health records (Vishwanath & Scamurra, 2007); analyze challenges to systems thinking and modeling in public health (Trochim & Cabrera, 2005); compare the existing structure of programs with the “ideal” or theoretical structure (Shern, Trochim, & LaComb, 1995); and explore the factors impacting the acceptance and use of evidence-based mental health programs for families and children (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009).

Concept mapping incorporates diverse viewpoints. Researchers have also found this mixed methodology particularly useful for understanding issues from multiple perspectives. For example, Nabitz, van den Brink, and Walburg (2005) explored the most important elements of quality in addiction treatment and then compared the perspectives of providers, consumers and the general public. In another study, this methodology was employed to gather staff views of what constitutes “supported employment” for individuals with severe mental illness (Trochim, Cook, & Setze, 1994) in an effort to develop a more comprehensive, operationally-based perspective to guide future empirical work. Davis (2007) conducted a CM study to conceptualize “cultural competence” in children’s mental health by gathering input from the perspective of families and professionals in four diverse communities. CM has been used to elucidate: needs of children with life-limiting illnesses (Donnelly, Huff, Lindsey, McMahon, & Schumacher, 2005); barriers to minority participation in clinical trials (Robinson & Trochim, 2007); and community supports desired by
sexual minority youth (Davis, Saltzburg, & Locke, 2010). In these and other studies, concept mapping has facilitated the incorporation of diverse perspectives to provide richer data for needs assessment, planning and evaluation.

Research Design

Concept Mapping Process Overview

Trochim’s concept mapping approach involves a series of structured and discrete stages: 1) Develop the research question, 2) Prepare to conduct the study, 3) Generate Ideas (brainstorming), 4) Structure the Data (rating and sorting), 5) Analyze the data, 6) Interpret the maps, 7) Utilize the maps for planning and evaluation, 8) Publish and present findings.

Stage 1: Develop research questions and aims

Stage 2: Prepare for the study and IRB submission

Stage 3: Generate ideas (Brainstorming)

Stage 4: Structure ideas – Rating and Sorting

Stage 5: Analyze data

Stage 6: Interpret graphical output (maps)

Stage 7: Utilize maps for planning and evaluation

Stage 8: Presentations and publications

Figure 1. The Concept Mapping Process (adapted from Trochim and Kane, 2007)
The first two steps in the concept mapping process are similar to those in any other research study. However, in keeping with the approach’s participatory research foundation, community partners are integrally involved in defining the research question and study aims. During Stage 2, community partners play a significant role in defining participant characteristics and addressing practical issues around data collection. In Stage 3, individual or group activities (e.g., brainstorming) are used to gather descriptive statements that are then used as data for the study. The Structuring of Ideas stage involves two steps. In the rating step, participants use a Likert-type scale to evaluate each of the statements based on pre-determined criteria. Through this process, participants can give value along one or more dimensions to each idea. In the second activity used for structuring ideas, participants are asked to sort the brainstormed ideas into piles or sets in whatever way makes conceptual sense to them. These individual sorts are entered into the computer to produce a conceptual map that illustrates how the full group thinks the different brainstormed statements are related to one another. Rating and sorting can be done in person or online. In Stage 5, statistically rigorous multivariate data analysis techniques (e.g., multidimensional scaling, hierarchical cluster analysis) are used to organize and analyze the data to produce multiple visual representations (maps). This statistical analysis lends structure and credibility to the qualitative data (Burke, et al., 2005). The resulting concept maps, which are expressed in the language of participants, facilitate reflection and learning. In particular, these maps help organize and present complex qualitative data making it easier to interpret and utilize. Group activities are used in the next stages of the study (Interpreting Maps and Utilizing Maps) to reflect on the relationship among ideas, their relative importance to one another and the implications of the findings for day-to-day practice. The inclusion of participant interpretation of the maps is an important step in establishing that the output – and the resultant organization of the data as displayed in various maps – has face, content and construct validity. For this study, data was analyzed using Concept Systems Global, a proprietary software package licensed from Concept Systems, Inc.
Stage 1: Preparing to Conduct a Participatory Research, Concept Mapping Study

Forming the research advisory team. As noted earlier, this participatory methodology is a collaboration between the researcher and community partners who make up a research team. For this study, the community organization was OhioHealth, a not-for-profit, faith-based, healthcare system which has been serving patients in central Ohio since 1891. The institution in this study is named with permission. The OhioHealth system provides tertiary care through six hospitals as well as hospice, home health and other community-based services.

Within OhioHealth, the primary stakeholder was Corey Perry, the System Director of Clinical Ethics. At the start of the study, Corey Perry had been an employee of OhioHealth for over fifteen years. He began his work at OhioHealth as a chaplain in the critical care unit and emergency room of one of the system’s hospitals. After obtaining his law degree, Mr. Perry took on more administrative responsibilities. Mr. Perry began serving as the Director of Clinical Ethics in 2009.

The Director of Clinical Ethics at OhioHealth is responsible for overseeing the organization’s seven clinical ethics advisory committees (EACs) and the Joint Ethics Advisory Committee (JEAC). The JEAC consists of representatives from each of the ethics committees who come together regularly to learn from each other and to be apprised of changes in the state or federal laws or other regulations that will impact the ethical implications of medical practice. When necessary, the JEAC works on hospital policies to bring OhioHealth into compliance with the law or regulatory standards in regard to ethics. The JEAC tracks trends in ethics issues on individual campuses and in the OhioHealth system with a database of the consultations provided. The JEAC decides what kind of education EAC members need and holds two Ethics Education Days a year. Working with the Director, the JEAC develops a system-wide strategic plan for the ethics committees; members are charged with implementing initiatives at individual institutions. The Director also works with corporate administration on strategies to improve the ethical climate of the OhioHealth system.
The proposed study included both a needs assessment and an evaluation of current performance. Personnel involved in a program or service under evaluation may feel judged. To partially address this concern, this study involved a multi-disciplinary group of stakeholders in the evaluation process (Issel, 2004). The Research Advisory Team (RAT) created for this study consisted of three members in addition to the researcher and the Director. The researcher served as the methodology expert and facilitator of the research process. The Director chaired the committee and was responsible for choosing the other Research Advisory Team members:

- Robin Walton, a chaplain who is the manager of pastoral care at Doctors Hospital and co-chairs the Ethics Advisory Committee at Doctors Hospital. In this role, she triages cases and determines which issues will necessitate a full committee review. Ms. Walton is the Doctors Hospital representative on the Joint Ethics Advisory Committee and is responsible for planning education for the orientation and training of EAC members across the system. Ms. Walton is also responsible for training chaplain interns.

- Darrell Spurlock, PhD, RN, a former critical care nurse, is a senior nurse researcher who leads new research projects at Riverside Methodist Hospital and facilitates evidence-based practice changes.

- Kristi Marshall, RN, BSN, is the Nurse Manager for the Neuro ICU at Riverside Methodist Hospital.

- The researcher, Kathleen Raffel, is a licensed clinical social worker, supervisor with over 35 years of experience. She has worked as a medical social worker in several different hospitals, a health educator for the public health department in San Francisco, and a patient education specialist at Mayo Clinic. She has a Masters in Business Administration and a graduate certificate in alternative dispute resolution. She is currently a doctoral student in social work at The Ohio State University where she has specialized in studying the dynamics of organizational decision-making.

At the time of the study, Ms. Raffel had been a community
representative on the OhioHealth Ethics Advisory Committee for Community Based Services for over four years and had provided continuing education for ethics committee members on conflict resolution, cultural diversity, and health literacy. It was through this work as an ethics committee member that Ms. Raffel met Corey Perry and Robin Walton. Ms. Raffel has provided workshops for social workers on bioethics and developed and taught a social work course on alternative dispute resolution strategies.

Based on her training and experience, Ms. Raffel became very interested in examining how ethics committees could potentially be more effective in supporting clinical staff who often seem frustrated with ethics committee services. It was a priority for her to include in the proposed study professions which have not been well represented in previous research and ensure that clinicians were able to express their needs and opinions. Ms. Raffel was also interested in exploring whether there might be opportunities for medical social workers to be better or differently utilized, particularly in supporting patients and families struggling with end-of-life decision-making. Consequently, in the discussion of the findings, Ms. Raffel planned to highlight implications for social work practice if any emerged from the data.

Ms. Raffel chose the methodology for this research and was responsible for ensuring that the study stayed true to the recommended approach. Ms. Raffel was highly committed to conducting a participatory study which could produce practical recommendations for ethics committee work. Therefore, she considered Corey Perry and the members of the research team essential, expert partners in every phase of this work. Ms. Raffel is licensed to use the proprietary software, Concept Systems Global, which was used in this research and has received training and extensive mentoring in the concept mapping methodology.
Please note that for the remainder of this report, Kathleen Raffel is referred to as the “researcher” and Corey Perry is the “Director.” All members of the team were listed as researchers when the study was submitted to the Institutional Review Boards at OhioHealth and Ohio State University for approval; the researcher and the Director were co-principle investigators. An administrative assistant supported the team’s efforts by scheduling meetings and assembling spreadsheets with participants email addresses. All members of the team gave permission to be identified in this study.

The research team played several essential roles in this study. After being introduced to the CM process, the team helped refine the research question and the aims of the study. The group confirmed that the correct stakeholder groups were identified and included. They guided the sampling and recruitment efforts and assisted with other logistical decisions (Cameron, 2007) such as scheduling the launch of different phases of the data collection. The group actively participated in the development of all of the data collection tools. More details on research team involvement are provided below. Ultimately, now that the study is completed, this group will work with the Director and the JEAC to help determine how the research findings can be best applied at OhioHealth.

Identifying the research aims. The study aims were developed based on the needs identified by the Director and refined by the multi-disciplinary research team and the researcher. The researcher’s input was based on four years of experience on an ethics advisory committee and a thorough analysis of the literature.

The aims of this study and their rationale were:

**Aim 1:** To create, based on multi-stakeholder input, an inventory of services ethics advisory committees could provide to contribute to work performed in the critical care setting. The Director wanted this inventory to guide both short and long term planning efforts for the EACs.

**Aim 2:** To collect opinion data about current EAC performance and the potential positive impact of suggested EAC activities. The Director wanted
this information to establish a baseline for current committee performance and to prioritize future committee activities based on their potential positive impact on patient care.

**Aim 3: To provide data that may improve the efficacy of OhioHealth in supporting clinicians and the work they do in the critical care settings.**

This study was supported by the Office of Mission and Ministry, which oversees the ethics committees and is responsible for establishing and supporting a positive ethical climate at OhioHealth. This study was seen as a mechanism for gathering data the system might use to develop education, programs or services for critical care staff who are more likely to confront ethical dilemmas on a daily basis than other clinicians in the hospital.

**Aim 4: To contribute to research in the field of bioethics by filling a noted gap in the literature about how clinicians, particularly those who have been under-represented in earlier studies, suggest an EAC can best support them and their work in the critical care setting.**

The Director hoped that the findings for this study would point to areas for future research within the OhioHealth system and in the field of bioethics. The Director and the researcher hoped study findings could be published and presented at regional and national bioethics meetings.

**Specifying the research questions.** The next step was to identify the specific questions to be answered in order to address the study aims. Because this was a participatory study, the Director and the researcher developed the research questions together. The questions reflect that this study was exploratory and was not hypothesis driven.

**Research question**

*How could clinical ethics committees support the staff and work in the critical care settings?*

**More specifically, the study explored these questions:**

a. How much positive impact do ethics committee members and non-ethics committee members think suggested activities could have on care?

b. How well do ethics committee members and non-ethics committee members think the ethics committees are currently performing the suggested activities?

c. Do ethics committee members and non-ethics committee members rate potential positive impact of suggested activities and current performance of ethics committees differently?
d. Do different disciplines rate the potential positive impact of suggested activities and current performance of ethics committees differently?

e. Do different hospitals and different critical care units rate the potential positive impact of suggested activities and current performance of ethics committees differently?

f. Do less experienced healthcare personnel rate the potential positive impact of suggested activities and current performance of ethics committees differently than do those with more years of experience?

g. Do ratings of the potential positive impact of suggested activities and current performance of ethics committees differ by racial group?

h. Do those who have requested an ethics committee consultation one or more times rate the potential positive impact of suggested activities and current performance of ethics committees differently than do those who have never requested a consultation?

i. Do those who have been involved in a patient care issue brought to an ethics committee rate the potential positive impact of suggested activities and current performance of ethics committees differently than do those who have never been involved in a patient care issue brought to an ethics committee?

j. Do those who use the ethics committee as their first resource when they have a question about an ethical dilemma rate the potential positive impact of suggested activities and current performance of ethics committees differently than do those who use other resources first?

**Stage 2: Preparing for the study and IRB submission**

**Defining study participants.** The next step in preparing to conduct a concept mapping study is to define the sample. The participants in this study were members of the seven Ethics Advisory Committees serving OhioHealth and clinicians affiliated with selected critical care units in four OhioHealth hospitals (H1, H2, H3, and H4 described in more detail below). The Director chose these hospitals based on his analysis of EAC consultation request data over the previous two years, his personal experience offering ethics consultations throughout the OhioHealth system, and the interest of individual committees in participating in a study which would inform
strategic planning efforts. Annually, the seven ethics committees at OhioHealth are asked to perform about 70 formal consultations. Approximately 50% of all consultations are performed at H2, 25% at H4, 14% at H3, and 5% at H1; the remaining consultations are divided equally among the remaining hospitals and the outpatient and hospice programs.

Critical care unit (CCU) staff were chosen because, like in most health care institutions, the majority of EAC requests at OhioHealth come from these units. For example, in 2011, at Hospital 1, 100% of the ethics consultation requests were from the critical care unit and at Hospital 2, 50% of the ethics consultation requests were from one of that hospital’s three CCUs. Throughout the entire OhioHealth system, 59% of ethics consultation requests in 2011 were initiated in a CCU. In addition, as noted in Chapter 2, the critical care unit is a setting in which clinicians face numerous ethical challenges which may create an ethical climate different from that in the other care environments.

To address limitations in previous research which have only included physicians and/or nurses, the research team decided to include a broader range of critical care staff in this study. Specifically, the team decided to include administrators, unit managers, attending physicians, case managers, chaplains, nurses, occupational therapists, pharmacists, physical therapists, residents and interns, respiratory therapists, and social workers. Although at OhioHealth patients can appeal to the hospital ethics committee when ethical issues arise, the Director did not wish to include patients in the sample of this study. Should OhioHealth wish to solicit patient and family input on the function of hospital ethics committees, this research will be conducted at a future date.

In concept mapping research, participants are involved in each of the stages: Generating Ideas (brainstorming), Structuring the Data (rating and sorting), Interpreting Maps, and Utilizing Maps. Depending upon the scope and purpose of a CM study, one set of participants may do all the activities. However, Trochim (1989) contends that it is not necessary for all participants to take part in every step of the process. For example, one group may do the idea generation, another may do the
sorting and rating, and a third do the interpretation and utilization of the maps. In published research, it is very common to have different participants in different phases of a CM study.

The research team decided that for the first two steps in the concept mapping process (Brainstorming and Rating), participants would be recruited from two of the hospitals in the OhioHealth system. Hospital 1 (H1) is a 201 bed teaching hospital with a total 10,397 patient admissions in 2011. This hospital has one 18 bed intensive care unit which had 355 admissions in 2011 (Ohio Department of Health, 2011a). The sample for Hospital 1 would be the ethics advisory committee members affiliated with this hospital and the multi-disciplinary staff noted above who work in or are affiliated with the critical care unit. H1 was chosen for this study because 100% of the formal ethics consultation requests come from the critical care unit, it is a teaching hospital, it serves a diverse, urban population, and the ethics committee was very committed to improving its services. Hospital 2 is a 795 bed tertiary care, teaching hospital with a total of over 50,000 patient admissions in 2011. This hospital has three critical care units with a total of 96 beds and over 3,000 admissions (Ohio Department of Health, 2011b). The sample for Hospital 2 (H2) would be the ethics advisory committee members affiliated with this hospital and the multi-disciplinary staff noted above who work in or are affiliated with at least one of the three critical care units (general intensive care, neuro intensive care, and cardiac critical care). H2 was chosen because approximately 50% of all formal ethics consultation requests in the OhioHealth system come from this hospital, it is a teaching hospital, and it has three large critical care units. Both Hospital 1 and Hospital 2 serve the same urban metropolitan county of approximately 1.2 million residents.

Because staff and EAC members at Hospitals 1 and 2 were being asked to do both brainstorming and rating, the team had some concern that the response rate for rating could be low. The team decided to request IRB permission to include two additional hospitals in rating, if needed, to get a sufficiently large and representative set of participants. Hospital 3 (H3) is a 204 bed hospital with one 15 bed critical care unit. There were 973 admissions to Hospital 3’s critical care unit in 2011 (Ohio
Department of Health, 2011c). Hospital 3 was included in the study because it is not a teaching hospital, it serves a primarily rural/suburban population, and it is physically distant from the main corporate offices thus necessitating that it work quite independently. Thus, inclusion of this hospital offered the opportunity to explore differences between hospitals of different size or located in different communities. Like Hospitals 1 and 2, Hospital 4 (H4) is a teaching hospital and serves the same urban population. Hospital 4 is a 377 bed hospital with a Level 1 Trauma Center serving almost half the counties in the state of Ohio; over 21,000 individuals were admitted to this hospital in 2011. Hospital 4 has two critical care unit with a total of 35 beds with 4,411 admissions in 2011 (Ohio Department of Health, 2011d). H4 was included because its critical care units provide trauma services to a diverse, inner city population.

The research team wished to have both EAC members and Non-EAC staff sort the brainstormed ideas so that a comparison could be made between how these two groups conceptualized ethics committee activities. However, the participation burden in concept mapping is quite high as the time commitment for doing both brainstorming and rating is approximately one hour. With this in mind, the research team decided to change some of the participant sample for the sorting step in the CM process. For sorting, the team wanted to include all of the committee members of all seven ethics advisory committees. Since ultimately all of the EACs would be analyzing the brainstormed ideas during their annual planning process, the RAT felt that including all members during the sorting step would increase committee member engagement and commitment to the study findings. For the critical care clinical staff, the research team decided to recruit from both H3 and H4.

For the cluster map interpretation session (a one time meeting of approximately two hours), the committee decided to have, if at all possible, a representative from each of the professions represented in the earlier stages of the research. The Director agreed to identify and personally invite these participants.

The next to last step in the concept mapping process is to teach stakeholders how to read and interpret the maps and graphical displays. Consequently, it was
decided that all members of the Joint Ethics Advisory Committee would be invited to this training. Each EAC in the healthcare system has three representatives on this committee. Committee representatives are responsible for conveying system level needs and decisions to their respective committees. The Directory wanted the training session conducted at a regularly scheduled JEAC meeting.

Recruitment plan. The research team decided that the primary method of recruitment would be through employee email. This method was chosen because it would enable the team to 1) reach clinicians working various shifts and in various locations and 2) embed a link to the online survey making it easy and convenient for staff to participate. Team members agreed to develop distribution lists and the administrative assistant agreed to organize and compile these. The Director agreed to send out the emails through his OhioHealth email account. Printed copies of the email letters would be made available to distribute on the critical care units if requested by unit managers or if individual employees did not have email addresses. Selected Ethics Advisory Committee members would receive an email at each phase of the study, and clinical staff would receive a differently worded email. However, all emails would describe the topic of the survey, explain how the results of the survey would benefit participants and OhioHealth and mention the “thank you gift.” To optimize response rate, the RAT decided to send a follow up email one week after the initial emails (Deutsken, 2004). In an effort to get input from the widest possible range of professionals, the team planned to send a third email to select professions if they were not represented in the sample who initially responded. Recruitment emails for all phases of the study can be found in Appendices A1-A10.

The research team also felt that announcements would be effective in recruiting staff. Consequently, the group developed a pre-written announcement for each phase which could be read to those in attendance at staff meetings. Because of restrictions placed by OhioHealth, it was not feasible to post flyers or announcements. Copies of the staff meeting announcements are in Appendices B1-B3.

Incentives. Funding ($1,500) was provided by the OhioHealth Office of Mission and Ministry to provide “thank you” gifts to clinical staff and ethics advisory
committee members who participated in the study. The committee decided that participants in the brainstorming activity would receive a $2.00 voucher which could be redeemed at an OhioHealth hospital cafeteria. Participants in rating would receive similar vouchers but for $5.00 in recognition of the extra time needed to complete this activity. EAC sorting participants would be given a $5.00 voucher if they completed the sorting in person during a regularly scheduled ethics committee meeting and a $10.00 voucher if they did the sorting online on their own time. All clinicians would be offered the $10.00 voucher for sorting online. The extra incentive for sorting was considered important for this phase of the study because the sorting process is time consuming and requires significant thought. In accordance with the faith values of this organization, it was decided that all participants, whether or not they completed the online surveys, would receive a “thank you” gift. To make it easy for participants, the research team decided that the vouchers would be accessed directly from the surveys through a link to a pdf which could be printed out and then redeemed. Participants in the final phases of the research, Interpreting and Utilizing Maps, would be given refreshments such as drinks, cookies and fruit during the discussion to thank them for their time; these participants would not receive gift vouchers. Copies of the gift vouchers can be found in Appendix C.

**Developing the focus prompt and rating questions.** In a CM study, the research advisory team develops a specific prompt that becomes the stimulus for participant brainstorming. According to Kane and Trochim (2007) the focus prompt generally takes the form of an incomplete sentence designed to lead participants to provide answers (p. 34). Each word in the focus prompt must be carefully considered and defined, as it becomes the stimulus that drives all the data generated. In this study, the focus prompt was designed to achieve study Aim 1: To create, based on multi-stakeholder input, an inventory of services ethics advisory committees could provide to contribute to work performed in the critical care setting. Prior to conducting the study, the RAT also had to develop the two questions used in the rating phase of the concept mapping process to provide comparative information on the ideas generated in brainstorming. These rating questions were directly tied to
Aim 2: To collect opinion data about current EAC performance and the potential positive impact of suggested EAC activities.

During several planning meetings and through email correspondence, the research team discussed potential wording for the focus prompt as well as for the two rating questions. Several options were written and then the researcher and the Director took the drafts to a group of ethics advisory committee members (n=4) and critical care clinicians (n=4) for their input. These volunteers discussed the options and pointed out where wording could be improved. Based on input from this group, the focus prompt and two rating questions were refined and then brought back to the RAT for final approval.

The focus prompt developed by the research advisory team was: *Something specific ethics committees could do to support staff and the work they do in the critical care setting is…*

The first rating question (Impact) was: *How much positive impact could this ethics committee activity have on the care provided in the critical care setting?*

A five point Likert scale was used to obtain a varied set of responses:

1 = Very small positive impact; 2 = Some positive impact; 3 = Moderate positive impact; 4 = Large positive impact; and 5 = Very large positive impact.

The second rating question (Performance) was: *How well does the ethics committee currently perform this activity or task?*

A five point Likert scale was used: 1 = Very poorly; 2 = Poorly; 3 = Adequately; 4 = Well; and 5 = Extremely well.

Because the Concept Systems Global software does not have an option for “Don’t Know” or “Does Not Apply,” the team decided that participants would be asked to leave an item unrated if they were unable to answer the question based on their knowledge or experience.

Demographic information. The research team decided to collect limited demographic information during the brainstorming and sorting stages. Demographic questions for these phases would be asked to insure adequate representation from each hospital, EAC, and profession. For the rating phase, the team developed five
additional questions. The demographic questions were written based on the research team’s expertise and an analysis of the scholarly literature. The rationale is provided for the eight demographic questions:

1) Because previous research (Eizenberg et al., 2009; Gordon & Hamric, 2006; Hamric & Blackhall, 2007; Lutzen, et al., 2003; McAuliffe, 2005; Torjuul & Sorlie, 2006; Vicentia, 1989) has shown administrators, physicians, nurses, social workers and other clinical staff differ in their needs for ethical decision-making support and their perceptions of clinical ethics committees, the research team asked respondents to identify their profession. Because research (Gacki-Smith & Gordon, 2005) has also shown that interns and residents use ethics advisory committees differently than do attending physicians, and two of the hospitals participating in the brainstorming and rating are teaching hospitals, the team separated these physician categories.

2) Research suggests that understanding ethics committees and hospital units as subcultures can help make sense of the dynamics surrounding the use of the committee services (Gordan & Hamric, 2006, p.232). For planning purposes, the Director wanted to be able to compare perceptions between the hospitals and among the critical care units. Therefore, participants were asked where they work (their hospital and clinical unit).

3) To plan educational programming more effectively, the Director wanted to know if newly trained clinicians viewed the current and potential performance of the EAC differently than did more experienced staff. Consequently, respondents were asked how many years they had worked in healthcare.

4) Several studies on ethical climate, moral distress and use of the ethics committee noted differences among different racial groups (Doyle, 2009; Duval et al., 2001; Jotkowitz, & Gesundheit, 2008; Orr, et al., 1996; Ulrich et al., 2007). Therefore, the study included a question on racial identity.

5) Because the research advisory team wished to make comparisons between the perceptions of EAC members and clinical staff, respondents were asked whether or not they had ever served on a clinical ethics committee.
6) To determine if there is a difference between those who have used EAC services and those who have not, there was a question asking how many times over the course of their career respondents had been involved in a situation brought to a clinical ethics committee.

7) To learn more about the characteristics and opinions of those who have initiated an ethics consultation request, respondents were asked how many times they, personally, had brought an issue to an EAC. The team was also interested in whether or not those who had used an ethics committee consult multiple times rated performance of the EACs differently than those who had never or rarely requested a consult.

8) The clinical ethics committee is only one of many resources that staff may use when facing ethical dilemmas or feeling moral distress (Filipova, 2009; Hoffman, 1991; Olson, 1995; Schulter, et al., 2008). The final demographic question asked staff to indicate whom they consult first when they face an ethical issue at work. The Director thought that this information might help the EAC provide more focused outreach, training and support.

The research team was concerned that a potentially very small respondent pool in some categories of the demographic questions might make it possible to identify respondents even though personal identifying information would not be requested. To address this, the team developed the following notice which would appear at the beginning of the demographic questions: “All demographic information will be kept confidential. If you wish to maintain anonymity and are concerned that answering a particular question will identify you, please choose “No answer” for that question. Specific wording for the demographic questions can be found in appendices Appendix E1-E3 and E-5 which also contain the survey instructions and other survey questions.

**Data collection plan.** Data collection for concept mapping can be done in person, online or in a combination of these. The research team decided that brainstorming, rating and sorting activities would be done via the Internet to facilitate recruiting as many respondents as possible. Collecting data through an online tool
was seen as having several advantages: 1) participants could work asynchronously and at their own convenience; 2) participants could return to the site as many times as they liked during the period the site was open; 3) it would facilitate collecting data from individuals who were at multiple locations or on “nights;” and 4) it would allow the researcher to work on other aspects of the project at the same time thus shortening the research process (Petrucci & Quinlan, 2007). Data collection was done through an online survey tool, LimeSurvey (for brainstorming) and the Concept Systems Global website (for rating and sorting). LimeSurvey was chosen for brainstorming because it was free and data would be collected and stored on a secure server at the Ohio State University College of Social Work. Concept Systems Global was chosen because this proprietary software has secure, online tools for rating and sorting and a sophisticated statistical package which produces the graphical displays, or maps, used for analysis. In both survey tools, participants were able to create a unique user name and password, which only they would know. The team did not want to ask participants to provide personally identifying information hoping this would generate more candid suggestions and ratings. The team also wanted to leave the option open for individual ethics committees to do sorting and rating in person if the committee chairs wished to do this. The Director agreed to bring this up with individual committee chairs. Finally, as noted earlier, the interpretation and utilization sessions were designed to be small group activities and would be done at an OhioHealth facility that could offer space. Time and location of these sessions were to be determined closer to these phases of the data collection.

After completing the above steps to prepare for the CM study, survey tools were developed and an IRB protocol was prepared and submitted to the OhioHealth IRB. After approval by OhioHealth, the protocol was submitted to and approved by the Ohio State IRB. Copies of the approved consent forms used for brainstorming, rating, sorting, in person rating and sorting, and the in person interpretation session can be found in Appendices D1-D5.
Stage 3: Brainstorming or Generation of Ideas (Data Collection)

Once the participants had been identified, recruitment plans and materials finalized, and the focus prompt and rating criteria developed, the concept mapping study advanced to the first phase of data collection: Generation of Ideas or Brainstorming. Emails were sent to critical care clinicians and ethics advisory committee members affiliated with H1 and to comparable participants at H2. One week after the initial email, a second reminder email was sent. In addition to these direct emails, critical care managers and team leaders at both hospitals were asked to send along the email to their staff; it is not known whether or not these requests were honored. IRB approved content for staff-meeting announcements was also sent to managers and team leaders. Again, it is not known whether or not these announcements were used. All correspondence was sent out through the Director’s email address using the mailing lists developed during the earlier project preparation phase. The recruitment email contained a direct link to the brainstorming survey in LimeSurvey. Once participants reached the Web page they were given the purpose of the study, text directions, and introduced to the focus prompt. Each participant could submit as many statements as they wished in response to the focus prompt. Brainstorming was done anonymously. A copy of the Brainstorming survey can be found in Appendix E1. The brainstorming survey was open for twenty-two days.

Idea synthesis. The brainstorming step in a concept mapping study may generate hundreds of ideas. During “idea synthesis” these statements are edited to create a relevant list of ideas that are clear, understandable and not redundant yet still true to the original suggestions. Kane and Trochim (2007) recommend limiting the final list of statements to between 100 and 125. More statements can significantly increase the burden on participants in later stages of the study, but significantly fewer statements can limit the effectiveness of the multi-dimensional scaling that is done as part of the statistical analysis.

In the current study, 247 separate suggestions were submitted by study participants. To begin the idea synthesis process, the suggestions, as written, were entered into an excel spreadsheet. The researcher and the Director independently
reviewed the set of ideas. During this first analysis, each reviewer noted compound ideas and questions about confusing statements. After this initial work, the reviewers met and discussed each item on the list and reached consensus on which items should be split resulting in an additional eight statements. Based on the discussion, two comments were eliminated as not relevant to the study (e.g. comments about employee “entitlements”), one was eliminated because it was outside the committee’s purview (seeing a patient to make a clinical determination whether or not a patient’s treatment is “futile”), one was removed because it is against the health system’s current corporate policy (providing open access to past committee consultation reports) and the Director did not wish to include it, and 12 were omitted because they were vague, unclear, confusing, or just a comment rather than a suggestion. At that point, the reviewers had a final working list of 240 suggestions. Of these, 21 were written as multi-sentence paragraphs. The two reviewers discussed each of these longer submissions and came to consensus on the central suggestion in each. For example, the central idea in this suggestion

#155  Somehow make the ethics committee's presence known to patients and families...not necessarily the committee's work and processes, but what the ethic committee stands to uphold. Perhaps develop an educational piece that supplements the patients bill of rights highlighting the fact that our goal is to honor the dignity and worth of each individual, respect the patient's right to make their own healthcare decisions and/or dictate who speaks on their behalf in the event they are not able to make their own decisions, etc.

was summarized in this statement for the rating and sorting stages of the study

Provide a pamphlet for patients and families on the principles and values underlying the work of the ethics committee.

Once the list of 240 usable statements had been created, the researcher began grouping statements which seemed to express similar concepts. After this first attempt at grouping was completed, the excel spreadsheet was sent to the Director who reviewed the groupings, then split them or combined them. For this process, the Director drew upon his experience as a hospital chaplain, a health system administrator, an attorney, and Director of clinical ethics at OhioHealth. Because this
was a participatory study, the Director’s perspective was as important in this analysis as the researcher’s.

Once there was agreement on the grouping of items, the researcher drafted one statement that seemed to capture the content of each group of suggestions. The goal of this step was to create a set of mutually exclusive statements without any loss of content from the usable submissions (Trochim, Stillman, Clark, & Schmidt, 2003, p. 141). At the same time, the researcher noted questions or concerns for further discussion. The Director then independently reviewed the list of draft statements, noted questions and suggested modifications and additions. The researcher and the Director met and reviewed each individual statement to make sure it was 1) an accurate reflection of the associated submissions, 2) grammatically correct, 3) easy to read and understand, and 4) not redundant with other statements. After this multi-stage discussion and editing process, a list of 96 individual statements was created. This list was sent to the other members of the research advisory team along with an unsorted, unedited list of the original suggestions and a reminder of the two rating questions. The full research advisory team then met and reviewed, discussed, and came to consensus on the final wording for each of the statements. Each member of the research team brought to bear his or her experience in nursing, critical care, pastoral care and/or research. As a result of this meeting, two items were deleted as they were considered redundant with other statements and one statement was divided into two statements to improve clarity. After this meeting, the researcher edited the 95 remaining statements to incorporate all of the wording changes suggested by the team. The final list of 95 statements with the supporting brainstormed ideas is included in Appendix F.

The final list of 95 statements was entered into the Concept Systems Global software and shuffled to create a random list which would not reflect the researchers’ underlying categorizations. It is not uncommon for participants to leave a rating question incomplete (i.e., rate the statements at the beginning of the list but not at the end). With this in mind, two statements were purposefully put at the bottom of the list because they seemed less directly related to critical care unit activity and it was
felt that if they were not rated because of respondent fatigue, the loss of information would not be as significant as it would be for other statements. The two statements were:

94. Provide chart notes (exclusively available to physicians) to help with documentation
95. Have a medical social worker in ER 24 hours a day

Stage 4: Structuring of Ideas Through Rating and Sorting (Data collection)

Rating.

Participant sample. The second phase of data collection was Rating. Emails were sent to critical care clinicians and ethics advisory committee members affiliated with H1 and to comparable participants at H2. The email contained a direct link to the rating survey in Concept Systems Global. Ten days after the initial email, a second reminder email was sent. In addition to these direct emails, critical care managers, team leaders, and residency program directors at both hospitals were asked to send along the email to their staff; it is not known whether or not these requests were honored. IRB approved content for staff-meeting announcements was also sent to managers and team leaders. Again, it is not known whether or not these announcements were used although several people said they would make this effort on our behalf.

After two weeks, 58 participants had completed the Impact rating scale and 45 had completed the Performance scale. The RAT hoped to get 100 completed rating responses. Therefore, the team decided to extend the data collection period and to add H3 to the rating sample. The recruitment email that had been sent to H1 and H2 was sent to the H3 EAC members and to the staff in the H3 critical care unit. After one week, a reminder email was sent to H3 participants. All correspondence was sent out through the Director’s email address using the mailing lists developed during the earlier, project preparation phase. The rating phase was open four weeks.

The rating recruitment email contained a direct link to the rating survey in Concept Systems Global. Once participants reached the Web page they were given
the purpose of the study and text directions. Each participant was asked to rate each of the 95 statements selected or developed during the idea synthesis step against the two rating questions. Participants were instructed to rate all statements along the “Impact” dimension first and then rate all statements on the “Performance” dimension. A copy of the Rating survey can be found in Appendix E2.

**Cleaning the data - rating.** When the rating phase of data collection was closed, the data needed to be “cleaned.” Cleaning the data involved a two step process. First, the researcher evaluated whether or not each participant had completed answering the two rating questions. Concept Systems defines a “completed” rating as one in which at least 50% of the statements are rated (Michael Huffman, personal communication, February 19, 2013). Therefore, if a participant rated 48 or more statements in response to the “Impact” question, then these ratings were retained during this first round of analysis. The same criterion was applied to the responses to the “Performance” rating question. It was possible that a participant might “complete” both of the rating questions, only one, or neither. After incomplete rating responses were eliminated, the researcher then analyzed all the remaining responses for problematic rating patterns. Additional rating responses were then eliminated because the participant gave the same value score to each of the 95 items. When this two step analysis was completed, 84 Impact ratings and 61 Performance ratings remained and were included in the remainder of the concept mapping analysis.

**Sorting process.**

**Participant sample.** Recruitment emails were sent to EAC members serving on four different hospital ethics committees and the Joint Ethics Advisory Committee. The Director decided not to include the EAC from H2 in sorting as informal feedback from these committee members indicated that they were unwilling to participate further in the study. Two of the committees (the EAC for H1 and the EAC for community-based services) chose to do their sorting in person at a regular monthly meeting. Email sorting invitations were not mailed to the members of these two committees who missed their monthly meeting. Emails were also sent to clinical staff at H3 and H4. Again, invitations were mailed to professionals who work in the
hospital’s critical care unit or support the unit on an as needed basis. All interns and residents at H4 were invited to participate. As with the other hospitals, there was no way to identify whether or not interns and residents had rotated through the critical care rotation.

One week after the initial recruitment email, a reminder email was sent. A staff meeting announcement flyer was sent to the nurse manager in the H4 critical care unit to use if she wished. As in the previous data collection step, respondents could link directly to the survey in Concept Systems Global from the recruitment email. All correspondence was sent out through the Director’s email address using the mailing lists developed during the earlier, project preparation phase. The online sorting survey was open for 12 days.

For the online sorting activity, participants were asked to sort or organize the 95 brainstormed statements into “piles” of ideas which were conceptually similar. Full instructions and demographic questions for the online sorting process can be found in Appendix E3.

The two ethics advisory committees which requested to do the sorting in person did so during part of a regularly scheduled monthly meeting. The two committees met independently, but the process used for collecting the sort data was the same at each meeting. In preparation for these sorting sessions, the researcher created cards with one brainstormed statement and ID number printed on each. The cards were assembled into decks of 95 cards. The researcher also created printed “In-person” consent forms, demographic questions, sort instruction sheets and sort recording forms. The “Instructions for Sorting and Recording” and the “Sort Recording Sheet” were developed by Concept Systems, Inc. to be used when participants are doing this phase of the study in person; copies of these documents can be found in Appendix E4. The demographic questionnaire for this activity is found in Appendix E5. Note, these instructions are very similar to, but not identical with, the instructions participants received if they did this step online, reflecting the slightly different constraints imposed by the online data collection system. At each meeting, each committee member was given a packet of the printed materials and a deck of
statement cards. Next, participants were asked to read and sign a copy of the “In-
person” consent form. The signed form was collected by the researcher or the
Director. Participants were given a copy of the consent form for their own records.
Next, participants were asked to complete a paper copy of the demographic questions.
Then, the researcher or the Director read the sorting instructions to the group and
answered questions. The paper recording sheets and demographic questions from
these participants were collected and the data were entered into the online survey by
the researcher.

Cleaning the data – sorting. Sorted data was also subjected to a review
process before it was included in the statistical analysis. First, partially completed
sorts were eliminated; 78 or more statements had to be sorted for the sorts to be
included in further analysis. After incomplete sorts were eliminated, all completed
sorts were reviewed individually. Additional sorts were eliminated at this point for
several reasons: the items seemed to be randomly assigned to sort piles and the piles
were un-named; the items were assigned sequentially to sort piles rather than on the
basis of similar meaning; the sorting was done on the basis of priority (a rating task)
rather than on conceptual similarity; or all items were assigned their own piles. To
meet time constraints imposed by the needs of the health system and the researcher,
the sorting phase was closed in ten days. After the close of the sorting phase, ten
individuals contacted the researcher or the Director indicating that they wanted to
finish their sorts; unfortunately, these sorts had already been removed from the
analysis as they were not completed at the time the sorting was closed.

Stage 5: Representation of Ideas (Data Analysis)

Once the rating and sorting steps had been completed, the demographic data
was tabulated and the core map analysis was conducted. The Concept Systems, Inc.
software was used to: a) create an aggregated similarity matrix from the sort data, b)
locate each statement on a two-dimensional map using multidimensional scaling
(MDS), c) conduct a hierarchical cluster analysis of the MDS to divide the statements
into groups (Kane & Trochim, 2007), and d) create the point and cluster maps which are the fundamental graphical displays in a concept mapping study.

**Multi-dimensional scaling.** After the researcher had entered the in-person sorts and checked and approved the online sorts, the Concept Systems Global, Inc. software converted each sort into a binary (0,1) matrix that was as large as the statement set. Since this concept mapping study had 95 statements in the final edited list, the matrix had 95 rows and 95 columns. A “1” was entered in each cell if the row and column statements were placed in the same pile by a participant. A “0” was entered if the statements were not sorted together. By transforming each participant’s sort data into a common data structure (a binary square similarity matrix), it was possible to aggregate data for all participants (Sutherland & Katz, 2005). Higher numbers in the matrix indicated that statements were more often sorted together by a greater number of participants. The summed squared similarity matrix became the input for the multidimensional scaling analysis. Demographic data which was entered by each participant remains linked to each sort.

According to Kruskal and Wish (1978) MDS is a statistical technique that can reduce the sort data from multiple respondents to two dimensions representing the hidden structure of the data (in this case, ways in which an ethics committee could support the staff and the work they do in a critical care setting). This technique calculates how similar or different objects (e.g., statements) are perceived to be. This distance can be used to create a geographical representation of points, each representing a different statement, on a map. Statements, which are considered similar to each other (sorted together more often), will appear closer on the map, and statements which are seen as dissimilar (sorted together less often) will be farther apart. While MDS can be done on a number of dimensions, Kruskal and Wish (1978) argue that when MDS solutions are going to be used primarily to generate and display clustering results a two dimensional solution is adequate and easier to interpret. This is an important consideration since the maps in this study will be used by the stakeholders as well as the researcher. In addition, by keeping the MDS to two dimensions, the ratings can then be added to create a third dimension (Concept
In CM the two-dimensional MDS solution can be rotated without affecting the interpretation. In the process of creating the first graphical representation, a point map, some distances must be interpolated introducing some error. Consequently, after the MDS was computed, a stress value was calculated. A stress value reflects the goodness of fit of the two dimensional map and the original similarity matrix (Kruskal & Wish, 1978). A low stress value indicates that participants sorted the statements in similar ways thus requiring less interpolation while a higher stress value indicates that participant sorting was highly dissimilar requiring more interpolation. In a comprehensive review of studies using the CM process, the average stress value was .28 (SD = .04, range .17-.34, 95% CI (.27, .29)), which is higher than is typically recommended in MDS (0.10) (Rosas & Kane, 2012). A standard stress value cut-off for CM has not been established. However, general guidelines suggest that stress values between .05 and .35 are acceptable depending upon the purpose of the research (Petrucci & Quinlan, 2007). The stress values of the three point maps generated (all sorters, non EAC sorters, and EAC member sorters) are presented in the findings.

Hierarchical cluster analysis. Each point on the two-dimensional map can be assigned an x and y value which will be used for the next step in the statistical analysis, hierarchical cluster analysis. The Concept Systems Global, Inc. software uses the Ward’s algorithm to create clusters. This algorithm begins by having each statement in its own cluster then progressively combines clusters (by minimizing “the sum of the squares of the distances between all statements in any two hypothetical clusters that might be joined” (Kane & Trochim, 2007, p. 99)) until all statements are in one cluster. A cluster map allows the researcher and others to see detailed ideas organized into groups so that many concepts can be considered together in relationship to one another.

The final number of clusters for each concept mapping project is determined through statistical analysis, expert judgment, correspondence with established concepts, and participant input. There is no correct mathematical solution or “right” number of clusters in a CM study. The average number of clusters in the Rosas and
Kane (2012) review was 8.93 (range of 6 - 14) with an average number of statements per cluster of 11.

Cluster analysis for this study was conducted in several steps. First, using the cluster replay function in the Concept Systems Global, Inc. software, the researcher examined all of the cluster solutions within a certain range (20 clusters down to 5 clusters) for each of the three point maps which were generated. While the actual hierarchical cluster structure was determined by the statistical analysis, the researcher used qualitative analysis to determine whether it made sense to merge clusters as the number of clusters decreased (Jackson & Trochim, 2002). The optimal number of clusters was one in which each cluster had a recognizable theme and clusters were not redundant (Concept Systems, Inc., personal communication, July 21, 2011). Through this process, the researcher generated three draft cluster maps (one for all-participants, one for Non-EAC staff only, one for EAC members only).

In the second step in the cluster analysis, the researcher met with the Director. The Director independently went through the same cluster analysis process with the three maps and came to the same number of clusters as the researcher did. Then, the Director and researcher examined the cluster maps solutions for all three maps. The researcher and Director reached consensus that both the All Participant and Non-EAC only maps represented the data more clearly and usefully than did the ethics committee-only map. While most of the clusters in the EAC Only map were very cohesive, several clusters seemed to contain loosely related statements. For example, one cluster in the EAC Only map contained the following statements (among others):

- 27. Help staff connect with pastoral care if staff’s personal religious beliefs are being challenged
- 28. Help family members understand their legal and ethical rights
- 47. When an ethical dilemma has not been handled in an ideal way, have non-committee staff participate in committee review of the dilemma

Based on a qualitative analysis, the clusters on the All Participant and Non EAC maps seemed more cohesive than did those on the EAC Only map. Therefore, the co-
investigators decided to bring both of these cluster solutions to an in-person cluster interpretation session which would provide additional insight into these maps.

**Cluster interpretation session.** Seven healthcare practitioners, who were also OhioHealth ethics advisory committee members, were personally invited by the Director to come to a two hour cluster interpretation session. After signing consent forms, participants were given a brief overview of the concept mapping process. The researcher then presented the point map for all-participants and explained how the map represented the relationships among the brainstormed ideas. After the participants understood how to “read” a point map, they were shown the point map for all participants and the point map for Non EAC participants. The remaining discussion in the Interpretation session was recorded (audio only). The group discussed how the point maps were similar and different. Then, participants were shown the 8-cluster all-participant map and given a printed report which listed the statements grouped by cluster. Participants read through this report and then discussed how they thought the data within each cluster fit together and whether or not there were any individual items that did not seem to fit. Although Concept Systems Global, Inc. software suggests possible names for clusters based on the names submitted by sorters, these suggestions were not used in this study. Instead, the participants were instructed to suggest cluster names based on what they saw as underlying themes or commonalities in the statements. This qualitative approach was used to stimulate discussion about the content of the clusters. After doing this process for this cluster map, the group followed the same process for the 7-cluster, Non EAC cluster map. After this analysis, the group discussed the differences between the two maps. Then they were asked to choose which map they thought would be the better one to use for EAC planning and evaluation. Six of the seven invited members voted for the Non EAC map. It was noted that in light of the research question (How can ethics committees support the staff and work in the critical care units?), it made sense to prioritize the conceptualization of the Non EAC staff and thus emphasize their point of view. Therefore, this is the map that was used in the remaining analysis. Because there was insufficient time to come to a final
agreement on cluster names during this session, the researcher and the Director chose the final cluster labels from the list of suggestions generated during the meeting.

A qualitative comparison of the all-participants and Non EAC maps was made by the researcher. Recorded comments from the interpretation session were also used in this analysis to better understand the two maps. Further discussion of the differences between the all-participant and Non EAC maps is presented in Findings.

**Rating analysis.** The ratings completed by participants were used to calculate average ratings on each rating dimension for each statement. Once the final map was chosen, the rating data could be combined with the selected point map and cluster map, providing an overlay of stakeholder opinions on the maps and adding another dimension to the analysis. On maps showing individual points, average ratings are represented by stacked blocks; the more stacked blocks a point (or statement) has, the higher the rating. On a cluster map, ratings of the statements in the cluster are averaged. The average aggregated ratings are then represented by layers with the more layers representing higher ratings.

**Pattern matches and go-zones.** The rating data and demographic data could be combined with the sort data through the Concept Systems Global, Inc. software to create point rating maps and cluster rating maps mentioned above as well as pattern matches and go-zones. These graphical representations, combining all of the collected data, were created in preparation for the “Utilization of Maps” instruction session with the Joint Ethics Advisory Committee and to answer the research questions chosen by the Director.

Pattern matching graphics can be used to compare the equivalent data from two cluster rating maps allowing the comparison between two groups of participants or between the two rating questions. Pattern matching shows a rank ordering of cluster ratings on the two variables of interest as well as a correlation (Pearson product-moment) between the variables. The r value in pattern matching is based on the average of the clusters and the relative ranking of the clusters. For this study, a pattern match was used to compare how the two stakeholder groups (Non EAC staff and EAC members) rated the potential impact of different ethics committee activities.
on the work in the critical care unit; a similar pattern match was used to compare ratings of perceived current performance of the EACs. Additional pattern matches were created to compare other sub-groups (e.g., nurses and physicians; H1 and H2, etc.) based on the request of the Director. Based on the recommendation of a statistician at Concept Systems, a pattern match comparison was only done if there was an n of 5 or greater in a sample (Scott Rosas, personal communication, March 13, 2013). Pattern matches were also made to compare the two rating questions across clusters. In this way, the potential impact of a particular cluster of suggestions could be compared to how well participants perceived it was currently being done.

Concept Systems Global, Inc. software also permits the production of “go-zone” graphics. The go-zone is a bi-variate graph that plots individual statements within a cluster on the two rating dimensions. One of the rating dimensions is on the \( Y \) axis and the other is on the \( X \) axis. The plot is divided into four quadrants by the vertical line representing the average rating of the \( x \) dimension and the horizontal line representing the average rating of the \( y \) dimension. The upper right hand quadrant contains statements in the cluster that were ranked above the mean on both variables. Go-zone maps help stakeholders analyze the data and prioritize action plans. Go-zones were prepared for each of the seven clusters as well as for selected sub-groups of participants. Selected go-zones are presented in the Findings.

**Stages 6: Interpret Graphical Output and Stage 7: Utilize Maps for Planning and Evaluation**

The Joint Ethics Advisory Committee was given a training session on how to interpret the concept maps generated by this study. This training session was intended to increase stakeholder buy-in to the findings, enhance service effectiveness by providing a structured opportunity for the group to reflect on current practice and share responsibility for the process and outcomes (McWilliam et al., 2009; Petrucci & Quinlan, 2007). Multiple maps were produced during the course of the concept mapping analysis and some were more useful to the stakeholders than others. Therefore, prior to the training session, the researcher produced and analyzed all of
the pattern matches and go-zones suggested by the Director. Then, the researcher and the Director met and chose a representative set of maps to bring to the group.

During the training session, the researcher and the Director: 1) gave an overview of the research process; 2) presented and explained the point map; 3) provided a list of numbered statements (with rating data) organized by cluster; 4) presented and explained the cluster map with labels; and 5) presented and explained pre-selected pattern match and go-zone graphics. The researcher and the Director then lead a short discussion of several selected maps showing participants how to interpret and potentially utilize the data. After the training sessions, the JEAC were given a set of maps (pre-selected for utility by the Director) and instructed to use the data to begin the strategic planning process for their respective committees and hospitals.

After the completion of this dissertation, the Director will provide a written executive summary to OhioHealth highlighting the most significant findings of this study. In addition, the Director will present the findings to the Mission/Ministry and Community Needs Committee which funded the study and will have executive oversight of any efforts undertaken as a result of this research. As noted earlier, concept mapping data has proven particularly useful in developing both planning and evaluation tools. However, further involvement of the researcher is beyond the scope of this study.
Chapter 4: Findings

Participants

Participants - Brainstorming or generation of ideas. Two hundred and ninety-five emails were sent to critical care clinicians and ethics advisory committee members affiliated with H1, and 495 emails were sent to comparable participants at H2. When the brainstorming survey was closed, 141 people had entered ideas in response to the focus prompt. Brainstorming response rate by profession is detailed in Table 1 below. The overall response rate was 17.8% which is lower than predicted for a short, online survey. However, the incentive was very small (a $2.00 coupon for the hospital cafeteria) and the timing of data collection (between Thanksgiving and Christmas) may have hindered participation.

Stage 1: Brainstorming Participant Pool (by hospital)

H1 (n=295) + H2 (n=495) = 790

Recruitment Emails Sent (EAC and Non EAC)

EAC members (n=37) + Non EAC staff (n=753) = 790 emails sent

Responded to Brainstorming Prompt (EAC and Non EAC)

EAC members (n=18) + Non EAC staff (n=123) = 141 total respondents

Figure 2. Brainstorming, Recruited and Responded
All members of the ethics committees serving H1 and H2 (n=37) received an invitation to participate in this phase of the study. The response rate of EAC members was 50%. Of the total responses (n=141), 12.8% (n=18) were from EAC members although EAC members made up only 4.8% of the invited participant sample. Because results of this study have the potential to directly impact the work of these committees, a higher response rate for this group was anticipated.

37.3% of the total Brainstorming recruitment emails were sent to critical care staff and EAC members at H1 but only 20.6% of the responses were from H1 affiliated personnel. 62.7% of the emails were sent to critical care staff and EAC members at H2 and 70.2% of the total responses were from H2 affiliated personnel. Thirteen of the 141 respondents did not indicate a place of employment.

Several factors limited the use of the response data. Dietician, Case manager, and Speech Language Pathologist were inadvertently not included in the LimeSurvey choices and therefore these responses are included in Other. Consequently, there is not a specific response rate for these professionals for this stage of the study. Respiratory therapists at H2 do not have email addresses. Invitations to participate were printed out, and the manager of this department was asked to put the invitations in the respiratory therapists’ mailboxes. It is not known how many respiratory therapists actually received invitations; therefore, the response rate for these therapists cannot be determined. Of note, in this and all other online phases of this study, participants were instructed to check “No answer” if they wished to remain anonymous. 3.5% of Brainstorming respondents chose not to identify their profession.

The response rate for nurses was lower than that of other disciplines. For example, the response rate for nurses was 17.5%, but it was 33.3% for pharmacists and 44.4% for social workers. However, the percentage of respondents who were nurses (43.3%) is proportionally representative the percentage of nurses in the original sample (44.2%). Brainstorming response rates by profession are presented in Table 1.

Invitations were sent to all interns and residents at both H1 and H2 (n =284).
However, there was no way to determine in advance whether or not an intern or resident had ever rotated through the critical care service. Therefore, unlike the other professionals recruited for the study who were affiliated in some way with the critical care unit or the EAC, some of the interns and residents who received an invitation were not in the position to brainstorm because they had no relevant experience. This factor may explain the relatively low response rate in this group.

Table 1

Brainstorming Response Rate by Profession

<table>
<thead>
<tr>
<th>Discipline</th>
<th># Emails sent (H1)</th>
<th># Emails sent (H2)</th>
<th>Total # emails sent (H1+H2)</th>
<th>Total # responses</th>
<th>Response rate %</th>
<th>% emails sent</th>
<th>% total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator/Manager/Attorney</td>
<td>8</td>
<td>5</td>
<td>13</td>
<td>2</td>
<td>15.4</td>
<td>1.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Attending Physician</td>
<td>18</td>
<td>9</td>
<td>27</td>
<td>7</td>
<td>25.9</td>
<td>3.4</td>
<td>5.0</td>
</tr>
<tr>
<td>Chaplain</td>
<td>15</td>
<td>3</td>
<td>18</td>
<td>9</td>
<td>50</td>
<td>2.3</td>
<td>6.4</td>
</tr>
<tr>
<td>Nurse</td>
<td>300</td>
<td>49</td>
<td>349</td>
<td>61</td>
<td>17.5</td>
<td>44.2</td>
<td>43.3</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0.3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>8</td>
<td>1</td>
<td>9</td>
<td>3</td>
<td>33.3</td>
<td>1.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>20</td>
<td>0.6</td>
<td>0.7</td>
</tr>
<tr>
<td>Resident or Intern</td>
<td>120</td>
<td>164</td>
<td>284</td>
<td>23</td>
<td>8.1</td>
<td>35.9</td>
<td>16.3</td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td>unk</td>
<td>40</td>
<td>40</td>
<td>6</td>
<td>na</td>
<td>5.0</td>
<td>4.3</td>
</tr>
<tr>
<td>Social Worker</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td>4</td>
<td>44.4</td>
<td>1.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>15</td>
<td>34</td>
<td>20</td>
<td>58.8</td>
<td>4.3</td>
<td>14.2</td>
</tr>
<tr>
<td>No answer</td>
<td>19</td>
<td>15</td>
<td>34</td>
<td>20</td>
<td>58.8</td>
<td>4.3</td>
<td>14.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>495</td>
<td>295</td>
<td>790</td>
<td>141</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Hospital data combines EAC members and Non EAC members. Detailed breakdown of professional affiliation of just EAC members is presented under Sorting in Table 8.

Participants - Rating. Emails were sent to critical care clinicians and ethics advisory committee members affiliated with H1 (n=294) and H2 (n=499). Because of a lower than hoped response rate from H1 and H2 during the first two weeks that the
rating survey was open, H3 (n=61) was added to the rating phase bringing the final possible rating sample to 854.

One hundred and ten people responded to the email invitation to rate the brainstormed questions. During the data “cleaning” process, five participants were removed from the study because they did not consent; eight were removed because they started the rating surveys but did not, in fact, rate any of the questions; seven were removed because they rated less than half of the statements and six were removed because they rated all of the statements with the same score. Twenty-three people who successfully finished the Impact rating survey did not do the Performance rating survey. No one finished just the Performance rating survey. At the end of the rating data cleaning, 84 Impact ratings and 61 Performance ratings were included in the remainder of the concept mapping analysis.

Stage 4 Structure Ideas - Rating:

Rating Participant Pool (by hospital)
H1 (n=294) + H2 (n=499) + H3 (n=61) = 854

Rating Recruitment Emails Sent (EAC and Non EAC)
EAC members (n=57) + Non EAC staff (n=797) = 854 emails sent

Completed at Least One Rating Survey (EAC and Non EAC)
EAC members (n=20) + Non EAC staff (n=64) = 84 total respondents

Figure 3. Recruited and successfully completed one or more rating surveys
Of the emails sent out during recruitment for Rating, 57 of the 854 (6.67% of total emails) were sent to members of H1, H2, and H3 Ethics Advisory Committees; however, 20 of the 84 who completed the rating task (23.8%) were EAC members.

Response rates again varied by hospital. 34.42% of the emails went to H1 personnel and 21.43% of the completed responses were from H1. 58.43% of the emails sent out went to H2 and 54.76% of the completed rating responses were from H2. While only 7.14% of the emails went to H3, 17.86% of the completed ratings were from this hospital. In this survey, Dietician and Case manager were included in the response choices for the rating survey, but Speech and Language pathologist was not listed. Once again, no occupational therapists or case managers chose to participate. The relatively low response rate from interns and residents may possibly be explained as noted above.

The overall low response rate may be due to a variety of factors. One, the recruitment email may have been too long; staff may not have bothered reading through the entire message. Two, the rating task was quite time consuming (up to 40 minutes) which is very demanding for staff trying to complete this task at work. Three, the task itself is quite demanding and participants can become fatigued and discouraged if they are not highly motivated by the topic or the incentive.

The responses to the rating survey generally reflected a proportionally representative sample of professionals working in or affiliated with the critical care units. Detailed information about recruitment emails and rating response rates by discipline are presented in Table 2. Details on the responses by rating survey are presented in Table 3.
### Table 2

**Rating Response Rate by Hospital and Profession**

<table>
<thead>
<tr>
<th>Discipline</th>
<th># Emails sent (H1)</th>
<th># Emails sent (H2)</th>
<th># Emails sent (H3)</th>
<th>Total # emails sent (H1+H2+H3)</th>
<th>% Total emails sent</th>
<th>% Total finished one or more ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin/manager/attorney</td>
<td>8</td>
<td>6</td>
<td>5</td>
<td>19</td>
<td>2.2</td>
<td>6.0</td>
</tr>
<tr>
<td>Attending Physician</td>
<td>18</td>
<td>9</td>
<td>2</td>
<td>29</td>
<td>3.4</td>
<td>10.7</td>
</tr>
<tr>
<td>Case Manager</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>12</td>
<td>1.4</td>
<td>0</td>
</tr>
<tr>
<td>Chaplain</td>
<td>15</td>
<td>3</td>
<td>1</td>
<td>19</td>
<td>2.2</td>
<td>4.8</td>
</tr>
<tr>
<td>Dietician</td>
<td>13</td>
<td>5</td>
<td>3</td>
<td>21</td>
<td>2.5</td>
<td>3.6</td>
</tr>
<tr>
<td>Nurse</td>
<td>300</td>
<td>49</td>
<td>19</td>
<td>368</td>
<td>43.1</td>
<td>39.3</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>0.4</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>8</td>
<td>1</td>
<td>15</td>
<td>24</td>
<td>2.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>11</td>
<td>1.3</td>
<td>1.2</td>
</tr>
<tr>
<td>Resident or Intern</td>
<td>120</td>
<td>164</td>
<td>0</td>
<td>284</td>
<td>33.3</td>
<td>10.7</td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td>n.a.</td>
<td>40</td>
<td>6</td>
<td>46</td>
<td>5.4</td>
<td>4.8</td>
</tr>
<tr>
<td>Social Worker</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>11</td>
<td>1.3</td>
<td>6.0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>0.7</td>
<td>7.1</td>
</tr>
<tr>
<td>No answer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>499</strong></td>
<td><strong>294</strong></td>
<td><strong>61</strong></td>
<td><strong>854</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Table 3

Impact Rating and Performance Rating, Response Rate by Profession

<table>
<thead>
<tr>
<th>Discipline</th>
<th># Finished Impact Rating</th>
<th>% Total finished Impact Rating</th>
<th># Finished Performance Rating</th>
<th>% Total finished Performance Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin/manager/attorney</td>
<td>5</td>
<td>5.95</td>
<td>5</td>
<td>8.20</td>
</tr>
<tr>
<td>Attending Physician</td>
<td>9</td>
<td>10.63</td>
<td>6</td>
<td>9.84</td>
</tr>
<tr>
<td>Attorney</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Case Manager</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Chaplain</td>
<td>4</td>
<td>4.76</td>
<td>3</td>
<td>4.92</td>
</tr>
<tr>
<td>Dietician</td>
<td>3</td>
<td>3.57</td>
<td>3</td>
<td>4.92</td>
</tr>
<tr>
<td>Nurse</td>
<td>33</td>
<td>39.29</td>
<td>22</td>
<td>36.07</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>4</td>
<td>4.76</td>
<td>3</td>
<td>4.92</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>1</td>
<td>1.19</td>
<td>1</td>
<td>1.64</td>
</tr>
<tr>
<td>Resident or Intern</td>
<td>9</td>
<td>10.71</td>
<td>7</td>
<td>11.48</td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td>4</td>
<td>4.76</td>
<td>3</td>
<td>4.92</td>
</tr>
<tr>
<td>Social Worker</td>
<td>5</td>
<td>5.95</td>
<td>3</td>
<td>4.92</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>7.14</td>
<td>5</td>
<td>8.20</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
<td>1.19</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>84</td>
<td>100.00</td>
<td>61</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The drop-off in response rate between rating question number 1 and rating question number 2 has been documented in other concept mapping studies. Rosas and Kane (2012) note that while the use of the web for concept mapping facilitates greater participation than face to face rating, the level of attrition from completion of rating 1 to rating 2 is greater when the web is used exclusively (p.239). Since many of our respondents were completing the rating activity during work hours, the research team anticipated that the response rate could be low for this time intensive task and the drop-off between rating 1 and 2 could be quite high. The final number of Impact raters (n=84) and Performance raters (n=61) in our study is quite similar, in fact, to the average numbers (rating 1: n=82 and rating 2: n=66) that Kane and Rosas (2012) found in their quantitative pooled analysis of 69 individual concept mapping
studies (p. 239). Despite the drop-off between rating 1 and rating 2 in our study, rating 2 remains broadly representative of those invited to participate and is quite similar in the distribution of professions to rating 1.

**Participants - Sorting.** Seventy-one emails were sent to EAC members serving on four different hospital ethics committees and the Joint Ethics Advisory Committee. Two of the committees (the EAC for H1 and the EAC for community-based services) chose to do their sorting in person at a regular monthly meeting. Nine committee members from the H2 EAC and seven members of the Ethics Advisory Committee for Community Based Services participated in the in-person sorting activity.

Three hundred and fourteen emails were also sent to clinical staff at H3 and H4. Again, invitations were mailed to professionals who work in the hospital’s critical care unit or support the unit on an as needed basis. All interns and residents at H4 were invited to participate. As with the other hospitals, there was no way to identify who had or had not rotated through the critical care rotation.

Eighty one sorts were started. After the data cleaning process, 18 sorts were removed because they were incomplete (i.e., less than 78 statements had been sorted). All completed sorts were then reviewed individually. Additional sorts were eliminated at this point for several reasons: the items seemed to be randomly assigned to sort piles (n=6) and the piles were un-named; the items were assigned sequentially to sort piles rather than on the basis of similar meaning (n=1); the sorting was done on the basis of priority (a rating task) rather than on conceptual similarity (n=1); or all items were assigned their own piles (n=1). In sum, of the 81 sorts started, 54 were retained for further analysis. Of those 54 sorts, 22 were done by Non EAC staff and 32 were done by EAC members (16 online and 16 in person).
Stage 4: Structure Ideas - Sorting:

Sorting Participant Pool (by EAC and hospital)
7 EACs (n=95) + H3 (n=61) + H4 (n=253) = 409

Recruitment In Person and By Email (EAC and Non EAC)
EAC members (n=95) + Non EAC staff (n=314) = 409

Sorts Retained for Further Analysis (EAC and Non EAC)
EAC members (n=32) + Non EAC staff (n=22) = 54 retained sorts

Figure 4. Recruited and successfully completed sorting activity

Participants - Cluster analysis interpretation session. In addition to the researcher and the Director, seven individuals participated in the cluster analysis interpretation session. All seven serve on ethics advisory committees; six different committees and the Joint Ethics Advisory Committee were represented. The participants included one chaplain, one social worker, one critical care nurse manager, one hospice coordinator, one director of nursing, one outcomes manager, and one nurse who serves as a community representative on one of the ethics committees. All of the participants in this session had participated in some other phase of the study.

Demographic information

Additional demographic data was collected from participants in the rating phase of the study. This data was collected to facilitate a more nuanced analysis of the rating and sorting responses. Except where noted, this demographic information
applies only to those who completed one or both of the rating questions. Because of limitations in the license agreement the researcher held with Concept Systems Global, Inc., it was not possible to retain the information of those who started but did not complete the rating activity.

Participants were asked how many years they had worked in healthcare. Responses ranged from a minimum of 1 year to a high of 45 years. The average number of years worked was 14.61, the median was 11 years, and the mode was five years. The standard deviation was 11.93 years.

Rating participants were asked to indicate their race. Information on the racial distribution is presented in Table 4. No personal identifiers linked individual respondents to their racial identity.

Table 4

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American/Black</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>2</td>
<td>2.38</td>
</tr>
<tr>
<td>Caucasian/White</td>
<td>80</td>
<td>95.24</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>1</td>
<td>1.19</td>
</tr>
<tr>
<td>Native American</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bi-racial or Multi-racial</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
<td>1.19</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>84</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Rating participants were asked to indicate how many times they had been involved in a patient care issue which had been brought to an ethics advisory committee. Information on frequency of involvement in these issues is presented in Table 5. 69.05% of respondents had, over the course of their careers, been involved in one or more patient care issue for which EAC assistance had been requested.
Table 5

*Frequency of Involvement in Patient Care Issues Brought to an EAC*

<table>
<thead>
<tr>
<th>Number of times involved</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>26</td>
<td>30.95</td>
</tr>
<tr>
<td>1-3 times</td>
<td>34</td>
<td>40.48</td>
</tr>
<tr>
<td>4-6 times</td>
<td>12</td>
<td>14.29</td>
</tr>
<tr>
<td>7 or more times</td>
<td>12</td>
<td>14.29</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>84</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Rating participants were asked to indicate how many times they had personally initiated a request for an ethics advisory committee consultation. Information on frequency of these requests is presented in Table 6. 38.1% of the participants had personally initiated a request for a consultation from an ethics advisory committee.

Table 6

*Frequency of Initiating a Request for an Ethics Consultation*

<table>
<thead>
<tr>
<th>Number of times has personally requested an EAC consult</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>52</td>
<td>61.90</td>
</tr>
<tr>
<td>1-3 times</td>
<td>24</td>
<td>28.57</td>
</tr>
<tr>
<td>4-6 times</td>
<td>1</td>
<td>1.19</td>
</tr>
<tr>
<td>7 or more times</td>
<td>7</td>
<td>8.33</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>84</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

All rating participants were asked: “When you have questions about an ethical dilemma involving your clinical work, who is the first person you usually consult?
(choose one).” The eight individuals from H2 who did in-person sorts also provided this information, but this question was not asked of online sorters. Information on frequency of responses is presented in Table 7.

### Table 7

**Person You Consult First When You Have an Ethical Dilemma**

<table>
<thead>
<tr>
<th>Consulted first</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>My direct supervisor</td>
<td>31</td>
<td>33.69</td>
</tr>
<tr>
<td>My program director</td>
<td>2</td>
<td>2.17</td>
</tr>
<tr>
<td>A more senior resident</td>
<td>5</td>
<td>5.43</td>
</tr>
<tr>
<td>A co-worker at OhioHealth</td>
<td>34</td>
<td>39.95</td>
</tr>
<tr>
<td>A colleague outside of OhioHealth</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>My team (in a team meeting)</td>
<td>1</td>
<td>1.09</td>
</tr>
<tr>
<td>An individual member of an ethics advisory committee</td>
<td>8</td>
<td>8.70</td>
</tr>
<tr>
<td>A clinical ethics advisory committee</td>
<td>4</td>
<td>4.34</td>
</tr>
<tr>
<td>A member of the pastoral care department</td>
<td>1</td>
<td>1.09</td>
</tr>
<tr>
<td>My spiritual advisor</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>My spouse or partner</td>
<td>1</td>
<td>1.09</td>
</tr>
<tr>
<td>Another family member</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>A close friend</td>
<td>2</td>
<td>2.17</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.17</td>
</tr>
<tr>
<td>No one</td>
<td>1</td>
<td>1.09</td>
</tr>
<tr>
<td>TOTAL</td>
<td>92</td>
<td>100</td>
</tr>
</tbody>
</table>

### Brainstorming or Generation of Ideas

As noted in the Methods chapter, 247 separate ideas were suggested by the participants in the brainstorming activity. After being reviewed as described in Chapter 3 in the section “Idea Synthesis,” a final list of 95 statements was created. Table 9 contains the list of statements, in the order they were presented to participants during rating and sorting. A list of the numbered statements with the original supporting suggestions (as written) is included in Appendix F. Suggestions which were eliminated because either 1) the wording was vague, unclear, confusing or just a
comment rather than a suggestion (n=12) or 2) they were outside the purview of the clinical ethics committee or not permissible by corporate policy (n = 4) are included at the end of this table. In some cases, suggestions were shortened to preserve the anonymity of the participant; note is made where this action has been taken.

Table 8  
*Statements, Numbered in the Order Presented to Participants During Rating and Sorting*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Use simulations and role playing exercises to teach staff about potential ethical situations that could arise in the clinical setting</td>
</tr>
<tr>
<td>2.</td>
<td>Identify when difficult clinical situations or difficult families require debriefing for staff and make a referral to get this going</td>
</tr>
<tr>
<td>3.</td>
<td>Come to staff meetings periodically to increase associate awareness of ethics committee resources and provide opportunities to dialogue about ethics</td>
</tr>
<tr>
<td>4.</td>
<td>Ensure that whatever steps are taken in patient care are consistent with ethical practice, Ohio law and OhioHealth policy</td>
</tr>
<tr>
<td>5.</td>
<td>Provide information to all staff on how to contact the committee to discuss an issue or ask a question without generating a full consult</td>
</tr>
<tr>
<td>6.</td>
<td>Be physically present to help bedside personnel better assess emerging ethical issues</td>
</tr>
<tr>
<td>7.</td>
<td>Decide who should be the decision maker when family is estranged and friends are sincerely involved with the patient</td>
</tr>
<tr>
<td>8.</td>
<td>Provide education and training to staff on when they are permitted to be relieved from a case for ethical reasons</td>
</tr>
<tr>
<td>9.</td>
<td>Mediate between staff members who are in disagreement on how to approach an ethical dilemma</td>
</tr>
<tr>
<td>10.</td>
<td>Provide opportunities for employees to be able to talk to someone about their feelings when dealing with critically ill patients</td>
</tr>
<tr>
<td>11.</td>
<td>Provide information sheets at the start of the ICU experience with examples of commonly encountered ethical dilemmas that may arise</td>
</tr>
<tr>
<td>12.</td>
<td>Provide a newsletter to staff on current events and hot topics in bioethics</td>
</tr>
<tr>
<td>13.</td>
<td>Provide support for staff who wish to be relieved from a case for ethical reasons</td>
</tr>
<tr>
<td>14.</td>
<td>Communicate with front line staff about the situation and the status of the ethics consult</td>
</tr>
<tr>
<td>15.</td>
<td>Provide thorough, concise recommendations when consulted</td>
</tr>
</tbody>
</table>

Continued
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16.</td>
<td>Work with pastoral care, nursing, and/or social work to establish daily rounds in the waiting rooms to talk with families about issues like life support or code status</td>
</tr>
<tr>
<td>17.</td>
<td>Automatically become involved anytime family members make a decision that appears to be inconsistent with patient's Living Will</td>
</tr>
<tr>
<td>18.</td>
<td>Provide practical tools staff can use with family members to provide answers and guidance with common ethical dilemmas</td>
</tr>
<tr>
<td>19.</td>
<td>Provide clear information on HOW to get the ethics committee involved</td>
</tr>
<tr>
<td>20.</td>
<td>Provide education on the types of cases that are appropriate for an ethics consult versus questions that should go to legal or human resources</td>
</tr>
<tr>
<td>21.</td>
<td>Create flow charts showing the decision trees for common ethical dilemmas</td>
</tr>
<tr>
<td>22.</td>
<td>Give guidance to staff on how to deal with family members who wish to continue with treatment that is deemed futile</td>
</tr>
<tr>
<td>23.</td>
<td>Work with palliative care to assist with pain management, goals of care and end-of-life decisions</td>
</tr>
<tr>
<td>24.</td>
<td>Become involved in cases where families are struggling with the issue of whether or not to place a feeding tube</td>
</tr>
<tr>
<td>25.</td>
<td>Create a safe haven where staff can discuss distressing ethical concerns</td>
</tr>
<tr>
<td>26.</td>
<td>Involve clinical nutrition in ethics consults when there are issues related to nutrition and hydration</td>
</tr>
<tr>
<td>27.</td>
<td>Help staff connect with pastoral care if staff’s personal religious beliefs are being challenged</td>
</tr>
<tr>
<td>28.</td>
<td>Help family members understand their legal and ethical rights</td>
</tr>
<tr>
<td>29.</td>
<td>Conduct unit-based meetings to discuss ways in which the committee could be best utilized</td>
</tr>
<tr>
<td>30.</td>
<td>Make it clear that any critical care staff member can request an ethics consult</td>
</tr>
<tr>
<td>31.</td>
<td>Be available to meet with family members of gravely ill patients so they have the opportunity to discuss end-of-life decisions before a crisis arrives</td>
</tr>
<tr>
<td>32.</td>
<td>Educate staff on OhioHealth’s approach to futile treatment</td>
</tr>
<tr>
<td>33.</td>
<td>Maintain an informational website for families to help them prepare for discussions with critical care staff</td>
</tr>
<tr>
<td>34.</td>
<td>Educate staff about State of Ohio laws related to care of terminally ill patients</td>
</tr>
<tr>
<td>35.</td>
<td>Create a screening tool to be used at admission to identify situations that may become ethically difficult</td>
</tr>
<tr>
<td>36.</td>
<td>Inform customer service that the ethics committee has been called in to consult on care of a particular patient</td>
</tr>
<tr>
<td>37.</td>
<td>Round daily on the critical care unit to discuss ethical issues related to patient care</td>
</tr>
</tbody>
</table>

Continued
Table 8 continued

38. Survey staff regularly on what the ethics committee can do to support the work in the critical care units
39. Inform critical care staff of what to expect from an ethics consult and how the consults affect care
40. Be visible and present in clinical activities, including on "off shifts"
41. Get opinions from staff directly involved in care of the patient

42. When a situation arises where an ethics committee consult may be indicated, provide information on how prior cases have been resolved
43. Ensure that whatever decisions are made are grounded in the best interests of the patient
44. Be available to assist staff communicate with families when it feels like neither side is understanding the other
45. Be proactively involved from the beginning of every critically ill patient's stay not just when consulted
46. Offer a summary of the ethics committee meeting to explain the process and reasoning behind its decisions
47. When an ethical dilemma has not been handled in an ideal way, have non-committee staff participate in committee review of the dilemma
48. Help identify the primary contact for the patient
49. Talk with physicians and staff about the decision making behind the conclusions reached in an ethics consult
50. Provide articles to staff presenting research, case studies or expert opinion on ethical issues and dilemmas
51. Meet with staff one on one to understand what might be learned from a particular case
52. Help families realize staff are there to help them and the patient not to judge them or the patient or "kill off" their family member
53. Provide online learning describing specific situations, common problems and their resolution
54. Provide periodic in-service training by reviewing cases or situations and discussing how these might be approached
55. Help explain in layman's terms the rationale physicians have for withdrawal of care
56. Provide peer to peer support groups for staff dealing with difficult ethical issues
57. Hear from all sides of the ethical dilemma in a private setting before discussing with the entire committee

Continued
Table 8 continued

58. Offer inservices to staff to study and discuss interesting ethical cases from beginning to end
59. Assist in developing a policy on when family members can be at the bedside during a code
60. Meet with families of patients whose treatments are considered futile to assist them in understanding why treatments are considered futile
61. Be physically present to review the case with the social worker and nursing staff when patients appear to have been either abused or neglected by their caregivers
62. When requested, meet with families that seem to be at odds with the medical staff
63. Help staff distinguish between a bioethical dilemma and a disagreement about physician’s care plan
64. Make services of the ethics committee well known and contact information for the ethics committee widely available
65. Have a process in place to assist staff when care decisions need to be made and there is no decision maker
66. Communicate with patients and families about the availability of the clinical ethics committee
67. Have a regular article in newsletter or hospital's print publication providing information on the committee's functions and how to access committee services
68. Provide regular staff education on ethical standards and issues related to critical care
69. Identify and acknowledge best practice, high-quality, ethical decision making
70. Meet with families who are in crisis about decision making for the care of their loved ones
71. Facilitate provision of appropriate support when staff are showing signs of burnout
72. Provide lectures to staff on current events and hot topics in bioethics
73. Provide a pamphlet for patients and families on the principles and values underlying the work of the ethics committee
74. Have the ethics committee communicate with front line staff through the medical record
75. Encourage brown bag discussion of day to day ethical concerns
76. Educate staff on what treatments physicians may refuse to provide
77. Acknowledge individuals who demonstrate high quality ethical decision making so they can serve as a role models for peers
78. Provide education about basic ethical principles
79. Be easily available 24/7 to clarify ethical standards and for difficult decisions, such as withdrawing care

Continued
Table 8 continued

80. Provide resources to help staff "untangle" themselves when they are conflicted ethically about a patient they are caring for
81. Educate residents on how to approach families and explain code status in layman's terms
82. Provide clear guidelines on when it is appropriate to get the ethics committee involved
83. Provide staff education on advance directives such as living will, healthcare power of attorney
84. Respond and meet promptly and make decisions quickly
85. Round regularly on the critical care unit to discuss ethical issues related to patient care
86. Provide clear, easy to access definitions of code status (e.g., DNR-CC)
87. Provide staff with a card listing the chain of medical decision makers in families
88. Have staff members come to ethics committee meetings to present different ethical dilemmas they have encountered in practice
89. Assist in developing a policy on dealing with disruptive families
90. Provide training in crucial conversations and communication skills
91. Offer education on spiritual and religious concerns that may impact patient and family decision making
92. Be a liaison with the legal department when there are problems with guardianship
93. Provide staff education on how to deal with unrealistic, angry or difficult patients and families
94. Provide chart notes (exclusively available to physicians) to help with documentation
95. Have a medical social worker in ER 24 hours a day

Structuring of ideas

Point maps. Once the sort data had been entered into the Concept Systems Global, Inc. software, point maps were generated. The underlying statistical analysis for this process, multi-dimensional scaling, is described in Methods under “Representation of Ideas (Data Analysis).” Three different point maps were generated: one for all sorters (n=54), one for EAC Member sorters only (n=32), and one for Non-EAC Staff only (n=22).

As noted in Chapter 3, the multi-dimensional scaling analysis provides a stress
value to indicate the goodness of fit of the data on the point map. The stress values for the three point maps generated for this study were: All Participants, 0.25; EAC Members only, 0.27; and Non-EAC Staff Only, 0.28. While using the sort data from the largest group yielded the lowest stress value, all three maps fell within the range recommended by Rosas and Kane (2012).

The point map is a two dimensional representation of how the individual ideas relate to each other based on the sorting data. Each point on a point map represents an individual statement. Numbers on the point map correspond with those found in the statement list in Table 8. Ideas which are close together on the point map were sorted together more often by participants. In other words, ideas which are close together tend to be more similar in meaning. When ideas are far apart on the map, it means they were less often sorted together and thus are less similar in meaning. Items in the center of a map tend to bridge, or connect, to all the areas of the map. The point map for All Participants is presented in Figure 5, for Non-EAC Staff Only in Figure 6, and for EAC Members only in Figure 7.
Figure 5. Point map, All Participants (Stress value = 0.25)

Figure 6. Point map, Non-EAC Staff Only (Stress value = 0.28)
A visual comparison of the three maps shows that some points are placed similarly and some are not. For example, these four statements which can be found at the top of Figures 5 and 6:

7. Decide who should be the decision maker when family is estranged and friends are sincerely involved with the patient

16. Work with pastoral care, nursing, and/or social work to establish daily rounds in the waiting rooms to talk with families about issues like life support or code status

17. Automatically become involved anytime family members make a decision that appears to be inconsistent with a patient’s Living Will

48. Help identify the primary contact for the patient

appear close together on the All Participant and Non-EAC Staff Only maps. In addition, these points all appear on the outer edges of the maps. On the other hand, on...
the EAC Member only map, # 7 and a #16 are not close together. In other words, while the Non-EAC participants saw these statements as closely related, the EAC members saw them as less closely related. 

Other differences are apparent when comparing the maps. While these statements

74. Have the ethics committee communicate with front line staff through the medical record

40. Be visible and present in clinical activities, including on "off shifts"

appear on the outer edge of the All Participants and EAC Member Only maps, they appear in the center of the Non EAC Staff Only map.

In contrast

4. Ensure that whatever steps are taken in patient care are consistent with ethical practice, Ohio law and OhioHealth policy

35. Create a screening tool to be used at admission to identify situations that may become ethically difficult

appear close to each other at the center of the All Participants map; however, on the Non EAC Staff map, they appear on opposite sides. On the EAC Only map #4 is near the center perhaps reflecting committee member perceptions that this action is closely related to all of the various activities suggested. However, #35 is on the very far edge of the map suggesting that the two ideas are not closely linked conceptually by ethics committee members. These examples illustrate some of the differences between the three maps, reflecting some of the ways in which the Non-EAC Staff perception of the ideas differs from those of EAC Member participants or of the whole group when EAC member perceptions are added to the sort data.

Cluster maps. Once the point maps were generated, the Concept Systems Global, Inc. software conducted a hierarchical cluster analysis to group the points on the map into clusters. The cluster analysis process is described in detail in the “Hierarchical cluster analysis” section of the Methods chapter.

After completing the cluster analysis process, the researcher and the Director brought two different, unlabeled, cluster maps (one based on the All Participants
point map and one based on the Non EAC Staff Only point map) to the Interpretation session. The two cluster maps are presented in Figures 8 and 9, with points (without statement numbers) and the labels generated during this session.

*Figure 8. 8 Cluster Map Based on All Participant Point Map*
The two maps have several strong similarities. In both maps, there is a cluster that relates to staff development as well as one that has to do with increasing the overall awareness of the committee and what it has to offer clinicians (Developing awareness of EAC and Outreach & accessibility). However, there are notable differences between the two maps as well. In the All Participants map, there are two clusters that are related to the committee’s process: “Process improvement” and “Committee consultation process.” This emphasis most likely reflects the inclusion of sorting data from EAC members who are focused on committee operations and procedures as part of their membership duties. However, in the Non EAC Staff Only map, there are no similar clusters. In the Non EAC Staff Only map, there is a cluster which focuses on the ethics committee serving as a liaison with patients and families. While the All Participant map also has clusters related to “Patient & family education & management” and “Consultation with families,” the emphasis in the two maps is subtly different with clinicians stressing the liaison function. Non EAC Staff
participants also see the ethics committee serving as a liaison between the critical care units and the rest of the hospital system; this function is not as clearly identified in the organization of the All Participant map.

Perhaps the most striking difference between the two maps concerns the cluster “Visibility” which appears on the Non EAC Staff map but does not appear as a separate cluster on the All Participants map. Even more striking is that the Non EAC participants place this cluster, which contains statements about the ethics committee being visible and present in the critical care unit, in the center of the map. One participant at the Interpretation session saw this cluster as “the hub” of the Non EAC Only map with the other committee functions (represented by the other clusters) “coming off as spokes.” During the Interpretation session, the existence and centrality of the Visibility cluster on the Non EAC Only map was the primary driver in choosing this map as the basis for all the remaining analysis. In addition, the group felt it that this map would help focus attention on the Non EAC Staff perception of needs and priorities since this perspective is what is currently missing in EAC planning efforts. Table 9, presented after the bridging analysis, provides the statements organized by cluster for the Non EAC Staff Only map.

As noted under Hierarchical cluster analysis in the Methods chapter, the researcher and the Director agreed that both the all-participant and clinician-only maps represented the data more clearly and usefully than did the committee-only map; therefore, the cluster map for the EAC Only data is not included.

**Bridging analysis.** The Concept Systems Global, Inc. software provides additional indices that can be used for understanding a cluster map. The program will compute a “bridging” value for each statement which can be used to assess how strongly it is related to ones similar in meaning or tends to “bridge” a more diverse set of statements (Jackson & Trochim, 2002). Cluster bridging values are a measure of how cohesive the statements within a cluster are with the other statements around them. Bridging values can range between 0.0 and 1.0. Statements or clusters with a low bridging value can be considered “anchors” because they seem to identify or reflect the core meaning of that area of the map (Kane and Trochim, 2007). If a
statement has a high bridging value this may indicate that the statement’s relationship to other individual statements or other areas of the map may be stronger than its relationship to statements within its cluster. Ideas on the outer edge of a cluster often “bridge” or connect with ideas in a nearby cluster. While a high bridging value may indicate that the item bridges or ties other statements together, it may also indicate that it was not seen as consistently linked to the other brainstormed ideas and was difficult to sort (Jackson & Trochim, 2002). Table 9 contains the bridging values of each cluster and each statement.

Table 9

<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>78.</td>
<td>Provide education about basic ethical principles</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>54.</td>
<td>Provide periodic in-service training by reviewing cases or situations and discussing how these might be approached</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>58.</td>
<td>Offer inservices to staff to study and discuss interesting ethical cases from beginning to end</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>76.</td>
<td>Educate staff on what treatments physicians may refuse to provide</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Provide education on the types of cases that are appropriate for an ethics consult versus questions that should go to legal or human resources</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Use simulations and role playing exercises to teach staff about potential ethical situations that could arise in the clinical setting</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>50.</td>
<td>Provide articles to staff presenting research, case studies or expert opinion on ethical issues and dilemmas</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Provide clear information on HOW to get the ethics committee involved</td>
<td>0.04</td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>Inform critical care staff of what to expect from an ethics consult and how the consults affect care</td>
<td>0.04</td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>Educate staff about State of Ohio laws related to care of terminally ill patients</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td>72.</td>
<td>Provide lectures to staff on current events and hot topics in bioethics</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Provide education and training to staff on when they are permitted to be relieved from a case for ethical reasons</td>
<td>0.05</td>
<td></td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Staff development</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>32</td>
<td>Educate staff on OhioHealth’s approach to futile treatment</td>
<td>0.05</td>
</tr>
<tr>
<td>68.</td>
<td>68</td>
<td>Provide regular staff education on ethical standards and issues related to critical care</td>
<td>0.05</td>
</tr>
<tr>
<td>53.</td>
<td>53</td>
<td>Provide online learning describing specific situations, common problems and their resolution</td>
<td>0.05</td>
</tr>
<tr>
<td>93.</td>
<td>93</td>
<td>Provide staff education on how to deal with unrealistic, angry or difficult patients and families</td>
<td>0.08</td>
</tr>
<tr>
<td>11.</td>
<td>11</td>
<td>Provide information sheets at the start of the ICU experience with examples of commonly encountered ethical dilemmas that may arise</td>
<td>0.08</td>
</tr>
<tr>
<td>5.</td>
<td>5</td>
<td>Provide information to all staff on how to contact the committee to discuss an issue or ask a question without generating a full consult</td>
<td>0.09</td>
</tr>
<tr>
<td>91.</td>
<td>91</td>
<td>Offer education on spiritual and religious concerns that may impact patient and family decision making</td>
<td>0.09</td>
</tr>
<tr>
<td>18.</td>
<td>18</td>
<td>Provide practical tools staff can use with family members to provide answers and guidance with common ethical dilemmas</td>
<td>0.11</td>
</tr>
<tr>
<td>83.</td>
<td>83</td>
<td>Provide staff education on advance directives such as living will, healthcare power of attorney</td>
<td>0.13</td>
</tr>
<tr>
<td>90.</td>
<td>90</td>
<td>Provide training in crucial conversations and communication skills</td>
<td>0.13</td>
</tr>
<tr>
<td>21.</td>
<td>21</td>
<td>Create flow charts showing the decision trees for common ethical dilemmas</td>
<td>0.14</td>
</tr>
<tr>
<td>12.</td>
<td>12</td>
<td>Provide a newsletter to staff on current events and hot topics in bioethics</td>
<td>0.20</td>
</tr>
<tr>
<td>67.</td>
<td>67</td>
<td>Have a regular article in newsletter or hospital's print publication providing information on the committee's functions and how to access committee services</td>
<td>0.20</td>
</tr>
<tr>
<td>81.</td>
<td>81</td>
<td>Educate residents on how to approach families and explain code status in layman's terms</td>
<td>0.26</td>
</tr>
<tr>
<td><strong>Count Std. Dev. Variance Min Max Average Median</strong></td>
<td></td>
<td><strong>26  0.06  0.00  0.00  0.26  0.08  0.05</strong></td>
<td></td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>2. Guidance</strong></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td></td>
<td>Give guidance to staff on how to deal with family members who wish to</td>
<td>0.17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>continue with treatment that is deemed futile</td>
<td></td>
</tr>
<tr>
<td>87.</td>
<td></td>
<td>Provide staff with a card listing the chain of medical decision makers</td>
<td>0.22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>in families</td>
<td></td>
</tr>
<tr>
<td>75.</td>
<td></td>
<td>Encourage brown bag discussion of day to day ethical concerns</td>
<td>0.34</td>
</tr>
<tr>
<td>82.</td>
<td></td>
<td>Provide clear guidelines on when it is appropriate to get the ethics</td>
<td>0.36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>committee involved</td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td></td>
<td>When a situation arises where an ethics committee consult may be</td>
<td>0.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>indicated, provide information on how prior cases have been resolved</td>
<td></td>
</tr>
<tr>
<td>89.</td>
<td></td>
<td>Assist in developing a policy on dealing with disruptive families</td>
<td>0.46</td>
</tr>
<tr>
<td>46.</td>
<td></td>
<td>Offer a summary of the ethics committee meeting to explain the</td>
<td>0.49</td>
</tr>
<tr>
<td></td>
<td></td>
<td>process and reasoning behind its decisions</td>
<td></td>
</tr>
<tr>
<td>86.</td>
<td></td>
<td>Provide clear, easy to access definitions of code status (e.g., DNR-CC)</td>
<td>0.50</td>
</tr>
<tr>
<td>59.</td>
<td></td>
<td>Assist in developing a policy on when family members can be</td>
<td>0.54</td>
</tr>
<tr>
<td></td>
<td></td>
<td>at the bedside during a code</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td></td>
<td>Create a screening tool to be used at admission to identify situations</td>
<td>0.59</td>
</tr>
<tr>
<td></td>
<td></td>
<td>that may become ethically difficult</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Count Std. Dev. Variance Min Max Average Median</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>0.13 0.02 0.17 0.59 0.41 0.43</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>3. Liaison with patients &amp; families</strong></td>
<td></td>
</tr>
<tr>
<td>48.</td>
<td></td>
<td>Help identify the primary contact for the patient</td>
<td>0.19</td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td>Work with pastoral care, nursing, and/or social work to establish daily</td>
<td>0.24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>rounds in the waiting rooms to talk with families about issues like life</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>support or code status</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td></td>
<td>Automatically become involved anytime family members make a decision</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>that appears to be inconsistent with patient's Living Will</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td></td>
<td>Become involved in cases where families are struggling with the issue</td>
<td>0.26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of whether or not to place a feeding tube</td>
<td></td>
</tr>
<tr>
<td>70.</td>
<td></td>
<td>Meet with families who are in crisis about decision making for the care</td>
<td>0.26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of their loved ones</td>
<td></td>
</tr>
<tr>
<td>62.</td>
<td></td>
<td>When requested, meet with families that seem to be at odds with the</td>
<td>0.27</td>
</tr>
<tr>
<td></td>
<td></td>
<td>medical staff</td>
<td></td>
</tr>
</tbody>
</table>

Continued
Table 9 continued

<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Liaison with patients &amp; families</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>3. Liaison with patients &amp; families</td>
<td>Decide who should be the decision maker when family is estranged and friends are sincerely involved with the patient</td>
<td>0.28</td>
</tr>
<tr>
<td>55.</td>
<td>55.</td>
<td>Help explain in layman's terms the rationale physicians have for withdrawal of care</td>
<td>0.28</td>
</tr>
<tr>
<td>31.</td>
<td>31.</td>
<td>Be available to meet with family members of gravely ill patients so they have the opportunity to discuss end-of-life decisions before a crisis arrives</td>
<td>0.30</td>
</tr>
<tr>
<td>52.</td>
<td>52.</td>
<td>Help families realize staff are there to help them and the patient not to judge them or the patient or &quot;kill off&quot; their family member</td>
<td>0.32</td>
</tr>
<tr>
<td>28.</td>
<td>28.</td>
<td>Help family members understand their legal and ethical rights</td>
<td>0.33</td>
</tr>
<tr>
<td>15.</td>
<td>15.</td>
<td>Provide thorough, concise recommendations when consulted</td>
<td>0.34</td>
</tr>
<tr>
<td>66.</td>
<td>66.</td>
<td>Communicate with patients and families about the availability of the clinical ethics committee</td>
<td>0.35</td>
</tr>
<tr>
<td>60.</td>
<td>60.</td>
<td>Meet with families of patients whose treatments are considered futile to assist them in understanding why treatments are considered futile</td>
<td>0.36</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>Identify when difficult clinical situations or difficult families require debriefing for staff and make a referral to get this going</td>
<td>0.39</td>
</tr>
<tr>
<td>Count Std. Dev. Variance Min Max Average Median</td>
<td>15 0.05 0.00 0.19 0.39 0.30 0.28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Visibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>14.</td>
<td>Communicate with front line staff about the situation and the status of the ethics consult</td>
<td>0.21</td>
</tr>
<tr>
<td>6.</td>
<td>6.</td>
<td>Be physically present to help bedside personnel better assess emerging ethical issues</td>
<td>0.21</td>
</tr>
<tr>
<td>74.</td>
<td>74.</td>
<td>Have the ethics committee communicate with front line staff through the medical record</td>
<td>0.21</td>
</tr>
<tr>
<td>40.</td>
<td>40.</td>
<td>Be visible and present in clinical activities, including on &quot;off shifts&quot;</td>
<td>0.22</td>
</tr>
<tr>
<td>85.</td>
<td>85.</td>
<td>Round regularly on the critical care unit to discuss ethical issues related to patient care</td>
<td>0.23</td>
</tr>
<tr>
<td>37.</td>
<td>37.</td>
<td>Round daily on the critical care unit to discuss ethical issues related to patient care</td>
<td>0.24</td>
</tr>
<tr>
<td>Count Std. Dev. Variance Min Max Average Median</td>
<td>6 0.01 0.00 0.21 0.24 0.22 0.22</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued
Table 9 continued

<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Liaison with system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td></td>
<td>Be available to assist staff communicate with families when it feels like neither side is understanding the other</td>
<td>0.20</td>
</tr>
<tr>
<td>45.</td>
<td></td>
<td>Be proactively involved from the beginning of every critically ill patient's stay not just when consulted</td>
<td>0.27</td>
</tr>
<tr>
<td>79.</td>
<td></td>
<td>Be easily available 24/7 to clarify ethical standards and for difficult decisions, such as withdrawing care</td>
<td>0.28</td>
</tr>
<tr>
<td>84.</td>
<td></td>
<td>Respond and meet promptly and make decisions quickly</td>
<td>0.31</td>
</tr>
<tr>
<td>23.</td>
<td></td>
<td>Work with palliative care to assist with pain management, goals of care and end-of-life decisions</td>
<td>0.31</td>
</tr>
<tr>
<td>61.</td>
<td></td>
<td>Be physically present to review the case with the social worker and nursing staff when patients appear to have been either abused or neglected by their caregivers</td>
<td>0.34</td>
</tr>
<tr>
<td>92.</td>
<td></td>
<td>Be a liaison with the legal department when there are problems with guardianship</td>
<td>0.38</td>
</tr>
<tr>
<td>36.</td>
<td></td>
<td>Inform customer service that the ethics committee has been called in to consult on care of a particular patient</td>
<td>0.42</td>
</tr>
<tr>
<td>43.</td>
<td></td>
<td>Ensure that whatever decisions are made are grounded in the best interests of the patient</td>
<td>0.43</td>
</tr>
<tr>
<td>26.</td>
<td></td>
<td>Involve clinical nutrition in ethics consults when there are issues related to nutrition and hydration</td>
<td>0.47</td>
</tr>
<tr>
<td>95.</td>
<td></td>
<td>Have a medical social worker in ER 24 hours a day</td>
<td>0.48</td>
</tr>
<tr>
<td>33.</td>
<td></td>
<td>Maintain an informational website for families to help them prepare for discussions with critical care staff</td>
<td>0.67</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Count Std. Dev. Variance Min Max Average Median</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12 0.12 0.01 0.20 0.67 0.38 0.36</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Outreach &amp; accessibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td></td>
<td>Make it clear that any critical care staff member can request an ethics consult</td>
<td>0.15</td>
</tr>
<tr>
<td>29.</td>
<td></td>
<td>Conduct unit-based meetings to discuss ways in which the committee could be best utilized</td>
<td>0.22</td>
</tr>
<tr>
<td>63.</td>
<td></td>
<td>Help staff distinguish between a bioethical dilemma and a disagreement about physician’s care plan</td>
<td>0.24</td>
</tr>
<tr>
<td>80.</td>
<td></td>
<td>Provide resources to help staff “untangle” themselves when they are conflicted ethically about a patient they are caring for</td>
<td>0.26</td>
</tr>
<tr>
<td>65.</td>
<td></td>
<td>Have a process in place to assist staff when care decisions need to be made and there is no decision maker</td>
<td>0.35</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>Come to staff meetings periodically to increase associate awareness of ethics committee resources and provide opportunities to dialogue about ethics</td>
<td>0.38</td>
</tr>
</tbody>
</table>

Continued
Table 9 continued

<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6. Outreach &amp; accessibility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>Survey staff regularly on what the ethics committee can do to support the work in the critical care units</td>
<td>0.41</td>
<td></td>
</tr>
<tr>
<td>64.</td>
<td>Make services of the ethics committee well known and contact information for the ethics committee widely available</td>
<td>0.49</td>
<td></td>
</tr>
<tr>
<td>69.</td>
<td>Identify and acknowledge best practice, high-quality, ethical decision making</td>
<td>0.54</td>
<td></td>
</tr>
<tr>
<td>88.</td>
<td>Have staff members come to ethics committee meetings to present different ethical dilemmas they have encountered in practice</td>
<td>0.63</td>
<td></td>
</tr>
<tr>
<td>73.</td>
<td>Provide a pamphlet for patients and families on the principles and values underlying the work of the ethics committee</td>
<td>0.92</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Count Std. Dev. Variance Min Max Average Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 0.21 0.04 0.15 0.92 0.42 0.38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. Ethical &amp; moral support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>Get opinions from staff directly involved in care of the patient</td>
<td>0.27</td>
<td></td>
</tr>
<tr>
<td>49.</td>
<td>Talk with physicians and staff about the decision making behind the conclusions reached in an ethics consult</td>
<td>0.38</td>
<td></td>
</tr>
<tr>
<td>77.</td>
<td>Acknowledge individuals who demonstrate high quality ethical decision making so they can serve as a role models for peers</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Provide support for staff who wish to be relieved from a case for ethical reasons</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Provide opportunities for employees to be able to talk to someone about their feelings when dealing with critically ill patients</td>
<td>0.49</td>
<td></td>
</tr>
<tr>
<td>51.</td>
<td>Meet with staff one on one to understand what might be learned from a particular case</td>
<td>0.50</td>
<td></td>
</tr>
</tbody>
</table>

Continued
The bridging analysis shows that six of the seven clusters have average bridging values below 0.50. The cluster, Staff Development, has a bridging value of 0.08 representing a very tightly related cluster. Statement #78 (Provide education about basic ethical principles) which has a bridging value of 0.0 serves as a logical “anchor” for the rest of the ideas in that cluster. The bridging value for cluster 7, Visibility, also has a low bridging value (0.22) indicating that this concept is a cohesive one. In contrast, a bridging value of 1.0 for statement #47 in cluster 7 indicates that this statements does not relate well to the other statements in its cluster. This statement is, in fact, on the very outermost edge of the map indicating that it is

<table>
<thead>
<tr>
<th>Cluster</th>
<th>#</th>
<th>Statement</th>
<th>Bridging Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Ethical &amp; moral support</td>
<td>9.</td>
<td>Mediate between staff members who are in disagreement on how to approach an ethical dilemma</td>
<td>0.50</td>
</tr>
<tr>
<td></td>
<td>94.</td>
<td>Provide chart notes (exclusively available to physicians) to help with documentation</td>
<td>0.50</td>
</tr>
<tr>
<td></td>
<td>25.</td>
<td>Create a safe haven where staff can discuss distressing ethical concerns</td>
<td>0.52</td>
</tr>
<tr>
<td></td>
<td>27.</td>
<td>Help staff connect with pastoral care if staff’s personal religious beliefs are being challenged</td>
<td>0.57</td>
</tr>
<tr>
<td></td>
<td>4.</td>
<td>Ensure that whatever steps are taken in patient care are consistent with ethical practice, Ohio law and OhioHealth policy</td>
<td>0.59</td>
</tr>
<tr>
<td></td>
<td>71.</td>
<td>Facilitate provision of appropriate support when staff are showing signs of burnout</td>
<td>0.59</td>
</tr>
<tr>
<td></td>
<td>57.</td>
<td>Hear from all sides of the ethical dilemma in a private setting before discussing with the entire committee</td>
<td>0.61</td>
</tr>
<tr>
<td></td>
<td>56.</td>
<td>Provide peer to peer support groups for staff dealing with difficult ethical issues</td>
<td>0.62</td>
</tr>
<tr>
<td></td>
<td>47.</td>
<td>When an ethical dilemma has not been handled in an ideal way, have non-committee staff participate in committee review of the dilemma</td>
<td>1.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Count Std. Dev. Variance Min Max Average Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>15   0.15 0.02 0.27 1.00 0.54 0.50</td>
</tr>
</tbody>
</table>
also not considered closely tied to any one concept but was, in fact, sorted with many
different statements. Through the Concept Systems software, a “spanning analysis”
can be conducted to identify how statements were sorted relative to other statements.
A spanning analysis of the Visibility cluster shows that it, in fact, does serve as a
“hub” connecting almost equally with all other areas of the map. Overall, the
bridging values and analysis confirmed that this map provides a meaningful
organization of the brainstormed ideas.

Rating analyses – cluster rating maps. The sorting process and subsequent
statistical analysis show how the ideas relate conceptually to one another. The rating
data, gathered through the rating survey, enables the researcher and the stakeholders
to assign values to both individual ideas and clusters of ideas. As noted in chapter 3,
participants were asked to rate each statement along two dimensions: Impact (How
much positive impact could this ethics committee activity have on the care provided
in the critical care setting?) and Performance (How well does the ethics committee
currently perform this activity or task?). The Concept Systems Global, Inc., software
computes average ratings for each statement and cluster. Appendix G contains the
average ratings (by both statement and cluster) for Impact and a similar table showing
ratings for Performance. Rating data in these appendices are shown for Non EAC
staff, EAC members, and for the all participants. Table 10 summarizes the average
cluster ratings for the two criteria for Non EAC staff and EAC members. This data is
analyzed in further detail in the sections below.
Table 10

*Impact and Performance, Cluster Averages for Non EAC Staff and EAC Members*

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact Non EAC n=64</th>
<th>Impact EAC n=20</th>
<th>Perform Non EAC n=46</th>
<th>Perform EAC n=15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.67</td>
<td>3.66</td>
<td>2.42</td>
<td>2.86</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.73</td>
<td>3.62</td>
<td>2.52</td>
<td>2.75</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.99</td>
<td>3.77</td>
<td>2.84</td>
<td>3.34</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.60</td>
<td>3.35</td>
<td>2.42</td>
<td>2.64</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.74</td>
<td>3.51</td>
<td>2.71</td>
<td>2.99</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.75</td>
<td>3.75</td>
<td>2.54</td>
<td>3.00</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.69</td>
<td>3.66</td>
<td>2.66</td>
<td>3.10</td>
</tr>
</tbody>
</table>

For reference, the scales used in the ratings were:

- **Impact**: 1 = Very small positive impact; 2 = Some positive impact; 3 = Moderate positive impact; 4 = Large positive impact; and 5 = Very large positive impact
- **Performance**: 1 = Very poorly, 2 = Poorly, 3 = Adequately, 4 = Well, and 5 = Extremely well

The software also combines the rating and sorting data to create a variety of graphical displays: point rating maps, cluster rating maps, pattern matches and go zones. The stakeholders in this study found the tables presented in Appendices G and H more useful for decision making than the point rating maps so no examples of this type of map are provided in this dissertation. The cluster rating map uses the average ratings across participants (or selected groups of participants) to indicate average value for each cluster. In a cluster rating map, the clusters are drawn with one to five layers, with each layer representing a quintile. Clusters with only one layer have an average rating in the lowest quintile while those with five layers have an average rating in the fifth, or highest, quintile. Cluster rating maps were produced to be used
in the presentation to the Joint Ethics Advisory Committee to quickly illustrate the different values Non EAC staff and EAC members had placed on different areas of the map. Four of the cluster rating maps used in the training session are presented below. The first two are Impact cluster rating maps; the second two are Performance cluster rating maps.
Figure 10. Impact Cluster Rating Map, Non EAC Raters

Figure 11. Impact Cluster Rating Map, EAC Member Raters
To compare the two cluster maps, it is important to note the scale to the left of each map. On the Non EAC Staff map, a cluster with only one layer, Visibility, has an average Impact value between 3.60 and 3.68. On the ethics committee map, the Visibility cluster also has only one layer but the EAC average Impact rating for Visibility is between 3.32 and 3.40. The cluster, Staff development, got a relatively high impact rating from EAC members. This is consistent with an ethics committee’s traditional role in providing education. On the other hand, Non EAC raters gave this cluster a low average rating relative to the other clusters. Nevertheless, the average ratings for this cluster (Non EAC = 3.67 and EAC = 3.62) are almost the same. What is evident from the Impact cluster rating maps is that Non EAC raters and EAC raters rank the potential positive impact of committee activities very differently reflecting different perceptions on what activities are most valuable to work in the critical care setting.

A similar comparison can be made between two Performance cluster rating maps.
Figure 12. Performance Cluster Rating Map, Non EAC raters

Cluster Legend
Layer Value
1 2.42 to 2.50
2 2.50 to 2.59
3 2.59 to 2.67
4 2.67 to 2.76
5 2.76 to 2.84

Liaison with patients & families
Liaison with system
Ethical & moral support
Visibility
Guidance
Outreach & accessibility
Staff development

Figure 13. Performance Cluster Rating Map, EAC Member Raters

Cluster Legend
Layer Value
1 2.64 to 2.78
2 2.78 to 2.92
3 2.92 to 3.06
4 3.06 to 3.20
5 3.20 to 3.34

Liaison with patients & families
Liaison with system
Ethical & moral support
Visibility
Guidance
Outreach & accessibility
Staff development
A visual comparison of the two maps indicates that Non EAC participants and ethics committee member participants have a fairly congruent perception of which groups of activities are performed better than others. Once again, however, further assessment is needed to understand the differences between the two rating groups. For example, “Liaison with patients and families” has five layers on each map. However, using the scale on the left of each map, we can see that while the ethics committee valued their performance on this cluster 3.20 to 3.34, Non EAC participants rated performance on this same cluster as 2.42 to 2.50. Nevertheless, both groups saw this as the area with the strongest committee performance.

The cluster maps provide a quick picture of how differently two groups may rate clusters along a similar dimension, but other graphical displays produced for concept mapping make comparisons between groups easier to interpret.

Rating analyses – pattern matches and go-zones. Concept Systems Global, Inc. software enables the researcher to compare ratings between two different groups of participants or two different ratings. By using the average rating of each cluster, the software can create a graphical representation called a pattern match. The pattern match is presented as a ladder graph, connecting cluster rating values on a pair of scales. A Pearson product moment correlation co-efficient (an $r$ value) shows the degree of similarity, or consistency, between the groups’ ranking of the average cluster values. The value of a pattern match is that it highlights areas of consensus and disagreement between different groups, making it easier to identify areas which may need attention or action.

Comparison of Impact and Performance ratings of Non EAC staff and EAC members. The third aim of the study was to “provide data that may improve the efficacy of OhioHealth in supporting clinicians and the work they do in the critical care settings.” As a first step in organizing the data to achieve Aim 3, the researcher compared the ratings of each cluster on Impact with its rating on Performance using the entire set of respondents (Figure 14 and Table 11). Next, to better understand the difference in the perspectives of Non EAC staff and ethics committee members, a pattern match was made to show a comparison of Non EAC and EAC ratings of
clusters on Impact (Figure 15 and Table 12) and a comparable one was created for the ratings on Performance (Figure 16 and Table 13). A comparison was also made for Impact versus Performance for just EAC members (Table 14) and just Non EAC staff (Table 15).

*Figure 14. Pattern Match: Impact (n=84) and Performance (n=61), All Rating Participants*
Table 11

Cluster Averages for All Participants, Impact (n=84) and Performance (n=61)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact n=84</th>
<th>Impact sd</th>
<th>Performance n=61</th>
<th>Perform sd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.67</td>
<td>0.37</td>
<td>2.53</td>
<td>0.28</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.70</td>
<td>0.42</td>
<td>2.57</td>
<td>0.21</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.94</td>
<td>0.29</td>
<td>2.97</td>
<td>0.27</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.54</td>
<td>0.32</td>
<td>2.48</td>
<td>0.26</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.69</td>
<td>0.49</td>
<td>2.78</td>
<td>0.40</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.75</td>
<td>0.32</td>
<td>2.65</td>
<td>0.27</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.68</td>
<td>0.31</td>
<td>2.77</td>
<td>0.33</td>
</tr>
</tbody>
</table>

The pattern match in Figure 14 shows the level of agreement between the Impact rating and the Performance rating for all of the participants in the study. The $r$ value of 0.82 for the pattern match in Figure 14 indicates that there was a strong agreement in the ranking of the clusters. In other words, clusters with higher impact scores also were generally receiving higher performance scores. The range of Impact ratings (3.54 to 3.94) indicates that, on average, the activities suggested in the clusters could have a moderate to high positive impact on care in the critical care setting. In contrast, the Performance ratings (2.53 to 2.97) showed that the average Performance rating for each area of the map was below “adequately.” This pattern match indicates that both Non EAC and EAC members see that ethic committee activities have the potential to have a positive impact on the staff and the work they do in the critical care unit but that the current performance level of the committee on the suggested activities has room for improvement.
Figure 15. Pattern Match: Impact Rating, Non EAC staff (n=64) and EAC Members (n=20)

Table 12

Impact, Cluster Averages for Non EAC staff (n=64) and EAC members (n=20)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact Non EAC</th>
<th>Impact Non EAC sd</th>
<th>Impact EAC</th>
<th>Impact – EAC sd</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.67</td>
<td>0.37</td>
<td>3.66</td>
<td>0.42</td>
<td>0.01</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.73</td>
<td>0.40</td>
<td>3.62</td>
<td>0.52</td>
<td>0.11</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>--</td>
<td>0.30</td>
<td>3.77</td>
<td>0.33</td>
<td>0.22</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.60</td>
<td>0.28</td>
<td>3.35</td>
<td>0.47</td>
<td>0.25</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.74</td>
<td>0.46</td>
<td>3.51</td>
<td>0.66</td>
<td>0.23</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.75</td>
<td>0.31</td>
<td>3.75</td>
<td>0.40</td>
<td>0.00</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.69</td>
<td>0.32</td>
<td>3.66</td>
<td>0.30</td>
<td>0.03</td>
</tr>
</tbody>
</table>
The $r$ value for the pattern match in Figure 15 indicates there is a moderate correlation between the Impact ratings of Non EAC staff and EAC members. Both groups ranked “Liaison with families” as the area with the highest positive impact and both rated “Visibility” the lowest. Non EAC staff placed a higher impact value on “Liaison with the system” than did EAC members. Nevertheless, as shown in Table 13, there is very little difference in the Impact rating scores between the two groups. In general, Non EAC staff gave higher Impact rating scores than did EAC members. In other words, Non EAC staff seem to have a slightly stronger belief that EAC activities can have a positive impact on the critical care unit than the EAC members believe they can.
Figure 16. Pattern Match: Performance Rating, Non EAC staff (n=46) and EAC members (n=15)

Table 13

Performance, Cluster Averages for Non EAC Staff (n=46) and EAC Members (n=15)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform Non EAC</th>
<th>Perform Non EAC (sd)</th>
<th>Perform EAC</th>
<th>Perform EAC (sd)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.42</td>
<td>0.22</td>
<td>2.86</td>
<td>0.50</td>
<td>0.44</td>
</tr>
<tr>
<td>Guidance</td>
<td>2.52</td>
<td>0.15</td>
<td>2.75</td>
<td>0.44</td>
<td>0.23</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>2.84</td>
<td>0.23</td>
<td>3.39</td>
<td>0.52</td>
<td>0.50</td>
</tr>
<tr>
<td>Visibility</td>
<td>2.42</td>
<td>0.19</td>
<td>2.64</td>
<td>0.51</td>
<td>0.22</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>2.71</td>
<td>0.33</td>
<td>2.99</td>
<td>0.78</td>
<td>0.28</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>2.54</td>
<td>0.18</td>
<td>3.00</td>
<td>0.57</td>
<td>0.46</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>2.66</td>
<td>0.29</td>
<td>3.10</td>
<td>0.50</td>
<td>0.44</td>
</tr>
</tbody>
</table>
The \( r \) value of 0.87 indicates that there is a strong to very strong congruence between the way that Non EAC staff and EAC members rank the ethics committees’ performance. However, the EAC members rank their performance in all areas higher than the Non EAC staff do. This is particularly true for “Liaison with patients & families,” “Outreach & accessibility,” “Staff development,” and “Ethical & moral support” which were all scored between 0.44 and 0.50 points higher by the EAC members than by the Non EAC participants. Of note, even though the EAC members gave themselves “higher grades” than the Non EAC staff gave them, the committees members only “awarded” themselves better than “adequately” or above on two clusters: Liaison with patients & families (3.34) and Ethical & moral support (3.10).

Table 14

*Impact (n=20) and Performance (n=15) Ratings, Cluster Averages for EAC Members*

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact EAC n=20</th>
<th>Impact - EAC sd</th>
<th>Performance EAC n=15</th>
<th>Perform EAC sd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.66</td>
<td>0.42</td>
<td>2.86</td>
<td>0.50</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.62</td>
<td>0.52</td>
<td>2.75</td>
<td>0.44</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.77</td>
<td>0.33</td>
<td>3.34</td>
<td>0.52</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.35</td>
<td>0.47</td>
<td>2.64</td>
<td>0.51</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.51</td>
<td>0.66</td>
<td>2.99</td>
<td>0.78</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.75</td>
<td>0.40</td>
<td>3.00</td>
<td>0.57</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.66</td>
<td>0.30</td>
<td>3.10</td>
<td>0.50</td>
</tr>
</tbody>
</table>
Table 15

*Impact (n=64) and Performance (n=46) Ratings, Cluster Averages for Non EAC Staff*

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact Non EAC</th>
<th>Impact – Non EAC sd</th>
<th>Performance Non EAC</th>
<th>Performance Non EAC sd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.67</td>
<td>0.37</td>
<td>2.42</td>
<td>0.22</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.73</td>
<td>0.40</td>
<td>2.52</td>
<td>0.15</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.99</td>
<td>0.30</td>
<td>2.84</td>
<td>0.23</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.60</td>
<td>0.28</td>
<td>2.42</td>
<td>0.19</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.74</td>
<td>0.46</td>
<td>2.71</td>
<td>0.33</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.75</td>
<td>0.31</td>
<td>2.54</td>
<td>0.18</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.69</td>
<td>0.32</td>
<td>2.66</td>
<td>0.29</td>
</tr>
</tbody>
</table>

The data presented in Tables 14 and 15 provide another way of comparing and contrasting the perceptions of Non EAC staff and EAC members. As noted above, both groups ranked potential for positive impact higher than current performance in all clusters. However, it is clear that the Non EAC staff see a greater disparity between Impact and Performance than the EAC members do. Perhaps most striking is that for the cluster Liaison with patients & families (the highest ranked cluster in terms of Impact) Non EAC staff see a much greater disparity between Impact and Performance than the EAC members do, pointing, perhaps, to a high priority area for process improvement.

Concept Systems Global, Inc. produces another helpful map, a go-zone, which can help identify and better understand high priority areas. The go-zone is a bivariate X-Y graph of ratings; the quadrants on the map are constructed by dividing the space with the mean value for each variable (Kane & Trochim, 2007, p. 126). Each point on the go-zone map represents a point in a particular cluster. Therefore, this graphic can help planners look more critically at individual action items within a cluster. To illustrate, below are Impact versus Performance go-zones for the cluster Liaison with patients & families. Figure 17 shows the go-zone for all participants, Figure 18 the
go zone for EAC members, and Figure 19 shows the go-zone of the same cluster for Non EAC staff. The numbers on the go-zone identify individual statements.

Figure 17. Go-zone: Liaison With Patients & Families, All participants
Figure 18. Go-zone: Liaison With Patients & Families, EAC members

Figure 19. Go-zone: Liaison with Patients & Families, Non EAC Staff
A comparison of the go-zone maps for the EAC members and Non EAC staff shows strong similarity between the organization of the statements. For example, both groups put the statement #15, “Provide thorough, concise recommendations when consulted,” on the outer edge of the upper right quadrant showing the activity has the highest perceived positive impact as well as the very highest performance. This indicates that the EAC would do well to continue providing concise recommendations after a consult. On the other hand, statement #7, “Decide who should be the decision maker when family is estranged and friends are sincerely involved with the patient,” is perceived by clinicians to have a strong positive impact (4.16) on care provided in the critical care unit but below adequate performance (2.87). EAC members see this same activity as having a moderate positive impact (3.55) and a better than adequate performance (3.73). Using a focused analysis such as this, the ethics advisory committees can use the data to implement very targeted changes in practice. This example demonstrates one way in which this study achieved Aim 3, providing data that may improve the efficacy of the health system in supporting clinicians and the work they do in the critical care settings. Go-zone maps for all of the clusters were created for use by the Joint Ethics Advisory Committee which oversees all of the ethics committees; JEAC members were taught how to interpret and utilize the maps for action planning and evaluation. Two additional go-zone maps (Staff development and Ethical & moral support) are presented and discussed later in this chapter. The remaining go-zone maps are not included in this dissertation.

Rating Analysis – Other Demographic Variables. To help focus other improvement efforts and to better understand varied opinions about ethics committee performance, the need for staff training and development, and views related to creating a positive ethical climate, the researchers used the demographic information to compare selected rating responses of:

- Different hospitals or units within the same hospital.
- Participants based on the number of times they had personally requested an ethics consult.
• Respondents who have been involved in multiple patient care issues brought to an ethics committee with those who have not.
• Participants who have been working in healthcare for less than 5 years with those who have worked in healthcare 5 or more years.
• Different professions particularly nurses, doctors, administrators and social workers.
• Respondents who consult an ethics committee or ethics consultant first when they encounter an ethical dilemma involving their clinical work with those who consult other resources first.

The findings presented below are selective not exhaustive; it is the information that was requested by the Director and the research advisory team to drive program and process improvement efforts.
**Comparison of Impact and Performance ratings among hospitals.** As the coordinator for all of the ethics committees within his health system, the Director was interested in comparing the rating responses of different hospitals. Figures 20, 21, and 22 compare the ratings of H1, H2, and H3 on the Impact dimension. A summary of Performance ratings by cluster and hospital are presented in Table 16.

*Figure 20. Pattern Match: Impact Rating, H1 (n=18) and H2 (n=46) (EAC members and Non EAC staff)*
Figure 21. Pattern Match: Impact rating, H2 (n=46) and H3 (n=15) (EAC members and Non EAC staff)

Figure 22. Pattern Match: Impact Rating, H1 (n=18) and H3 (n=15) (EAC members and Non EAC staff)
A comparison of the three different hospitals shows that there is not a fully consistent pattern of Impact rankings from campus to campus. For example, the highest ranked cluster for all three hospitals was Liaison with patients & families. But, among the other clusters there was also substantial variation. For example, Guidance is the second highest ranked cluster for H1 but the second to lowest cluster for H3. There is no “right or wrong” order for the clusters as each hospital is responding based upon its own perceived needs and system dynamics.

Table 16
*Performance, Cluster Averages by Hospital*

<table>
<thead>
<tr>
<th>Cluster</th>
<th>H1 n=14</th>
<th>H2 n=32</th>
<th>H3 n=10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.78</td>
<td>2.53</td>
<td>2.09</td>
</tr>
<tr>
<td>Guidance</td>
<td>2.76</td>
<td>2.63</td>
<td>2.11</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.14</td>
<td>3.01</td>
<td>2.43</td>
</tr>
<tr>
<td>Visibility</td>
<td>2.70</td>
<td>2.51</td>
<td>2.17</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>2.92</td>
<td>2.85</td>
<td>2.22</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>2.77</td>
<td>2.69</td>
<td>2.28</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.04</td>
<td>2.79</td>
<td>2.34</td>
</tr>
</tbody>
</table>

Average performance scores vary between clusters at the same hospital as well as across hospitals for the same cluster. The performance ratings at H1 are consistently higher than those of either H2 or H3. The ratings of H3 are consistently the lowest of the three hospitals in this sample. Further research would be needed to understand this pattern of ratings, but once again this points to the need for looking at ethics committees individually within the context of the hospital they serve.

*Comparison of Impact and Performance ratings of critical care units.* Based on his personal observations, the Director speculated that there would be differences
between the critical care units at H2. There were insufficient responses from H2 RMH 5 (n=4) to include this unit in a comparative analysis. However, a comparison was made between the other two critical care units, RMH 6 and RMH 4. RMH 6 is a neuro critical care unit and RMH 4 is a general critical care unit. Figure 23 and Table 17 provide information on the Impact ratings of the two units; Figure 24 and Table 18 provides comparative information on the Performance ratings.
Figure 23. Pattern Match: Impact rating, RMH 6 (n=16) and RMH 4 (n=9)

Table 17

Impact, Cluster Averages for RMH 6 (n=16) and RMH 4 (n=9)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact RMH 6</th>
<th>Impact – RMH 6 (sd)</th>
<th>Impact RMH 4</th>
<th>Impact RMH 4 (sd)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.86</td>
<td>0.48</td>
<td>3.67</td>
<td>0.63</td>
<td>0.19</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.96</td>
<td>0.43</td>
<td>3.69</td>
<td>0.63</td>
<td>0.27</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>4.17</td>
<td>0.26</td>
<td>3.96</td>
<td>0.54</td>
<td>0.21</td>
</tr>
<tr>
<td>Visibility</td>
<td>4.07</td>
<td>0.18</td>
<td>3.64</td>
<td>0.55</td>
<td>0.43</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>4.00</td>
<td>0.50</td>
<td>3.64</td>
<td>0.57</td>
<td>0.36</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>4.02</td>
<td>0.29</td>
<td>3.78</td>
<td>0.42</td>
<td>0.24</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.88</td>
<td>0.42</td>
<td>3.55</td>
<td>0.46</td>
<td>0.33</td>
</tr>
</tbody>
</table>
Table 18

Performance, Cluster Averages for RMH 6 (n=11) and RMH 4 (n=7)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform RMH 6</th>
<th>Perform RMH 6 sd</th>
<th>Perform RMH 4</th>
<th>Perform RMH 4 sd</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.49</td>
<td>0.31</td>
<td>2.21</td>
<td>0.27</td>
<td>0.28</td>
</tr>
<tr>
<td>Guidance</td>
<td>2.60</td>
<td>0.17</td>
<td>2.24</td>
<td>0.27</td>
<td>0.36</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>2.95</td>
<td>0.29</td>
<td>2.65</td>
<td>0.43</td>
<td>0.30</td>
</tr>
<tr>
<td>Visibility</td>
<td>2.53</td>
<td>0.21</td>
<td>2.14</td>
<td>0.29</td>
<td>0.39</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>2.75</td>
<td>0.34</td>
<td>2.67</td>
<td>0.45</td>
<td>0.08</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>2.57</td>
<td>0.17</td>
<td>2.36</td>
<td>0.25</td>
<td>0.21</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>2.67</td>
<td>0.26</td>
<td>2.46</td>
<td>0.40</td>
<td>0.21</td>
</tr>
</tbody>
</table>
RMH 6 and RMH 4 are critical care units in the same hospital and are served by the same ethics committee. Therefore, it is thought-provoking that Impact ratings for RMH 6 were higher on all of the clusters than the Impact ratings of RMH 4 and the Performance ratings followed the same pattern. In addition, the correlation between the rankings of the clusters was not perfect on either rating dimension although it was still strong. Of interest, the biggest difference in scores between RMH 6 and RMH 4 was on Visibility (on both Impact and Performance).

Comparison of Impact and Performance ratings of critical care unit clinicians and other hospital clinicians. Some clinicians (e.g., nurses) are assigned exclusively to a critical care unit; other healthcare personnel come to the unit as needed to provide specific therapeutic services. Residents and interns identified themselves as affiliated with H2 but not with specific critical care units. Therefore, “general clinicians” includes attending physicians, house staff, and allied health professionals that are not permanently assigned to a critical care unit. Note: All of the clinicians who work in or are affiliated with the critical care unit have specialized skills and the term “general” is used for the sake of convenience. Figure 25 is a pattern match comparing the Impact ratings of these two groups at H2, and Figure 26 is a pattern match of the comparable Performance ratings. Summary statistics are provided in Tables 19 and 20.
Figure 25. Pattern Match: Impact Rating, H2 General Clinicians (n=17) and H2 Critical Care Clinicians (n=29)

Table 19

Impact, Cluster Averages for H2 General Clinicians (n=17) and H2 Critical Care Clinicians (n=29)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact H2 general clinicians</th>
<th>Impact H2 CCU clinicians</th>
<th>Impact H2 CCU clinicians</th>
<th>Difference in ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.49</td>
<td>3.81</td>
<td>0.46</td>
<td>0.32</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.58</td>
<td>3.86</td>
<td>0.41</td>
<td>0.28</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.71</td>
<td>4.13</td>
<td>0.33</td>
<td>0.42</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.44</td>
<td>3.93</td>
<td>0.25</td>
<td>0.49</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.52</td>
<td>3.91</td>
<td>0.49</td>
<td>0.39</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.56</td>
<td>3.95</td>
<td>0.31</td>
<td>0.39</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.53</td>
<td>3.83</td>
<td>0.38</td>
<td>0.30</td>
</tr>
</tbody>
</table>
Table 20

Performance, Cluster Averages for H2 General Clinicians (n=11) and H2 Critical Care Clinicians (n=21)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform H2 general clinicians</th>
<th>Perform H2 general clinicians ( sd )</th>
<th>Perform H2 CCU clinicians</th>
<th>Perform H2 CCU clinicians ( sd )</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.78</td>
<td>0.40</td>
<td>2.40</td>
<td>0.46</td>
<td>0.38</td>
</tr>
<tr>
<td>Guidance</td>
<td>2.85</td>
<td>0.37</td>
<td>2.50</td>
<td>0.41</td>
<td>0.35</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.28</td>
<td>0.40</td>
<td>2.88</td>
<td>0.33</td>
<td>0.40</td>
</tr>
<tr>
<td>Visibility</td>
<td>2.74</td>
<td>0.35</td>
<td>2.38</td>
<td>0.25</td>
<td>0.36</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.02</td>
<td>0.45</td>
<td>2.76</td>
<td>0.49</td>
<td>0.26</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.07</td>
<td>0.39</td>
<td>2.50</td>
<td>0.31</td>
<td>0.57</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.08</td>
<td>0.28</td>
<td>2.63</td>
<td>0.38</td>
<td>0.45</td>
</tr>
</tbody>
</table>
A comparison of the ratings of clinicians at H2 who come to the critical care units as needed and those that work in the H2 units full time indicates that there is a moderate to strong correlation between the two groups both in how they rank ordered how EACs may have a potential positive impact on the work in the CCUs ($r = 0.73$) and about the current performance of the EACs ($r = 0.88$). However, on every cluster, CCU clinicians rated potential positive impact higher than did the general clinicians. The cluster with the biggest difference in Impact ratings was visibility (0.49). On every cluster, the CCU clinicians rated the current performance of the EACs less favorably than did the general clinicians. The cluster with the biggest difference in Performance ratings was Outreach & accessibility. Because of small sample sizes, a comparison could not be made between the critical care staff and general clinicians at H1 and H3.

**Comparison of Impact and Performance ratings based on frequency of requesting an ethics consult.** The research advisory team speculated that individuals who have initiated a request for an ethics consult might have a different viewpoint on the work of the ethics committee than those who have never initiated a request. With this in mind, all participants were asked how often they had initiated a consult request (Never, 1-3 times, 4-6 times, or 7 or more times). While multiple comparisons could be made, only two are presented here: 1) those who have requested a consult seven or more times and those who have requested a consult less than seven times and 2) those who have requested a consult with those who have never personally requested a consult. A comparison of those who have requested a consult seven or more times and those who have requested a consult less than seven times is made in Figures 27 and 28 and Tables 21 and 22. A comparison between those who have made a referral to an ethics committee and those who have not is presented in Figures 29 and 30 and Tables 23 and 24.
Figure 27. Pattern Match: Impact Rating, Requested an Ethics Consult 7 or More Times (n=7) and Those Who Have Requested a Consult Less Than 7 Times (n=77)

Table 21

Impact, Cluster Averages for Requested an Ethics Consult 7 or More Times (n=7) and Requested a Ethics Consult Less Than 7 Times (n=77)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact 7 or more</th>
<th>Impact 7 or more sd</th>
<th>Impact &lt;7 times</th>
<th>Impact &lt;7 times sd</th>
<th>Difference in ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.79</td>
<td>0.54</td>
<td>3.65</td>
<td>0.37</td>
<td>0.14</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.67</td>
<td>0.61</td>
<td>3.70</td>
<td>0.41</td>
<td>0.03</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.99</td>
<td>0.36</td>
<td>3.93</td>
<td>0.29</td>
<td>0.06</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.83</td>
<td>0.53</td>
<td>3.51</td>
<td>0.38</td>
<td>0.32</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.81</td>
<td>0.64</td>
<td>3.67</td>
<td>0.49</td>
<td>0.14</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>4.10</td>
<td>0.53</td>
<td>3.71</td>
<td>0.31</td>
<td>0.39</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.99</td>
<td>0.30</td>
<td>3.65</td>
<td>0.31</td>
<td>0.34</td>
</tr>
</tbody>
</table>
Figure 28. Pattern Match: Performance Rating, Requested an Ethics Consult 7 or More Times (n=6) and Those Who Have Requested a Consult < 7 Times (n=55)

Table 22

Performance, Cluster Averages for Requested an Ethics Consult More Than 7 Times (n=6) and Requested a Consult Less Than 7 Times (n=55)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform 7 or more n=6</th>
<th>Impact – 7 or more sd</th>
<th>Performance &lt; 7 times n=55</th>
<th>Perform &lt;7 times sd</th>
<th>Difference in ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.45 0.62</td>
<td>2.54 0.26</td>
<td>0.17</td>
<td>0.09</td>
<td></td>
</tr>
<tr>
<td>Guidance</td>
<td>2.35 0.63</td>
<td>2.60 0.17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.40 0.86</td>
<td>2.92 0.23</td>
<td>0.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visibility</td>
<td>2.56 0.65</td>
<td>2.47 0.22</td>
<td>0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison with system</td>
<td>2.97 0.96</td>
<td>2.76 0.36</td>
<td>0.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>2.68 0.66</td>
<td>2.65 0.23</td>
<td>0.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>2.89 0.54</td>
<td>2.76 0.31</td>
<td>0.13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
There does appear to be a difference between those who have made seven or more personal referrals to an ethics committee (High requesters) and those who have made referrals or requests for ethics consultations fewer than seven times. For example, there is a low correlation ($r = 0.33$) between the ranking of the Impact clusters between these two groups. High requesters are the only sub-group in the study to rate Outreach & accessibility as the highest impact cluster. The rating for Ethical & moral support is also among the top ranked Impact clusters for the High requesters while for all others this is closer to the bottom. The Performance ratings point to the fact that High requesters feel that the EACs perform better in acting as a Liaison with patients & families than do the other study participants. The High requester sample is very small and the standard deviation of their responses is high. Therefore, one must be very cautious in making any inferences from this data. However, the trends in this data would seem to indicate that High requesters see the ethics committee differently than do the others.
Figure 29. Pattern Match: Impact Rating, Requested an Ethics Consult (n=32) and Those Who Have Never Requested a Consult (n=52)

Table 23

Impact, Cluster Averages for Requested an Ethics Consults (n=32) and Never Requested an Ethics Consult (n=52)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact Requesters</th>
<th>Impact Requesters sd</th>
<th>Impact Never n=52</th>
<th>Impact Never sd</th>
<th>Difference in ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.65</td>
<td>0.36</td>
<td>3.67</td>
<td>0.39</td>
<td>0.02</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.66</td>
<td>0.44</td>
<td>3.73</td>
<td>0.42</td>
<td>0.07</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.97</td>
<td>0.33</td>
<td>3.91</td>
<td>0.28</td>
<td>0.06</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.56</td>
<td>0.34</td>
<td>3.53</td>
<td>0.34</td>
<td>0.03</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.70</td>
<td>0.27</td>
<td>3.67</td>
<td>0.53</td>
<td>0.03</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.78</td>
<td>0.30</td>
<td>3.73</td>
<td>0.35</td>
<td>0.05</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.73</td>
<td>0.29</td>
<td>3.64</td>
<td>0.33</td>
<td>0.09</td>
</tr>
</tbody>
</table>
Figure 30. Pattern Match: Performance Rating, Requested an Ethics Consult (n=25) and Those Who Have Never Requested a Consult (n=3)

Table 24

Performance, Cluster Averages for Requested an Ethics Consults (n=25) and Never Requested an Ethics Consult (n=36)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform Requestors</th>
<th>Perform Requestors sd</th>
<th>Perform Never</th>
<th>Perform Never sd</th>
<th>Difference</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.79</td>
<td>0.40</td>
<td>2.35</td>
<td>0.21</td>
<td>0.45</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Guidance</td>
<td>2.80</td>
<td>0.29</td>
<td>2.42</td>
<td>0.19</td>
<td>0.38</td>
<td>&lt;0.005</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.31</td>
<td>0.32</td>
<td>2.73</td>
<td>0.25</td>
<td>0.58</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Visibility</td>
<td>2.79</td>
<td>0.31</td>
<td>2.26</td>
<td>0.22</td>
<td>0.53</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.06</td>
<td>0.50</td>
<td>2.59</td>
<td>0.39</td>
<td>0.47</td>
<td>&lt;0.02</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>2.91</td>
<td>0.39</td>
<td>2.47</td>
<td>0.22</td>
<td>0.44</td>
<td>&lt;0.005</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.07</td>
<td>0.36</td>
<td>2.56</td>
<td>0.32</td>
<td>0.51</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
There a striking similarity between the Impact ratings of those who have made a referral to or requested an ethics consult and those who have not. The correlation between the two groups on the pattern match showed a very strong correlation \( (r=0.92) \) and there was very little difference in the average ratings of the clusters with the greatest difference being only 0.09. In the Performance rating, the two groups also showed a very strong correlation \( (r=0.95) \) in the relative ranking of the clusters. However, the average ratings on the clusters show that those who have requested consults rate the EAC performance better on all clusters. In fact, all of these differences are statistically significant with a range of \( p<0.02 \) to \( p<0.001 \). Note: T-tests were only calculated where both samples \( n \) was greater than or equal to 19. T-tests were only calculated for comparisons being made on the same rating dimension (e.g. either Performance or Impact). This standard was recommended by the statistician at Concept Systems (Scott Rosas, personal communication, March 13, 2013). For many of the pattern matches the sample sizes were too small (less than 19) to calculate a t-test. However, for this set of participants (Requested an ethics consult and Never requested an ethics consult), the samples were large enough for a comparison to be made.

*Comparison of Impact and Performance ratings based on frequency of being personally involved in a patient care issue brought to an EAC.* The research advisory team was interested in seeing whether individuals who had been personally involved (one or more times) in a patient care issue that was brought to an ethics advisory committee had a different assessment of the Impact and Performance of committee activities than did those who had never been involved in a patient care issue brought to the committee. Figures 31 and 32 compare these two groups and Tables 25 and 26 provide summary statistics.
Figure 31. Pattern Match: Impact ratings, Involved in Patient Care Issue Brought to EAC (n=58) and Never Involved in a Patient Care Issue Brought to EAC (n=26)

Table 25

Impact, Cluster Averages for Involved in Patient Care Issue Brought to EAC (n=58) and Never Involved in a Patient Care Issue Brought to EAC (n=26)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact Involved</th>
<th>Impact involved sd</th>
<th>Impact Never involved</th>
<th>Impact Never involved sd</th>
<th>Difference in ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.66</td>
<td>0.14</td>
<td>3.66</td>
<td>0.31</td>
<td>0.00</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.69</td>
<td>0.47</td>
<td>3.72</td>
<td>0.35</td>
<td>0.03</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>4.01</td>
<td>0.33</td>
<td>3.78</td>
<td>0.23</td>
<td>0.23</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.58</td>
<td>0.38</td>
<td>3.44</td>
<td>0.23</td>
<td>0.14</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.72</td>
<td>0.52</td>
<td>3.62</td>
<td>0.46</td>
<td>0.10</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.82</td>
<td>0.36</td>
<td>3.58</td>
<td>0.30</td>
<td>0.24</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.71</td>
<td>0.32</td>
<td>3.61</td>
<td>0.32</td>
<td>0.10</td>
</tr>
</tbody>
</table>
Figure 32. Pattern Match: Performance ratings, Involved in patient care issue brought to EAC (n=42) and Never involved in patient care issue brought to EAC (n=19)

Table 26

Performance, Cluster Averages for Involved in Patient Care Issue Brought to EAC (n=42) and Never Involved in Patient Care Issue Brought to EAC (n=19)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform Involved</th>
<th>Perform involved sd</th>
<th>Perform Never involved</th>
<th>Perform Never involved sd</th>
<th>Difference</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.41</td>
<td>0.33</td>
<td>2.79</td>
<td>0.24</td>
<td>0.38</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Guidance</td>
<td>2.43</td>
<td>0.25</td>
<td>2.89</td>
<td>0.20</td>
<td>0.03</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>2.87</td>
<td>0.30</td>
<td>3.17</td>
<td>0.22</td>
<td>0.23</td>
<td>&lt;0.005</td>
</tr>
<tr>
<td>Visibility</td>
<td>2.36</td>
<td>0.33</td>
<td>2.75</td>
<td>0.14</td>
<td>0.14</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>2.67</td>
<td>0.45</td>
<td>3.04</td>
<td>0.37</td>
<td>0.10</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>2.56</td>
<td>0.34</td>
<td>2.84</td>
<td>0.20</td>
<td>0.24</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>2.70</td>
<td>0.32</td>
<td>2.94</td>
<td>0.29</td>
<td>0.10</td>
<td>n.s</td>
</tr>
</tbody>
</table>
The correlation between the Impact ratings of those who had been involved (at least once) in a patient care issue and those who had not was $r = 0.68$, a moderate correlation. However, the difference in Impact rating scores was very small between the two groups, with the largest difference being only 0.24 (Outreach & accessibility). The correlation on Performance was very strong, with $r = 0.92$. Of note, those who had been involved (at least once) in a patient care issue brought to an EAC for consultation rated the committee’s performance lower in every cluster than did those who had never been involved in a patient care issue. In fact the difference was significant at the $p<0.001$ for two clusters, Staff development and Guidance and at the $p<0.005$ level for Liaison with patients & families.

**Staff development go-zone comparisons of those who have worked in healthcare fewer than five years with those who have worked in healthcare five years or more.** Staff development has historically been one of the main functions of clinical ethics committees. This study continues to reflect the importance of training staff about ethics as more than 25% of all statements fall into the Staff development cluster. The Director wanted to use the results of this study to prioritize training efforts. Therefore, he requested a go-zone analysis comparing the needs of those who have worked in healthcare fewer than five years with those who have worked in healthcare five years or more; he hypothesized that the learning needs of the two groups might be different. By using a go-zone analysis, the researcher and the Director wanted to identify specific action items that could be targeted for different sets of employees.
Figure 33. Go-zone: Staff Development, Worked in Healthcare < 5 years (Impact Raters, n=17 and Performance Raters, n=10)

Figure 34. Go-zone: Staff Development, Worked in Healthcare 5 or More Years (Impact Raters, n=67 and Performance Raters, n=51)
A comparison of the two go-zone maps shows some congruence between the perceptions of the two groups of employees. Most of the items with above average ratings in Impact were the same on both maps. A few items were given higher impact scores by the newer employees than by the more seasoned staff. For example:

8. Provide education and training to staff on when they are permitted to be relieved from a case for ethical reasons

11. Provide information sheets at the start of the ICU experience with examples of commonly encountered ethical dilemmas that may arise

68. Provide regular staff education on ethical standards and issues related to critical care

76. Educate staff on what treatments physicians may refuse to provide

Both sets of employees rated Performance for almost every item in staff development below a 3 (Adequately) although, on average, more experienced staff were less positive about EAC performance in this area. Overall, these maps indicate that EACs could serve the needs of all staff better by continuing to focus on the items in the right upper quadrant while increasing work on items in the right lower quadrants of the 5 or more years go-zone. Activities #8, 11, 68 and 76 should be included in the educational offerings targeted primarily to newer clinicians.

Comparison of Impact and Performance ratings of nurses, attending physicians, and house staff (interns and residents). The literature indicates that nurses, attending physicians, and house staff have different perceptions of ethics advisory committees and different needs from ethics consultations. A comparison of these three groups is presented in Tables 27 and 28. Because of the small sample sizes, medical and surgical specialties were combined.
### Table 27

*Impact, Cluster Averages for Nurses (n=33), Attending Physicians (n=9), and House Staff (n=9)*

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact nurses</th>
<th>Impact nurses sd</th>
<th>Impact attendings</th>
<th>Impact attendings sd</th>
<th>Impact house staff</th>
<th>Impact house staff sd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.77</td>
<td>0.40</td>
<td>3.44</td>
<td>0.62</td>
<td>3.39</td>
<td>0.34</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.87</td>
<td>0.42</td>
<td>3.57</td>
<td>0.38</td>
<td>3.38</td>
<td>0.40</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>4.16</td>
<td>0.33</td>
<td>3.76</td>
<td>0.34</td>
<td>3.33</td>
<td>0.34</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.81</td>
<td>0.27</td>
<td>3.15</td>
<td>0.70</td>
<td>3.07</td>
<td>0.51</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.91</td>
<td>0.46</td>
<td>3.52</td>
<td>0.62</td>
<td>3.26</td>
<td>0.44</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.75</td>
<td>0.30</td>
<td>3.60</td>
<td>0.43</td>
<td>3.24</td>
<td>0.26</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.75</td>
<td>0.34</td>
<td>3.53</td>
<td>0.45</td>
<td>3.24</td>
<td>0.40</td>
</tr>
</tbody>
</table>

### Table 28

*Performance, Cluster Averages for Nurses (n=22), Attending Physicians (n=6), and House Staff (n=7)*

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform nurses</th>
<th>Perform nurses sd</th>
<th>Perform attendings</th>
<th>Perform attendings sd</th>
<th>Perform house staff</th>
<th>Perform house staff sd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.36</td>
<td>0.23</td>
<td>2.78</td>
<td>0.55</td>
<td>3.17</td>
<td>0.36</td>
</tr>
<tr>
<td>Guidance</td>
<td>2.47</td>
<td>0.14</td>
<td>2.68</td>
<td>0.57</td>
<td>3.26</td>
<td>0.32</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>2.78</td>
<td>0.20</td>
<td>3.26</td>
<td>0.58</td>
<td>3.57</td>
<td>0.32</td>
</tr>
<tr>
<td>Visibility</td>
<td>2.35</td>
<td>0.18</td>
<td>2.31</td>
<td>0.47</td>
<td>3.12</td>
<td>0.22</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>2.63</td>
<td>0.29</td>
<td>2.71</td>
<td>0.72</td>
<td>3.38</td>
<td>0.38</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>2.45</td>
<td>0.19</td>
<td>2.85</td>
<td>0.56</td>
<td>3.42</td>
<td>0.28</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>2.50</td>
<td>0.23</td>
<td>2.93</td>
<td>0.62</td>
<td>3.45</td>
<td>0.35</td>
</tr>
</tbody>
</table>

On the Impact dimension, nurses had higher average cluster ratings than did either the attending physicians or the house staff. Attending physicians had higher average Impact ratings than the house staff did. A reverse pattern holds true for
Performance ratings with house staff giving higher average Performance scores on all clusters than either attending physicians or nurses. Attendings gave higher average Performance ratings on six out of seven clusters than nurses did; on the seventh cluster the Performance rating score was almost the same (attendings, 2.31 and nurses, 2.35). The differences in the scores between attendings and house staff seems to support earlier research which has treated these as two separate groups rather than combining them into one category, “physicians.”

Comparison of Impact and Performance ratings of nurses and other allied health staff. The research team wished to compare the ratings of nurses with other allied health professionals. In this study, case managers, chaplains, dieticians, occupational therapists, pharmacists, physical therapists, respiratory therapists and social workers were included in the allied health professional category. No case managers or occupational therapists participated in the rating phase of the study. Rating data is for staff at H1, H2 and H3. Tables 29 and 30 show the summary statistics for these comparisons.

Table 29
Impact, Cluster Averages for Nurses (n=33) and Allied Health Professionals (n=21)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact nurses</th>
<th>Impact nurses sd</th>
<th>Impact allied health</th>
<th>Impact allied health sd</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.77</td>
<td>0.40</td>
<td>3.62</td>
<td>0.40</td>
<td>0.15</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.87</td>
<td>0.42</td>
<td>3.70</td>
<td>0.53</td>
<td>0.17</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>4.16</td>
<td>0.33</td>
<td>4.00</td>
<td>0.35</td>
<td>0.16</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.81</td>
<td>0.27</td>
<td>3.50</td>
<td>0.41</td>
<td>0.31</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.91</td>
<td>0.46</td>
<td>3.67</td>
<td>0.61</td>
<td>0.24</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.75</td>
<td>0.30</td>
<td>3.71</td>
<td>0.38</td>
<td>0.04</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.75</td>
<td>0.34</td>
<td>3.80</td>
<td>0.32</td>
<td>0.15</td>
</tr>
</tbody>
</table>
Table 30

Performance, Cluster Averages for Nurses (n=22) and Allied Health Professionals (n=16)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform nurses</th>
<th>Perform nurses sd</th>
<th>Perform allied health</th>
<th>Perform allied health sd</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.36</td>
<td>0.23</td>
<td>2.34</td>
<td>0.32</td>
<td>0.02</td>
</tr>
<tr>
<td>Guidance</td>
<td>2.47</td>
<td>0.14</td>
<td>2.35</td>
<td>0.27</td>
<td>0.12</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>2.78</td>
<td>0.20</td>
<td>2.87</td>
<td>0.28</td>
<td>0.09</td>
</tr>
<tr>
<td>Visibility</td>
<td>2.35</td>
<td>0.18</td>
<td>2.39</td>
<td>0.24</td>
<td>0.04</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>2.63</td>
<td>0.29</td>
<td>2.60</td>
<td>0.51</td>
<td>0.03</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>2.45</td>
<td>0.19</td>
<td>2.50</td>
<td>0.34</td>
<td>0.05</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>2.50</td>
<td>0.23</td>
<td>2.68</td>
<td>0.39</td>
<td>0.18</td>
</tr>
</tbody>
</table>

The differences between the Impact ratings of nurses and other allied health personnel range between 0.04 (Outreach & accessibility) and 0.31 (Visibility). The nurses who are all working exclusively in the critical care unit have indicated that the day-to-day visibility of the ethics committee in unit activities is more important than have the other allied health staff who work throughout the hospital and only come to the units as needed. The range of differences between the Performance ratings is even smaller than those of the Impact ratings: 0.02 (Staff development) to 0.18 (Ethical & moral support).

Comparison of Impact ratings of social workers and other allied health professionals. The researcher was interested in learning whether medical social workers assigned to the critical care units have a different perspective on the work of the ethics committee than do other allied health professionals. There were sufficient Impact ratings (n=5) from social workers to do the analysis for this rating dimension but not a sufficient number to make comparisons on the Performance dimension. Below are pattern matches and summary data showing a comparison between social workers and nurses and social workers and other non-nursing, allied health professionals. The allied health professionals included in this analysis were:
chaplains, dieticians, pharmacists, physical therapists, and respiratory therapists; there were no case manager or occupational therapist Impact raters.

![Figure 35. Pattern Match: Impact Rating, Social Workers (n=5) and Nurses (n=33)](image)

### Table 31

**Impact, Cluster Averages for Social Workers (n=5) and Nurses (n=33)**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact SW</th>
<th>Impact SW sd</th>
<th>Impact RN</th>
<th>Impact RN sd</th>
<th>Difference in ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>4.12</td>
<td>0.43</td>
<td>3.77</td>
<td>0.40</td>
<td>0.35</td>
</tr>
<tr>
<td>Guidance</td>
<td>4.00</td>
<td>0.48</td>
<td>3.87</td>
<td>0.42</td>
<td>0.13</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>4.17</td>
<td>0.48</td>
<td>4.16</td>
<td>0.33</td>
<td>0.01</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.80</td>
<td>0.43</td>
<td>3.81</td>
<td>0.27</td>
<td>0.01</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.83</td>
<td>0.59</td>
<td>3.91</td>
<td>0.46</td>
<td>0.08</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>4.18</td>
<td>0.41</td>
<td>3.75</td>
<td>0.30</td>
<td>0.35</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>4.29</td>
<td>0.31</td>
<td>3.75</td>
<td>0.34</td>
<td>0.54</td>
</tr>
</tbody>
</table>
There are some strong similarities and differences between the response patterns of the social workers and the nurses. Both groups gave almost identical average ratings to Liaison with patients & families and Visibility. However, the pattern match of social workers and nurses has an $r=0.06$ showing a weak to negligible correlation between the cluster rankings. Particularly striking are the differences in the relative placement of Liaison with the system, Staff development, and Ethical & moral support. While nurses endorse Liaison with the system as the second highest ranked cluster in terms of Impact, social workers rank this cluster second to lowest. Despite this difference in the ranking of this cluster, the average Impact ratings between the two groups was almost the same (3.83 and 3.91). In contrast, social workers rank Staff development higher than do nurses and also give it a higher Impact rating. The difference in the Staff development Impact ratings was 0.35. Perhaps most striking is both the relative ranking and the average ratings of Ethical & moral support. Social workers ranked this cluster the highest while nurses ranked it at the bottom. The difference in the Ethical & moral support ratings between the two groups was 0.54.
Table 32

*Impact, Cluster Averages for Social Workers (n=5) and Non-nursing Allied Health Professionals (n=16)*

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact SW</th>
<th>Impact SW sd</th>
<th>Impact Non-RN allied health</th>
<th>Impact Non-RN allied health sd</th>
<th>Difference in ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>4.12</td>
<td>0.43</td>
<td>3.46</td>
<td>0.45</td>
<td>0.66</td>
</tr>
<tr>
<td>Guidance</td>
<td>4.00</td>
<td>0.48</td>
<td>3.60</td>
<td>0.62</td>
<td>0.40</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>4.17</td>
<td>0.48</td>
<td>3.95</td>
<td>0.36</td>
<td>0.22</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.80</td>
<td>0.43</td>
<td>3.41</td>
<td>0.46</td>
<td>0.39</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.83</td>
<td>0.59</td>
<td>3.61</td>
<td>0.65</td>
<td>0.22</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>4.18</td>
<td>0.41</td>
<td>3.56</td>
<td>0.40</td>
<td>0.22</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>4.29</td>
<td>0.31</td>
<td>3.65</td>
<td>0.39</td>
<td>0.64</td>
</tr>
</tbody>
</table>

Figure 36. Pattern Match: Impact Rating, Social Workers (n=5) and Non-nursing Allied Health Professionals (n=16)
The Impact pattern match comparing social workers and other non-nursing, allied health staff shows a moderate correlation of $r=0.43$. Both groups placed Visibility as the lowest ranked cluster. However, no other clusters were ranked the same. The difference in Impact ratings was quite high ranging from 0.22 (Liaison with patients & families and Liaison with system) to 0.66 (Staff development). The difference in Impact ratings for Ethical & moral support was also high at 0.64.

The two pattern matches comparing social workers to nurses and other allied health personnel point to some interesting underlying differences among these sets of healthcare personnel. However, the small sample sizes and relatively large standard deviations should temper any immediate conclusions.

**Comparison of Impact and Performance ratings of administrators and staff providing patient care.** Administrators and managers may have a different perspective on how the ethics committees can have the greatest positive impact on the care provided in the critical care unit than do staff who are seeing patients. Similarly, administrators may rate the performance of the EAC activities differently. Because administrators make up such a high percentage of EAC membership at OhioHealth (34.4%), it is important to understand whether these committee members see ethics committee activities in the same way as care providers do. Respondents who checked “Other” or “No answer” were excluded from this analysis. Respondents self-identified as administrators/managers; some of these respondents may have a clinical background. Figures 37 and 38 and Tables 33 and 34 provide a comparison between these two groups.
Figure 37. Pattern Match: Impact Rating, Administrators (n=5) and Staff Providing Care (n=72)

Table 33

Impact, Cluster Averages for Administrators (n=5) and Staff Providing Patient Care (n=72)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact admin</th>
<th>Impact admin sd</th>
<th>Impact provide care</th>
<th>Impact provide care sd</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.95</td>
<td>0.38</td>
<td>3.63</td>
<td>0.39</td>
<td>0.32</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.78</td>
<td>0.58</td>
<td>3.71</td>
<td>0.41</td>
<td>0.08</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>3.69</td>
<td>0.59</td>
<td>3.95</td>
<td>0.29</td>
<td>0.26</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.60</td>
<td>0.40</td>
<td>3.54</td>
<td>0.35</td>
<td>0.06</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.62</td>
<td>0.68</td>
<td>3.69</td>
<td>0.49</td>
<td>0.07</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.93</td>
<td>0.36</td>
<td>3.72</td>
<td>0.31</td>
<td>0.21</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.64</td>
<td>0.45</td>
<td>3.68</td>
<td>0.30</td>
<td>0.04</td>
</tr>
</tbody>
</table>
**Table 34**

*Performance, Cluster Averages for Administrators (n=5) and Staff Providing Care (n=51)*

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform admin</th>
<th>Perform admin sd</th>
<th>Perform provide care</th>
<th>Perform provide care sd</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>2.52</td>
<td>0.50</td>
<td>2.52</td>
<td>0.27</td>
<td>0.00</td>
</tr>
<tr>
<td>Guidance</td>
<td>2.44</td>
<td>0.31</td>
<td>2.57</td>
<td>0.20</td>
<td>0.13</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>2.87</td>
<td>0.48</td>
<td>2.97</td>
<td>0.23</td>
<td>0.10</td>
</tr>
<tr>
<td>Visibility</td>
<td>2.33</td>
<td>0.76</td>
<td>2.46</td>
<td>0.21</td>
<td>0.13</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>2.97</td>
<td>0.81</td>
<td>2.73</td>
<td>0.36</td>
<td>0.24</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>2.64</td>
<td>0.56</td>
<td>2.65</td>
<td>0.26</td>
<td>0.01</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>2.84</td>
<td>0.69</td>
<td>2.74</td>
<td>0.30</td>
<td>0.10</td>
</tr>
</tbody>
</table>
The pattern match comparing the Impact ratings of administrators and staff providing care shows a very weak to negligible correlation ($r=0.06$). While administrators had Liaison with patients & families as the fourth highest ranked Impact cluster, those providing patient care had it at the top. In contrast, administrators rated Staff development as the cluster with the highest potential positive Impact but those who provide care placed this cluster second to last. The pattern match for Performance shows more congruence with a strong correlation of $r = 0.84$. The Performance ratings themselves were also quite close with differences ranging from 0.00 to 0.24.

**Comparison of Impact and Performance rating by racial group.** Although the research team hoped to compare the rating data of different racial groups, this analysis was not possible because 81 of the 84 raters self-identified as Caucasian/White.

**Comparison of Impact and Performance ratings of those who consult an ethics committee first when they have questions about an ethical dilemma involving clinical work with those who consult another resource first.** To better understand where staff get support and advice when struggling with ethical issues encountered in practice, rating participants were asked to indicate who they consult first. Figures 39 and 40 and Tables 35 and 36 present a comparison between those who use EAC services first and those who find other resources.
Figure 39. Pattern Match: Impact Rating, Those Who Consult the EAC first (n=9) and Those Who Use Other Resources First (n=74)

Table 35
Impact, Cluster Averages for Those Who Consult the EAC first (n=9) and Those Who Use Other Resources First (n=74)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Impact EAC first</th>
<th>Impact EAC first sd</th>
<th>Impact other resource</th>
<th>Impact other resource sd</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.71</td>
<td>0.47</td>
<td>3.67</td>
<td>0.36</td>
<td>0.04</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.62</td>
<td>0.63</td>
<td>3.72</td>
<td>0.40</td>
<td>0.10</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>4.19</td>
<td>0.31</td>
<td>3.92</td>
<td>0.30</td>
<td>0.27</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.48</td>
<td>0.60</td>
<td>3.56</td>
<td>0.32</td>
<td>0.08</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.80</td>
<td>0.60</td>
<td>3.68</td>
<td>0.49</td>
<td>0.12</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>4.00</td>
<td>0.54</td>
<td>3.72</td>
<td>0.31</td>
<td>0.28</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.96</td>
<td>0.37</td>
<td>3.66</td>
<td>0.31</td>
<td>0.30</td>
</tr>
</tbody>
</table>
Figure 40. Pattern Match: Performance Rating, Those Who Consult the EAC first (n=7) and Those Who Use Other Resources First (n=53)

Table 36

Performance, Cluster Averages for Those Who Consult the EAC first (n=7) and Those Who Use Other Resources First (n=53)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Perform EAC first</th>
<th>Perform EAC first sd</th>
<th>Perform other resource</th>
<th>Perform other resource sd</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff development</td>
<td>3.35</td>
<td>0.64</td>
<td>2.42</td>
<td>0.24</td>
<td>0.93</td>
</tr>
<tr>
<td>Guidance</td>
<td>3.27</td>
<td>0.63</td>
<td>2.49</td>
<td>0.17</td>
<td>0.78</td>
</tr>
<tr>
<td>Liaison with patients &amp; families</td>
<td>4.03</td>
<td>0.49</td>
<td>2.83</td>
<td>0.25</td>
<td>1.17</td>
</tr>
<tr>
<td>Visibility</td>
<td>3.17</td>
<td>0.40</td>
<td>2.40</td>
<td>0.24</td>
<td>0.77</td>
</tr>
<tr>
<td>Liaison with system</td>
<td>3.54</td>
<td>0.78</td>
<td>2.68</td>
<td>0.37</td>
<td>0.86</td>
</tr>
<tr>
<td>Outreach &amp; accessibility</td>
<td>3.48</td>
<td>0.59</td>
<td>2.54</td>
<td>0.24</td>
<td>0.94</td>
</tr>
<tr>
<td>Ethical &amp; moral support</td>
<td>3.70</td>
<td>0.44</td>
<td>2.66</td>
<td>0.33</td>
<td>1.04</td>
</tr>
</tbody>
</table>
The Impact pattern match shows a strong correlation ($r=0.79$) between those who go to an EAC first for advice and those who go to other resources first. The differences in cluster ratings on the Impact dimension range from 0.04 to 0.30. The Performance pattern match shows a very strong correlation ($r=0.94$). Despite this very strong correlation, however, the difference in cluster ratings between the two groups varies from a low of 0.77 for Visibility to a high of 1.17 for Liaison with patients & families. In other words, although the two groups rank order the Performance clusters in a very similar way, the assessment of how well the EAC perform the different activities is very different. Those who go to the EAC first rate the Performance of the EAC higher in every area than do those who go to other resources first.

**A go-zone analysis of Ethical & moral support.** A go-zone analysis of the cluster, Ethical & moral support, helps identify the EAC actions that could have the most impact in assisting staff in this domain.

![Go-Zone: Ethical & Moral Support Non EAC Staff](image)

*Figure 41. Go-Zone: Ethical & Moral Support Non EAC Staff*
The statements to the right of 3.68 on the x-axis are those that are seen as having the most positive impact on care in the critical care unit. Six items are in the upper right hand quadrant indicating that these activities are currently performed at better than the average rating (2.66); this average rating is between “poor” and “adequately.” The statements in this quadrant are:

4. Ensure that whatever steps are taken in patient care are consistent with ethical practice, Ohio law and OhioHealth policy

9. Mediate between staff members who are in disagreement on how to approach an ethical dilemma

10. Provide opportunities for employees to be able to talk to someone about their feelings when dealing with critically ill patients

41. Get opinions from staff directly involved in care of the patient

49. Talk with physicians and staff about the decision making behind the conclusions reached in an ethics consult

57. Hear from all sides of the ethical dilemma in a private setting before discussing with the entire committee

There are four items in the lower right quadrant. These items have been rated by clinicians as potentially having a greater than average positive impact on care but are perceived to have a less than average performance by the EAC. The items in this quadrant are:

13. Provide support for staff who wish to be relieved from a case for ethical reasons

25. Create a safe haven where staff can discuss distressing ethical concerns

47. When an ethical dilemma has not been handled in an ideal way, have non-committee staff participate in committee review of the dilemma

71. Facilitate provision of appropriate support when staff are showing signs of burnout
There were seven other suggestions included in the Ethical & moral support cluster. These items were all rated below average on the Impact dimension although all were rated, on average, at least a 3 (moderate positive impact) by clinicians:

27. Help staff connect with pastoral care if staff’s personal religious beliefs are being challenged

13. Provide support for staff who wish to be relieved from a case for ethical reasons

51. Meet with staff one on one to understand what might be learned from a particular case

56. Provide peer to peer support groups for staff dealing with difficult ethical issues

57. Hear from all sides of the ethical dilemma in a private setting before discussing with the entire committee

77. Acknowledge individuals who demonstrate high quality ethical decision making so they can serve as a role models for peers

94. Provide chart notes (exclusively available to physicians) to help with documentation
Chapter 5: Discussion

Introduction

The purpose of this exploratory, mixed methods study was to gather data that would provide a better understanding of how ethics committees, particularly those in a specific health system, might be more effective in supporting clinicians and the work they do in the critical care settings. As noted in the Introduction, previous research on ethics committee work has uncovered several problems which this study attempted to address. First, ethics committees frequently lack information on what they could do to meet the needs of clinicians who are facing ethical and moral dilemmas making it difficult for committees to be proactive and effective in establishing committee composition, determine the training needs of committee members, and plan and support relevant services. Second, it has been difficult to understand the needs of the full spectrum of healthcare providers who work in the critical care units – an environment in which end-of-life issues often create difficult and morally distressing dilemmas. Needs assessments have most often provided a top-down, management perspective rather than the views of constituent stakeholders. Third, ethics committees may do many different activities but these are often inadequately operationalized and difficult to evaluate. Consequently, ethics committees often do a poor job of assessing their own performance or using performance data to plan future activities. Finally, only a limited number of studies have examined how different committee activities might impact care. If the ultimate goal of ethics committees is to support excellent patient care, then more information is needed on which activities might potentially provide the most benefit.

Findings for the study were presented in Chapter 4. This chapter will begin with a brief review of how the research process was used to meet the study aims. Next, implications for ethics committees, both in this healthcare system and
nationally, will be presented. This section is followed by suggestions for ways in which medical social workers might become more actively engaged in resolving conflicts and supporting ethical practice in the critical care units, particularly at the end of life. Chapter 5 ends with an acknowledgement of study limitations and directions for future research.

**Meeting the Aims of the Study**

Aim 1 was achieved through Phase 1 of the concept mapping process. During the brainstorming activity, EAC members and non-EAC staff contributed ideas in response to the focus prompt: *Something specific ethics committees could do to support staff and the work they do in the critical care setting is...* Participants brainstormed almost one hundred different ways that an ethics committee could support the staff and work in the critical care unit. Some of these suggestions, such as “Provide education about basic ethical principles” reflected traditional committee practice. Others, such as “Work with pastoral care, nursing, and/or social work to establish daily rounds in the waiting rooms to talk with families about issues like life support or code status” point to new directions for ethics committee efforts.

During the sorting activity these statements were organized into seven different clusters of conceptually similar ideas. Finally, these clusters were labeled during the Interpretation session described in Chapter 3. The seven clusters were: Staff Development, Guidance, Outreach & accessibility, Visibility, Liaison with system, Liaison with patients & families, Ethical & moral support. The cluster map provides a framework for looking at ethics committee activities based on the needs identified by stakeholders. And, individual statements within each cluster help operationalize broader committee functions.

To achieve Aim 2, EAC members and Non-EAC staff were asked to rate each of the suggested activities on how much positive impact it could have on care. While the two groups both rated “Liaison with patients & families” as the area with highest potential positive impact and “Visibility” as the lowest, there was less agreement about the relative impact of the other activities. Broadly speaking, the non-EAC staff
thought that the suggested activities could have more positive impact on patient care than did the EAC members. Both groups were also asked to rate how well the ethics committees were currently performing on each of the proposed ideas. In Performance, EAC members rated their performance higher than did the non-EAC members. Views about potential impact and perceived current performance varied among the three hospitals which participated in the rating activity. Within the same hospital, ratings varied between critical care units. A number of other variables - profession, years in healthcare, involvement with ethics committee consults, and use of the ethics committee as the first resource when questions about an ethical dilemma arise – also seemed to influence how items were rated for potential positive impact and perceived current performance. Because 95 different suggestions were generated in this study, rating data provides important insight for prioritizing the suggestions and directing practice, particularly at OhioHealth.

To achieve Aims 3 and 4, in this chapter each cluster will be examined. Suggestions for ethics committee practice will be presented based on the statements, current research, and the observations of the researcher and the Director. Prior to presenting the findings of this study to the Joint Ethics Advisory Committee, the Director decided to focus strategic planning for the coming years on the 25 items that had a Non-EAC Impact rating of 4.01 (Large positive impact) or above. As part of the analysis of each cluster, these high priority items will be noted and discussed. While the cluster groupings were determined by a statistical process, this discussion of the clusters themselves is a qualitative analysis.

Implications for Ethics Committee Practice – A Cluster by Cluster Analysis

Staff development. The largest of the seven clusters was Staff development with 26 statements. Based on the very low bridging values for the Staff Development cluster, sorters saw all the ideas as being closely related. Nevertheless, there were still important distinctions within this cluster providing direction for both the content of education and the method in which it is delivered.
Many of the statements included in this cluster reflected common practice of ethics committees. For example, the following statements reflect strategies that many ethics committees use to fulfill their education responsibility:

1. Use simulations and role playing exercises to teach staff about potential ethical situations that could arise in the clinical setting

54. Provide periodic in-service training by reviewing cases or situations and discussing how these might be approached

78. Provide education about basic ethical principles

A number of suggestions related to topics of particular concern in the critical care unit where end-of-life decisions are the most common triggers of ethical dilemmas. Through the statements below, staff voiced the need to have and understand concrete information which could inform decision-making.

34. Educate staff about State of Ohio laws related to care of terminally ill patients

68. Provide regular staff education on ethical standards and issues related to critical care

76. Educate staff on what treatments physicians may refuse to provide

83. Provide staff education on advance directives such as living will, healthcare power of attorney

Some suggestions implied that staff need more education on when and how to access ethics committees and what to expect from a committee consultations. This is consistent with previous research (Bell, 2003; Glacki-Smith & Gordon, 2005). Among the suggestions for this form of education were:

5. Provide information to all staff on how to contact the committee to discuss an issue or ask a question without generating a full consult

19. Provide clear information on HOW to get the ethics committee involved

20. Provide education on the types of cases that are appropriate for an ethics consult versus questions that should go to legal or human resources
39. Inform critical care staff of what to expect from an ethics consult and how the consults affect care

Other suggestions added much more breadth and depth to the staff education function. For example, these activities

90. Provide training in crucial conversations and communication skills
81. Educate residents on how to approach families and explain code status in layman's terms
93. Provide staff education on how to deal with unrealistic, angry or difficult patients and families

point to educational content that is not directly related to bioethics but clearly relates to the communication challenges in the critical care setting which can contribute to ethical dilemmas and a poor ethical climate.

OhioHealth was not only interested in what staff wanted to learn but how they wanted the content delivered. In fact, several suggestions were made about alternative methods for educating staff. Several suggestions were made for non-traditional methods of delivering content on ethics:

32. Provide online learning describing specific situations, common problems and their resolution
12. Provide a newsletter to staff on current events and hot topics in bioethics.

**Implications for ethics committees.** The findings in this study affirm that ethics committees at OhioHealth are looked to as a resource for education about ethics. Staff indicated a need for basic information about ethics and ethical and legal standards. Formal education about bioethics is limited for many practitioners, including physicians (Landau, 2000b; Moon & Orr, 1993). Consequently, many healthcare providers enter practice without a sufficient grounding in ethical principles and decision-making frameworks to feel comfortable applying these in day-to-day practice. Grady et al. (2008) found that nurses and social workers who had ethics education were more likely to request an ethics consult or discuss morally troubling issues with their colleagues. These finding have been supported by other researchers (Boland, 2006; Jansson & Dodd, 2002; Pugh, 2011; Rogers, Babgi, & Gomez, 2008)
who also note that continuing education, which is intensive and practical, is particularly effective. In other words, working professionals seem to learn ethical principles and legal standards best when they are shown how to apply them in real-life situations. The ethics committee should consider providing multi-disciplinary educational opportunities so that healthcare team members can see how professional ethical standards may vary and discuss how these differences may impact the ethical decision-making process.

In the future, rating data could be used at OhioHealth to prioritize educational offerings for staff depending upon their profession or years in healthcare. As noted in findings (and shown in Figures 33 and 34), new staff members need different education than more experienced staff do. In particular, new staff need education and training on when they are permitted to be relieved from a case for ethical reasons; ethical standards and issues related to critical care; and treatments that physicians may refuse to provide. It was also suggested that new staff would benefit from information sheets on common ethical dilemmas that may arise, particularly in the critical care unit.

The participants also suggested that ethics committees provide education that would help staff develop skills which would enable them to handle ethically challenging situations more successfully. Ethics committees have not traditionally seen themselves as responsible for helping staff acquire communication and conflict resolution skills (Singer, et al., 2001) even when it is evident that lack of skills may be contributing to problems in resolving ethical dilemmas. Providing training in “crucial conversations” and “dealing with angry or unrealistic families” may be well beyond the capability of a volunteer ethics committee. In general, committee members are not expected to have expertise in staff training and development. In addition, committees rarely have the resources to develop curriculum and provide intensive skill building sessions. Although staff in this and other studies (Racine & Hayes, 2006) seem willing to learn in a variety of different ways (e.g., online, through newsletters), the committee may not have the capacity to create content and deliver it in different formats. Nevertheless, ethics committees may want to consider whether
there are other resources in the institution (e.g., human resources) which can become partners in providing these programs. For example, OhioHealth is intending to work with medical education to help address the suggestion, “Educate residents on how to approach families and explain code status in layman’s terms,” which received a Non-EAC Impact rating of 4.26. Research (Jansson & Dodd, 2002; Lang, 2008; O’Donnell et al., 2008, Pugh, 2011; Shirey, 2005) has shown that ethics education promotes a more positive ethical environment, more job satisfaction, and increased ethical action with less moral distress.

Providing education to staff about when and how to access the ethics committee points to the need for staff to learn about the role of the committee and how the committee’s services complement other work in the hospital. Three statements, “Provide clear information on HOW to get the ethics committee involved,” “Provide information to all staff on how to contact the committee to discuss an issue or ask a question without generating a full consult,” and “Provide education on the types of cases that are appropriate for an ethics consult versus questions that should go to legal or human resources” all received Impact scores over 4.0. While EAC members self-rated their Performance in this area as 3.0 (Adequately) or above, Non-EAC participants rated all of these items as 2.83 or below. At OhioHealth, this indicates that participants believe that EACs have the opportunity to improve their positive impact on care in the critical care settings if they can do a better job of educating staff about the appropriate questions to bring to the ethics committee and the process for initiating a request for a consult. Several years ago, the OhioHealth Ethics Advisory Committee for Community Based Services developed a small information card for staff. On this card, staff were given guidance on steps to take when they encountered an ethically troubling situation and contact information for the committee. Additional simple resources such as this are now being considered for the other ethics committees in the healthcare system and might be useful for other hospitals as well.

The traditional ethics committee role of staff development will remain a top priority at OhioHealth. However, the Director stated that the study pointed to moving
beyond basic ethics content to “the creation of a vibrant ethics education program with targeted activities.” For example, the Director plans to develop, in partnership with Medical Education and Resident Research, an evidence-based training program for residents on end-of-life conversations. Similar opportunities may exist with the Colleges of Medicine or Nursing or the School of Health and Rehabilitation Sciences at Ohio State.

At OhioHealth and elsewhere, an expanded role in providing ethics education may strain existing committee resources. When possible, committees should consider forging partnerships with other departments in the hospital. Ethics committees could advocate for funds to provide seminars, workshops and ethics education days that could be discipline specific or broadly applicable; these could be co-sponsored with nursing, social services, or medical education. Committee membership might be expanded to include staff with expertise in training and development; these individuals might work as a sub-committee of the full EAC and not be involved directly in consultations or hospital policy issues.

Guidance. Staff development is one of the three primary activities performed by most ethics committees; the other two are consultation on ethical matters and hospital policy development. In this study, the cluster “Guidance” captures elements of these last two functions.

Of the 247 suggestions submitted during Brainstorming, only two concerned new corporate policies. Both were retained for the list of 95 statements used in rating and sorting. Participants made very specific suggestions about hospital policies that might be helpful to the staff and work in the critical care setting:

59. Assist in developing a policy on when family members can be at the bedside during a code

89. Assist in developing a policy on dealing with disruptive families

Other statements in this cluster related to guidance that the committee could give. Guidance could take a number of different forms from written information to screening tools which could offer direction on how to approach difficult situations.
22. Give guidance to staff on how to deal with family members who wish to continue with treatment that is deemed futile

35. Create a screening tool to be used at admission to identify situations that may become ethically difficult

82. Provide clear guidelines on when it is appropriate to get the ethics committee involved

86. Provide clear, easy to access definitions of code status (e.g., DNR-CC)

87. Provide staff with a card listing the chain of medical decision makers in families

Participants also noted that knowing how ethical dilemmas have been analyzed and resolved can guide future decision making:

42. When a situation arises where an ethics committee consult may be indicated, provide information on how prior cases have been resolved

46. Offer a summary of the ethics committee meeting to explain the process and reasoning behind its decisions

**Implications for ethics committees.** In her research, McAuliffe (2005) found that a lack of clear policies and guidelines contributed to an ethically stressful environment. In contrast, when staff can be confident of their actions because they know in advance not only their ethical obligation but also organizational policies, they are much less likely to feel moral uncertainty which can lead to moral distress (Cox, 2008, p. 199). Martin and Cullen (2006) note that when principles of practice are clear, this seems to promote psychological well-being and a positive ethical climate because they provide a predictable basis for interaction (p.187). Participants in our study suggested very specific guidance and policies, particularly around interactions with difficult families and end-of-life care. Item #22, “Give guidance to staff on how to deal with family members who wish to continue with treatment that is deemed futile,” received a Non-EAC Impact rating of 4.3 and will be addressed in the strategic plan for ethics committees at OhioHealth. The suggested hospital policy about family presence at the bedside during a code while not rated as highly could also potentially take the pressure off personnel who want to focus their attention on
the patient during a medical emergency and remove feelings of guilt if families are prohibited from the room. As noted in Chapter 2, two factors contributing to a poor ethical climate in the critical care unit were challenges in communicating with families and issues around resuscitation and futility. Our findings suggest that if the ethics committees could help staff address these problems with clear policies, these efforts could, in turn, improve the ethical climate in the critical care units. While hospital policy development or review may not be a frequent activity for ethics committees, they clearly remain important ones.

As noted in the literature review, it is often difficult to identify who can act on behalf of a patient who has become unable to make informed treatment decisions and this ambiguity leads to tension for staff, patients and families. Code status (i.e., whether or not to resuscitate a patient) can be challenging to explain, especially during a medical crisis. Tools to make the different code statuses easier to understand could potentially lessen tension and disagreement about end-of-life choices. In this study the suggestion “Provide clear, easy to access definitions of code status (e.g., DNR-CC)” received a Non-EAC Impact score of 4.32 but a Non-EAC performance score of only 2.52 (between Poorly and Adequately). Providing screening tools and simple information sheets could serve to improve the ethical environment by removing ambiguity (Bell & Breslin, 2008). Once created these tools would be easy to replicate and distribute throughout a hospital or health system.

Participants also suggested that they wanted more transparency from the ethics committee about how recommendations are reached. While ethics committee decisions do not set precedent, they nevertheless offer insight that can be applied in future situations. Opportunities for educating staff are lost if committees do not share more openly with all members of the healthcare team. In addition, staff may be left with lingering questions and concerns and a sense of being underserved and excluded (Robichaux & Clark, 2006) if they do not understand how the committee has approached an ethical problem. HIPAA and medical liability concerns may make it more challenging to provide follow up to the healthcare team. It may also be difficult to communicate with all clinicians involved in a patient’s care. However, ethics
committee should consider developing mechanisms for giving feedback to the team such as debriefing sessions which may need to be offered on several occasions in order to reach practitioners who work nights or irregular hours. Clinicians who are affiliated with the critical care unit (e.g., respiratory therapy, dietetics) should be included in the follow up communication.

**Outreach & accessibility.** In many settings, ethics committees work reactively: they wait for clinicians, or less often patients and families, to bring issues to them. However, the suggestions generated in this study indicate that participants believe that active, personal outreach by the ethics committee and better accessibility can support staff and the work they do in the critical care units.

Several suggestions included in the cluster “Outreach & accessibility” reflect participant desire to interact directly with ethics committee members:

3. Come to staff meetings periodically to increase associate awareness of ethics committee resources and provide opportunities to dialogue about ethics

29. Conduct unit-based meetings to discuss ways in which the committee could be best utilized

63. Help staff distinguish between a bioethical dilemma and a disagreement about physician’s care plan

38. Survey staff regularly on what the ethics committee can do to support the work in the critical care units

88. Have staff members come to ethics committee meetings to present different ethical dilemmas they have encountered in practice

Staff appear to want face to face contact with members of the committee and the opportunity to shape the committee’s work with feedback. Direct outreach may help develop trust so that staff feel comfortable requesting assistance when a crisis occurs.

Other statements point to the desire for the committee’s support to be easily available to all members of the healthcare team.

30. Make it clear that any critical care staff member can request an ethics consult
64. Make services of the ethics committee well known and contact information for the ethics committee widely available.

Some statements in this cluster imply that the committee can increase its reach if it provides resources to clinicians in the critical care setting. For example:

65. Have a process in place to assist staff when care decisions need to be made and there is no decision maker.

73. Provide a pamphlet for patients and families on the principles and values underlying the work of the ethics committee.

80. Provide resources to help staff "untangle" themselves when they are conflicted ethically about a patient they are caring for.

The final statement in the cluster on outreach and accessibility was:

69. Identify and acknowledge best practice, high-quality, ethical decision making.

When high quality, ethical decision making is identified and acknowledged by the ethics committee, this may help providers in the critical care setting understand how to approach ethical dilemmas and when to come to the committee for additional support and guidance. Identifying role models may also serve as a form of staff development as practitioners can learn by example in the context of their work environment.

**Implications for ethics committees.** Gaudine, et al. (2011), in a qualitative study of Canadian nurses and doctors, identified a number of barriers to the use of ethics committees. The primary barriers were lack of knowledge about: what issues were appropriate for a consultation; what procedure to follow to request assistance; the benefits and purpose of the committee; and the expertise of the ethics committee members. Those who were aware of the existence of the ethics committee and knew how to make a request for a consult were still reluctant to use the committee’s services because they did not have experience with the committee or had not observed someone else initiating a request. Nurses also noted that they did not know how to recognize what was an ethical issue or how to determine whether or not the issue was serious enough to justify an ethics consult. Several studies (Kerridge,
Pearson, & Rolfe, 1998; Landau, 2000a) have documented that allied health professionals are reluctant to use ethics committee services because of communication failures and distrust among different disciplines. Gordon and Hamric (2006, p. 232) found that nurses had little knowledge of the existence of ethics committees, but those who did felt they had no direct access to them due to existing institutional power structures. When nurses did approach the ethics committee, nurses seemed to feel it was a “last resort.” Jansson and Dodd (2002) in a study of medical social workers found that only 30% of the respondents worked in hospitals which “frequently” or “always” encouraged them to make referrals to an ethics committee. In fact, many hospitals do stipulate that only physicians can initiate a request for an ethics consultation (McGee, 2001).

Gaudine et al. (2011) also noted factors that facilitated a request for ethics committee assistance. For example, having information available within the organization about the ethics committee, the opportunity to attend meetings or meet committee members, and ethics education were all factors which helped staff feel more comfortable using an ethics committee. In this study two related statements (“Make it clear that any critical care staff member can request an ethics consult” and “Make services of the ethics committee well known and contact information for the ethics committee widely available”) received EAC and Non-EAC Impact ratings over 4.1 and will be part of OhioHealth’s strategic plan. A study by Schick and Guo (2001) found that the ethics committee chairs who were surveyed felt that the factor least important to the success of their committees was being accessible. In this study, however, EAC members ranked these outreach and accessibility items among the most important of the 95 suggested activities. In other words, from the perspective of ethics committee consumers, outreach and accessibility may be, in fact, quite important for committee success.

The suggestions made by the participants in this study seem to support the findings that healthcare practitioners want a personal contact with ethics committee members, explicit permission to request a consultation, and role models. Other resources from the committee such as a pamphlet that can be given to patients and
families were also seen as helpful. If ethics committees wish to fulfill their mission of supporting ethical care, they must move beyond the “if you build it, (they) will come” mindset. Active, personal outreach appears to be an important element of supporting staff and the work they do in the critical care setting. Unfortunately, because most committees have a volunteer membership outreach efforts can be very challenging. Nevertheless, committee members, perhaps on a rotating basis, should be encouraged to spend “face time” with clinicians in unit or staff meetings. Recruiting new members (particularly non-physicians) who are charged with this effort might also help build trust in the committee’s work and relevance. Robichaux and Clark (2006) suggested that a nursing ethics committee, working under the umbrella of the institutional ethics committee, might strengthen the moral community of nurses and provide a forum for those who are uncomfortable bringing their concerns forward to a larger group dominated by physicians and administrators.

**Visibility.** “Visibility” is the cluster in the center of the map. In concept mapping, this central location signifies that the ideas in the cluster bridge, or connect with, all the other clusters. The statements in the Visibility cluster suggest that ethics committee members could be even more involved in clinical activities than was suggested in “Outreach & accessibility.” In fact, these statements seem to suggest that the ethics committee move beyond a purely consultant role to become a more regular member of the healthcare team, communicating in person and through chart notes. For example:

6. Be physically present to help bedside personnel better assess emerging ethical issues

14. Communicate with front line staff about the situation and the status of the ethics consult

37. Round daily on the critical care unit to discuss ethical issues related to patient care

40. Be visible and present in clinical activities, including on "off shifts"
74. Have the ethics committee communicate with front line staff through the medical record

85. Round regularly on the critical care unit to discuss ethical issues related to patient care

**Implications for ethics committees.** By being visible and physically present, the ethics committee or consultant can answer questions as they arise, before tensions and misunderstandings develop. A number of institutions have instituted ethics consultation services which complement the full ethics committee (Buchanan, Desrochers, Henry, Thomasson, & Barrett, 2002; Cohn, Goodman-Crew, Rudman, Schneiderman, & Waldman, 2007; Helft et al., 2009; Richter, 2007; Schneiderman, Gilmer, Teetzel, et al, 2003). The task of the consultant or consultant team is to participate regularly in rounds and team meetings; mediate conflicts among staff or between the healthcare team and the family or surrogate; and help clinicians distinguish between ethical dilemmas and other problems in the system or communication. The consultants provided mentoring to staff by pointing out best practices. Many of these programs started with a physician ethicist, but later found other disciplines were well accepted and successful in addressing ethical conflict. Ethics consultations have been successfully provided by single consultants, teams, persons with medical and law degrees as well as social workers and theologians who identified value-laden treatment conflicts and provided help with communication and consensus building.

Researchers report that clinicians seem to prefer a less formal, non-bureaucratic approach with an individual ethicist they know and trust over a full committee consultation (Buchanan, et al., 2002; Marshall & Robson, 2003; Richter, 2007; Schneiderman, et al., 2003; Svantesson, Aderzen-Carlsson, Thorsen, Kallenberg, & Ahlstrom, 2007). Cohn et al. posit, "Ethics consultation helps the healthcare providers diffuse responsibility for making end-of-life decisions and provides an infrastructure that allows for and supports communication with patients/families at the end of life" (2007, p. 144). In a prospective, controlled study Dowdy, Robertson, and Bander (1998) found that offering proactive ethics
consultation to clinicians providing care for critically and terminally ill patients led to more frequent communication, more frequent decisions to forgo life-sustaining treatment and reduced lengths of stay in the ICU. The researchers described their intervention as a form of “preventive ethics” designed to address problems before conflict developed. In addition, Dowdy et al. noted the importance of shifting the focus from “ethical problems” to good clinical communication and sound ethical dialogue. The group found that after the intervention, nurses and doctors were more likely to include family members in advance patient care planning (p. 257). Others (Santiago, & Abdool, 2011; Schneiderman, Gilmer, & Teezel, 2003) have had similar findings as well as cost savings for both patients and hospitals.

While research supports the use of an ethics consultant who can become a member of the healthcare team, there are some challenges with this approach. Richter (2007) expressed concern that the liaison could become too attached to the team and lose objectivity. While some (e.g., Dubler, 2007) recommend that the ethics consultant put notes in the medical record to improve team communication, many ethics consultants are told not to chart based on concerns of potential liability should there be a question of medical malpractice. Perhaps the biggest challenge to having a consultant round regularly with the healthcare team is having the personnel to do this.

Few ethics committees have a full-time ethics consultant. As noted earlier, most committees are composed of volunteers who have their own full-time clinical responsibilities. To partially overcome this barrier at OhioHealth, the Director is proposing that members of the ethics committee rotate call as “Consult Team Leads” and receive some financial compensation for this work. As Team Leads, committee members would be personally responsible for triaging with the clinicians. Visibility could also be enhanced through staff development activities which could be provided in the clinical setting at times convenient to staff. For example, a committee member, or ethics committee trained clinicians, might lead a brown bag “lunch” discussion of clinical ethics at midnight. This study supported the Director’s view that increased awareness of the committees in and of itself is not sufficient and that more personal
contact and availability, particularly with the critical care staff, was indicated as resources allow.

While visibility may play an important role in the potential positive impact of ethics committee activities, this cluster received the lowest average Impact rating (Non-EAC average Impact 3.6). Only one statement, “Communicate with front line staff about the situation and the status of the ethics consult,” received an Impact rating over 4.0 and was included in the strategic plan list. This suggestion aligns with other high priority items in the cluster “Liaison with system,” which is discussed next.

**Liaison with the system.** According to our study, an ethics committee may play two related roles as a “liaison:” with the hospital system and with patients and families. Personnel working in critical care expressed a need for assistance in linking with other resources. For example, in brainstorming it was suggested that the ethics committee could support staff and the work in the critical care unit if it would:

23. Work with palliative care to assist with pain management, goals of care and end-of-life decisions

26. Involve clinical nutrition in ethics consults when there are issues related to nutrition and hydration

33. Maintain an informational website for families to help them prepare for discussions with critical care staff

36. Inform customer service that the ethics committee has been called in to consult on care of a particular patient

43. Ensure that whatever decisions are made are grounded in the best interests of the patient

61. Be physically present to review the case with the social worker and nursing staff when patients appear to have been either abused or neglected by their caregivers

92. Be a liaison with the legal department when there are problems with guardianship
95. Have a medical social worker in ER 24 hours a day

It appears that the committee is being asked to identify the proper resources in the system and to create, activate or involve these resources as needed. As indicated in statements 61 and 92, even in the critical care unit issues go beyond end-of-life decision-making. Statement 95 points to the fact that work in a remote area of the hospital (the emergency room) can impact the work in the critical care unit. Having a social worker available in the Emergency Room could proactively alleviate some family conflicts and misunderstandings which can occur once the patient is in the critical care unit. The suggestion in statement 33 is outside of standard committee activities and would require assistance from the hospital’s IT department and perhaps other departments such as social services; nevertheless, participants thought that the ethics committee could play a role in developing this resource. The statement that seems to tie together this cluster is #43: Ensure that whatever decisions are made are grounded in the best interests of the patient.

Several statements in this cluster seem closely tied to those in Visibility. In this cluster, the suggestions reinforce the importance of the committee being quickly and easily available. These statements are:

44. Be available to assist staff communicate with families when it feels like neither side is understanding the other

45. Be proactively involved from the beginning of every critically ill patient's stay not just when consulted

79. Be easily available 24/7 to clarify ethical standards and for difficult decisions, such as withdrawing care

84. Respond and meet promptly and make decisions quickly

*Implications for ethics committees.*

An institutional ethics committee may be asked to help when uncertainty or conflict exists, when questions of moral, legal, or economic justification are raised, when problems of communication seem to be impeding patient care, or when it is simply unclear whom to ask for advice. (American Academy of Pediatrics, 2001, p. 205)
Because ethical problems can be so complex and multi-dimensional, it is not surprising that the ethics committee may be called on to network with appropriate resources. Without this “bigger picture” perspective, important viewpoints may be omitted and inter-departmental communication may be inadequate. By “ensuring that whatever decisions are made are grounded in the best interests of the patient,” the ethics committee helps assure that all parts of the system stay true to OhioHealth’s mission.

Committees could possibly play other roles as well. For example, while the ethics committee may not have the skill or resources to create educational materials for patients and families, it may be able to advocate that these be produced by other hospital departments. In a similar vein, the ethics committee does not have the authority to put a social worker in the emergency room 24 hours a day. Nevertheless, this suggestion points to the role social service could play in addressing potential ethical questions and concerns proactively, potentially relieving critical care staff. Although outside of its historic scope of practice, the committee could work with the department of social services and hospital administration to get this staffing in place. Corley et al. (2005) note that many of the concerns that trouble staff are not necessarily dramatic ones around end-of-life care but may have to do with organizational issues such as inadequate staffing or incompetent colleagues. If an ethics committee is willing to consider these varied concerns under its purview, the committee may be able to play a more active role in supporting a positive ethical climate.

Four items in this cluster (43, 44, 79, 84) are being included in the strategic planning document for OhioHealth EACs. Two of the statements speak to EACs being easily available and quick to provide guidance. Timely responses can reduce uncertainty and stress. The others emphasize the importance of good communication with families and the importance of keeping the patient’s best interests in mind. Additional suggestions for how the ethics committee might interface with families are presented in the next cluster.
Liaison with patients & families. The cluster, “Liaison with patients & families,” provides 15 specific suggestions for how an ethics committee might approach the consultation process. As noted in Chapter 2, when there are challenges in deciding who should be the decision-maker for patients who can no longer speak for themselves, this can have a negative impact on the ethical climate in the critical care setting. Participants suggested that the ethics committee could play a role in addressing these challenges if it could:

7. Decide who should be the decision maker when family is estranged and friends are sincerely involved with the patient

17. Automatically become involved anytime family members make a decision that appears to be inconsistent with a patient's Living Will

48. Help identify the primary contact for the patient

Another role identified for the ethics committee is to provide patient and family education. Education can take a number of forms:

28. Help family members understand their legal and ethical rights

55. Help explain in layman's terms the rationale physicians have for withdrawal of care

66. Communicate with patients and families about the availability of the clinical ethics committee

The suggestions could be done in face-to-face meetings, with printed materials, online resources or a combination of these. Further research would be needed to determine how best to provide this information, taking into account factors such as hospital resources and patient and family characteristics (e.g., cultural and religious values).

Discussions about end-of-life care are often the most time consuming and difficult for staff. Families frequently need extra assistance at this time, but staffing in the critical care unit may make this impossible. This unmet need can contribute to a more negative ethical climate in the critical care unit as staff realize they are not
providing optimal support. A number of statements call for the ethics committee to intervene with families when they are struggling with end-of-life decisions.

16. Work with pastoral care, nursing, and/or social work to establish daily rounds in the waiting rooms to talk with families about issues like life support or code status

17. Automatically become involved anytime family members make a decision that appears to be inconsistent with patient's Living Will

24. Become involved in cases where families are struggling with the issue of whether or not to place a feeding tube

31. Be available to meet with family members of gravely ill patients so they have the opportunity to discuss end-of-life decisions before a crisis arrives

60. Meet with families of patients whose treatments are considered futile to assist them in understanding why treatments are considered futile

70. Meet with families who are in crisis about decision making for the care of their loved ones

Ethics committee intervention may also include efforts to reduce tension and conflict between families and the care team. These three suggestions were made:

15. Provide thorough, concise recommendations when consulted

52. Help families realize staff are there to help them and the patient not to judge them or the patient or "kill off" their family member

62. When requested, meet with families that seem to be at odds with the medical staff

It was also suggested that when intervening with families, the ethics committees could consider the needs of clinicians:

2. Identify when difficult clinical situations or difficult families require debriefing for staff and make a referral to get this going

**Implications for ethics committees.** A strong theme running through this cluster is that ethics committees could support the work in the critical care unit by meeting directly with patients and families. The participants appear to be saying that staff need more than just a phone consultation; they believe the committee could be
supportive by being physically present and available to provide in-person education and counseling with families in distress.

For many of the suggestions it is not possible to tell why participants thought that if the committee could meet with patients and families this would support the staff and work in the critical care unit. It may be that staff feel overburdened fulfilling their clinical responsibilities and do not have the time and energy to give adequate attention to family needs. If this is the case, these suggestions may be a call for help. This was the interpretation of the Director and some of the participants in the Interpretation session. Or, it could be that staff do not have the necessary skills to provide crisis and grief counseling and that ethics committee representatives (they believe) would be better prepared to do this. Alternatively, participants may have recognized that patients and families are dissatisfied with the level of communication in the critical care unit. If this is the case, then any additional resources that might facilitate communication and the decision-making process could potentially help improve patient care and relieve family distress. Further research is needed to determine why these suggestions were made.

As noted in Chapter 2, Kaufer et al. (2008) found that inclusion of family members in the decision-making process had a strong relationship with overall satisfaction with the hospital experience. It appears that if an ethics committee can provide active, direct assistance to patients and families, there could potentially support staff and at the same time improve patient and family satisfaction. In an environment in which hospitals compete for patients and skilled clinicians, it seems these suggestions should receive serious consideration.

The cluster, “Liaison with patients & families,” had the highest average Impact rating, and eight of the fifteen statements received Impact ratings of 4.00 or higher. Six of these eight suggestions related to having someone from the EAC meet with patients and families. Of note, EAC members rated the potential positive Impact of these activities much lower than did Non-EAC members. For example, Non-EAC participants gave an Impact rating of 4.34 to the suggestion, “Meet with families of patients whose treatments are considered futile to assist them in understanding why
treatments are considered futile;” EAC participants rated this item 3.74. While there was agreement about the Impact of some items in this cluster (e.g., both Non-EAC and EAC participants gave an impact rating of 4.0 to statement #17), in general, EAC members did not perceive that their intervention with patients and families could have as much positive impact as the Non-EAC participants did.

Unfortunately, for most ethics committees, offering this level of involvement with patients and families would be very difficult. First, as noted earlier, committee members are usually volunteers who have other clinical or administrative duties. Second, many of the committee members, such as hospital administrators or counsel, do not have the skills to provide end-of-life counseling to grieving, distraught families. Third, among the recommended core competency skills of committee members are the abilities to identify and analyze values conflict, facilitate meetings, and listen and communicate well (American Society for Bioethics and Humanities, 2006). Specific skills in dispute resolution, however, are not considered part of the core competencies. Thus, ethics committee members may not be as skilled as needed in mediating disagreements between families and the care team or providing other counseling.

Other healthcare providers could potentially address the needs identified in this cluster. Many hospitals use palliative care teams which meet at the bedside to offer symptom control, address spiritual issues, and offer family support; these services are complementary to those of the ethics committee which is better prepared to offer a multi-disciplinary perspective on value conflicts (Moeller, 2012, p.100). Within the OhioHealth systems, some of the hospitals (e.g., H4) have a large and well-established palliative care service, but others (e.g., H1 and H3) have few palliative care staff. In the future, the Joint Ethics Advisory Committee at OhioHealth might advocate for an expansion of palliative care services within the system based on these study findings.

The JEAC might also promote the expanded, purposeful use of family conferences which have been used so successfully by other institutions (Azoulay, 2005; Kaufer et al., 2008; Kopelman, 2006; Larson & Tobin, 2000). Perhaps a pilot
project could be implemented at one of the OhioHealth hospitals in which certain “high risk” situations (such as when “family members make a decision that appears to be inconsistent with a patient's Living Will”) would automatically trigger a family meeting. Conferences could be led by a facilitator, working under the physician’s direction. To be most effective, the leader would need excellent skills in facilitation and advanced training in ethics provided through the ethics committee staff development program. Such conferences might address the need for assistance that is more proactive, visible and physically present in the critical care units and also serve as a method for demonstrating to interns and residents how to communicate with patients and families about end-of-life concerns (Larson & Tobin, 2000).

Other opportunities exist for new or creative programming to address the suggestions in this cluster. For example, Statement 16 suggested, “Work with pastoral care, nursing, and/or social work to establish daily rounds in the waiting rooms to talk with families about issues like life support or code status.” Foster (1980) described this crisis intervention role for social workers without making a specific connection between this service and the work of the ethics committee. At OhioHealth, pastoral care and social work may meet with families in the waiting room, but not necessarily to address end-of-life issues specifically. In addition, chaplain and social work staffing varies considerably among the hospitals in the system; what might be a possible, minor modification of practice in one facility might not be possible in another. The opportunity to use social workers to address patient and family concerns, particularly misunderstandings and conflicts about care, will be discussed in much greater detail in a later section of this chapter. Again, the ethics committees might be able to broaden their impact by collaborating with existing hospital resources rather than trying to address these suggestions on their own.

**Ethical & moral support.** In the cluster, “Liaison with patients & families,” there was a suggestion that ethics committees, “Identify when difficult clinical situations or difficult families require debriefing for staff and make a referral to get this going.” This statement relates to the topic in the final cluster, “Ethical & moral
support.” Within Ethical & moral support, two broad themes emerged. The first concerned the consultation process; the second had to do with facilitating support for staff.

Participants suggested seven different ways the ethics committee process could provide ethical and moral support:

4. Ensure that whatever steps are taken in patient care are consistent with ethical practice, Ohio law and OhioHealth policy

9. Mediate between staff members who are in disagreement on how to approach an ethical dilemma

41. Get opinions from staff directly involved in care of the patient

47. When an ethical dilemma has not been handled in an ideal way, have non-committee staff participate in committee review of the dilemma

49. Talk with physicians and staff about the decision making behind the conclusions reached in an ethics consult

51. Meet with staff one-on-one to understand what might be learned from a particular case

57. Hear from all sides of the ethical dilemma in a private setting before discussing with the entire committee

77. Acknowledge individuals who demonstrate high quality ethical decision making so they can serve as a role models for peers

The statements in this sub-cluster reinforce a theme discussed earlier in “Outreach & accessibility.” Participants are looking for a personal connection with the ethics committee; they want the opportunity to be heard. These suggestions echo Austin (2007) who noted that it “is in dialogical encounters that … ethical understanding takes shape” (p. 81). It appears that participants were saying that if the committees would include staff in the deliberation process this would help them feel supported. But, ethics committees are urged to make the exchange even-sided, safe, and private. The statement, “Ensure that whatever steps are taken in patient care are consistent with ethical practice, Ohio law and OhioHealth policy,” was sorted into Ethical & moral support and not in one of the other clusters that concerned committee process.
It appears that when the committee fulfills its fundamental mission this supports clinicians who are reassured that difficult choices are being made in the context of the highest standards.

The second theme that emerged in this cluster included statements about facilitating emotional support for staff:

10. Provide opportunities for employees to be able to talk to someone about their feelings when dealing with critically ill patients

13. Provide support for staff who wish to be relieved from a case for ethical reasons

25. Create a safe haven where staff can discuss distressing ethical concerns

27. Help staff connect with pastoral care if staff’s personal religious beliefs are being challenged

56. Provide peer to peer support groups for staff dealing with difficult ethical issues

71. Facilitate provision of appropriate support when staff are showing signs of burnout

These statements imply that staff working in the critical care unit have strong feelings about distressing ethical situations, particularly those that can occur when caring for critically ill patients. These concerns may lead to burnout or a desire to be relieved from care. Support may come from pastoral care, peer to peer support groups, or the opportunity to talk in a “safe space.” The participants see the ethics committee playing a role in providing or securing this emotional support for troubled staff.

Implications for ethics committees. Our study indicates that staff want a voice in ethical deliberations. However, many ethics committee intentionally, or unintentionally, limit clinician involvement in the consult process. Research shows that there is a potential danger in this practice even if it is more expedient. Ulrich et al. (2007) found that when social workers and nurses had more ethics education - but limited or no access to resources or a non-supportive ethical climate - they were more likely to experience frustration, dissatisfaction with their jobs, and moral distress. This seems to imply that if ethics committees provide ethics education but are not
available as a forum that staff can use for discussion, then the committees may, inadvertently, increase feelings of moral distress. While it is not practical in many instances to include all involved staff in ethics committee consults, a more inclusive approach may have long term benefits in terms of staff morale and emotional well-being.

At OhioHealth, a number of statements in the Ethical & moral support cluster (41. Get opinions from staff directly involved in care of the patient; 49. Talk with physicians and staff about the decision making behind the conclusions reached in an ethics consult) received potential positive Impact scores of 4.01 or higher. Staff wish to be consulted and receive feedback - in person. While the EAC may find it difficult at times to meet with staff, this personal contact could have a positive impact on care as well as on the level of moral distress. Over the next year, the Joint Ethics Advisory Committee members will be working with individual committees to determine how best to implement these recommendations at each hospital campus.

Statement #4, “Ensure that whatever steps are taken in patient care are consistent with ethical practice, Ohio law and OhioHealth policy,” received a Non EAC Impact score of 4.01. In the most recent staff satisfaction survey at OhioHealth, the ethical and moral focus of the organization was positively associated with staff satisfaction (Corey Perry, personal communication, March 31, 2013). This finding is consistent with the high potential Impact rating given to statement #4 and reinforces the importance of this ethics committee function.

In this study, 40% of respondents said the first person they consult when they have questions about an ethical dilemma is a co-worker. This finding is consistent with that reported by Gutierrez (2005) in a study of critical care nurses. Assistance from colleagues is likely to be informal and easy to obtain. But, it may be that while co-workers can offer much needed emotional support they do not have the requisite skills to analyze an ethical dilemma. During brainstorming, participants also suggested that ethics committees could provide ethical and moral support by identifying individuals who can serve as role models of good ethical decision making. Based on this study’s findings, OhioHealth is proposing to implement a program to
“spot light ethics champions” in the critical care settings. These individuals would receive special training to provide informal, proactive ethics problem-solving to staff in the unit and act as a conduit for earlier referrals to the ethics advisory committees when more guidance is indicated.

Our findings indicated that almost 36% of respondents go to either their supervisor or program director as their first source of advice when they have questions about an ethical dilemma. This information points to another opportunity for ethics committee intervention: providing advanced training for supervisors or unit managers. A number of authors (Bell & Breslin, 2008; Coles, 2010; Gutierrez, 2005; McAuliffe, 2005) have suggested that hospital leadership could promote a positive ethical environment and address moral distress by ensuring that staff have opportunities to speak with supervisors who have had ethics training. In particular, supervisors need to become comfortable promoting the discussion of every day concerns such as inadequate staffing levels or incompetent colleagues as well as difficult patient care issues (Corley, Minick, Elswick, Jacobs, 2005). Research by Parboteeah et al. (2010) found that supervisors played an important role in establishing a positive ethical climate by encouraging open communication and transmitting the organization’s ethical values and expectations. This dialogue in turn empowered staff who felt greater control over the work environment. Empowered employees found the ethical environment more “caring” and less “instrumental.”

To assist managers and supervisors, ethics committees might also consider co-sponsoring training in “The 4A’s to Rise Above Moral Distress” (Cox, 2008). This model, developed for nurses but also applicable for other allied health professionals, provides staff specific strategies to recognize and address their moral distress. As managers may also experience moral distress (Porter, 2010), it is important their needs are acknowledged and addressed as well and that they, too, are comfortable seeking support when needed from trusted, trained colleagues. Since supervisors and unit managers play such an important role in providing ethical advice, EACs might undertake a learning needs assessment of these employees and then provide targeted, ethics education to increase their skills and forge a connection between them and the
committee. Ethics committee members may also benefit from taking the “The 4A’s to Rise Above Moral Distress” training or something similar so that they can be more sensitive to the needs of staff who come for consultation.

The ethics committee could also offer ethical and moral support through adjunct services (Gutierrez, 2005; O’Donnell, et al., 2008) which provide a forum for discussion. Helft et al. (2009) implemented a consultation program in an intensive care unit to provide support and education to nursing staff. The goal of this program was to address moral distress by increasing staff skills and confidence in dealing with ethically challenging situations. Informal discussions were led by an ethicist, a social worker or a physician. All of the group leaders were members of the hospital’s ethics committee so that there could be continuity if a more formal consultation was indicated. This group also served as a forum for follow up and debriefing if an issue was sent for a formal review. An approach such as this could address a number of the concerns raised in this study by providing mentorship, proactive assistance and a safe forum for discussion of ethical issues. As demonstrated in Helft’s study, the social worker assigned to the critical care unit would be an excellent resource for leading these discussions.

Support groups have been suggested as a resource for providing ethical and moral support to staff (Phillips, 1992). These groups could provide a “safe haven” in which staff might discuss “distressing ethical concerns” or talk about their “feelings when dealing with critically ill patients.” Support groups could also be an appropriate intervention for staff who are “showing signs of burnout.” As indicated in the Non EAC go-zone map of this cluster (see Figure 41), all of these issues received greater than average Impact scores from the EAC staff in this study. So an intervention of this type could potentially have a positive impact on both care and staff well-being.

While clinical ethics committees rarely have the resources to provide support group leadership, the committees could advocate for their formation with unit supervisors and hospital administration. Support groups might be led by a social worker (Gutierrez, 2005) or by someone from pastoral care who could also assist when personal religious beliefs are being challenged (LaRocca-Pitts, 2004). As noted
in Chapter 4 in the discussion of Figures 35 and 36, social workers rated the potential positive Impact of Ethical & moral support the highest of all of the clusters with a score of 4.29. This was in stark contrast to the rating of this same cluster by nurses who gave the cluster an Impact score of only 3.75 resulting in a last place ranking. At OhioHealth, the Director interpreted this discrepancy to mean that “nurses are hurting and although they might not recognize the signs of distress and burnout, the social workers do.” If this is indeed the case, then social workers might play a role in educating other staff about moral distress and burnout and offering support individually or through groups. The small sample size in this study makes any firm conclusion impossible, but this finding points to potential new roles for the social worker, directions for new programming, and opportunities for additional research.

OhioHealth has been undertaking a strategic activity over the past year to address moral distress (Corey Perry, personal communication, March 31, 2013). This effort, which is being led by a Vice President for Quality, is evaluating an intervention in approximately twenty units across the system. At the time of this writing, details about this project were not available. However, this study adds to the data supporting the need to address moral distress and suggests that there may be opportunities for ethics committees to work collaboratively with other organizational initiatives and thus leverage resources.

Family and patient care conferences (first presented in Liaison with patients & families) have the potential to improve communication with family members, reduce conflict between family members and the healthcare team, and alleviate some of the problems that may lead to moral distress (Browning, 2013; Gutierrez, 2005). These meetings may open up opportunities for moral dialogue conducted, not in generalities, but in the context of particular staff, patients and families (Walker, 1993). By reducing moral distress and increasing patient and family satisfaction, care conferences may lead to a more “caring,” positive ethical environment.

Ethics committee members should also be prepared to mediate between care providers and between providers and family members. Consequently, committee members should become skilled in analyzing conflicts, negotiation, and mediation.
These skills are not currently included in recommended committee member competencies; however, this study suggests that this addition would enable committee members to provide more efficient consultations which may also feel more supportive and inclusive. Finally, ethics committees can support staff by creating guidelines which can facilitate decision-making (Gutierrez, 2005). When guidelines are available that are consistent with ethical practice, state laws, and institutional requirements, staff feel supported and potentially less troubled by the complex decisions that must be made in the critical care setting. This finding supports the importance of one of the three traditional ethics committee functions: assisting the hospital to develop policies with ethical implications.

**Ethical Climates**

This study made no attempt to measure ethical climate directly. However, some of the study findings may indicate that different ethical climates exist within the healthcare system. For example, within H2, critical care units rated Impact and Performance differently (see Figures 23 and 24 and Tables 17 and 18). This may indicate that the ethical climate in these two units is different. Different hospitals also rated Impact and Performance differently (see Figures 20, 21, and 22 and Table 16); again, this may indicate different ethical climates at these institutions. Nurses, who work exclusively in the critical care unit, rated Impact and Performance differently than did those staff who only come to the units as needed (see Tables 29 and 30). These differences may reflect differences in patient population, staffing, procedures, hospital resources, ethics committee history; they may be just artifacts of small sample size. Further study is needed to determine if the differences truly reflect differences in ethical climate or other factors.

**Different Disciplines/Different Perspectives**

As noted in the Introduction, previous studies on ethics committees have rarely included a multi-disciplinary perspective in either the planning of the research or in the study sample. The broad and inclusive sampling in this study was intended
to address this limitation. By the end of all three phases of the research, every invited
discipline except occupational therapy had contributed. While many of the sample
sizes were extremely small, the study nevertheless pointed to some interesting and
important differences between the different professionals.

**Different disciplines evaluate potential impact and current performance
differently.** Multiple comparisons were made between nurses and other healthcare
team members. As noted in the Findings, nurses rated Impact and Performance
differently from physicians, house staff (see Tables 27 and 28) and other allied health
professionals (see Tables 29 and 30). Nurses and social workers had a strikingly
different perception of the potential impact of providing ethical and moral support
(see Figure 35 and Table 31). It appears that critical care nurses have a distinctly
different view of ethics committee services. Why this is the case deserves further
research. Data from administrators and managers (see Figures 37 and 38 and Tables
33 and 34) show a striking contrast with that of care providers. Administrators and
managers were the only group to give staff education the highest Impact score; care
providers as a group gave Liaison with patients & families the highest rating and
ranked staff development near the bottom.

**Implications for ethics committees.** While sample sizes were small and
drawn from only one healthcare system, these findings point to several possible
implications for ethics committee practice. First, committees could be more sensitive
to the diverse needs of team members, particularly in terms of consultation (“Liaison
with patients & families), staff education, and ethical and moral support. A one size
fits all approach may leave some staff feeling dissatisfied, frustrated, and less
supported. In particular, since nurses provide the majority of care in the critical care
setting, their distinct perspective deserves further consideration as committees plan
and evaluate their services.

The different perspectives also suggest that ethics committee membership
should be given careful consideration. While administrators offer a valuable
perspective in ethics committee deliberations, particularly in providing an
organizational context, they nevertheless do not see the committee serving the same
role as healthcare staff do. Physician members are also key on an ethics committee as they provide necessary input on clinical decision-making. Nevertheless, they too can only represent one piece of the ethical discussion. An ethics committee dominated by administrators and physicians may limit its potential positive impact as it may not be taking into account the needs of all team members, taking advantage of multi-disciplinary expertise, or performing as well as it could be or needs to be.

A truly multi-disciplinary committee offers many advantages. For example, social workers can provide insight on family dynamics and on moral and ethical distress. Based on this study, it appears that social workers bring a distinct and important perspective to ethical discussions. Other allied health staff (e.g., pharmacy, respiratory therapy) bring other viewpoints to the table. Training specialists can provide consultation on optimizing ethics education programs. A purposely recruited committee can offer a richer perspective in ethical discussions and contribute resources and connections to expand the committee’s reach. Committee members with special expertise need not attend every meeting. An education sub-committee or a nursing ethics committee (suggested earlier in this chapter) could support the full group. A large, more diverse committee may have more flexibility in meeting the diverse roles which have been suggested.

A Consideration of Possible Roles for Medical Social Workers

This study had three objectives. The first was to complete a needs assessment which would direct planning and evaluation for the ethics committees in a large healthcare system in central Ohio. The second was to contribute to the scholarly literature on ethics committees by adding a multi-disciplinary perspective on how committee activities could align more closely with the needs of clinicians, patients, and families in the critical care settings. The third objective was to examine, based on study findings, roles social workers might play in supporting ethical practice, staff and families in the critical care units, and the activities of the ethics committees.

As noted in the Introduction, social workers bring significant training in assessment, family counseling, and communication to their jobs in the healthcare
setting. Unfortunately, these advanced skills are often not fully recognized or utilized by hospitals where the social worker may be perceived primarily as a discharge planner (Cowles & Lefcowitz, 1992; Jansson & Dodd, 2002; Judd & Scheffield, 2010; Landau, 2000). The findings of this study point to a variety of opportunities for social work intervention.

A number of the brainstorming suggestions for EAC activities reflect work that is currently done by many medical social workers or is a logical extension of their current duties. The most obvious was: “Have a medical social worker in ER 24 hours a day.” In many settings, social workers may already “Be a liaison with the legal department when there are problems with guardianship;” “Communicate with patients and families about the availability of the clinical ethics committee;” or “Help family members understand their legal and ethical rights.” Social workers may also “help decide who should be the decision maker when family is estranged and friends are sincerely involved with the patient” or “Meet with families who are in crisis about decision making for the care of their loved ones.” Less often, social workers work with pastoral care and nursing “to establish daily rounds in the waiting rooms to talk with families about issues like life support or code status.” By meeting with families in the intensive care unit, social workers can have a positive impact on family satisfaction (Sundararajan, et al., 2012) and offer the team assistance by being a “liaison with patients and families.” If social workers are not yet providing these services, then these duties could be considered opportunities for assisting families, broadly supporting ethics committee work, and contributing to a more positive ethical climate in the critical care setting.

Other suggestions made during brainstorming may also point to opportunities for an expanded social work role. For example, it was suggested that the ethics committee might “provide training in crucial conversations and communication skills” for staff working in critical care. Social workers could play a role in planning and teaching programs such as this. Several suggestions were made related to providing ethical and moral support to staff. As noted earlier in this chapter, social workers saw this as the area in which intervention from the ethics committee might
have the greatest impact on staff and care. Social workers could possibly be available to provide counseling when staff want “to talk to someone about their feelings when dealing with critically ill patients.” Social workers might also facilitate “peer to peer support groups for staff dealing with difficult ethical issues.” By providing this support to staff, social workers could complement the work of the ethics committee and offer services which are beyond the committee’s usual resources.

A number of statements suggested that the ethics committee could support the critical care units by being more proactive (e.g., “Be available to meet with family members of gravely ill patients so they have the opportunity to discuss end-of-life decisions before a crisis arrives”). Other statements pointed to the need for conflict resolution: “Mediate between staff members who are in disagreement on how to approach an ethical dilemma;” “Automatically become involved anytime family members make a decision that appears to be inconsistent with a patient's Living Will;” and “Meet with families that seem to be at odds with the medical staff.” These suggestions seem to create opportunities for preventive ethics in which problems are addressed before conflict develops and the focus is shifted from solving ethical problems to good clinical communication and sound ethical dialogue (Dowdy et. al., 1998).

Social workers may have the opportunity to serve an important role as adjuncts to the ethics committee who provide proactive, easily accessed, conflict resolution services to staff, patients and families. The conceptual model which follows is based on the premise that social workers, as trusted members of the healthcare team, are well-positioned to leverage their skills to address misunderstandings and conflict before full ethics committee involvement is needed. As an adjunct to the ethics committee, social workers could also help raise committee visibility (for both families and staff), improve communication between the critical care units and the committee, and provide timely intervention for families struggling with complex decision-making at the end of life.
Alternative Dispute Resolution for End-of-Life Conflicts

As noted in Chapter 2, miscommunication does not necessarily pose a further challenge to the resolution of ethical disputes: it may be the source of the dispute itself. Yet, miscommunications are unlikely to be cleared up in traditional ethics committee deliberations where committee members may not be sensitive to patterns of poor communication and the patient and family are not present (Gatter, 1999). Feister contends, "Against a backdrop of the ethical uncertainty surrounding many hospital-based conflicts, and given the deep value disagreements that exist in the United States at this time and the relative infrequency of ethics consults, perhaps traditional ethics consultation should be replaced with bioethics mediation that will aid and support the legitimate decision makers in these cases, namely, the patients and their families" (Feister, 2007, p. 32).

Since the early 1990s, attorneys, dispute resolution professionals and, less often, healthcare providers, have explored the use of mediation for resolving disputes in medical settings. Some have approached the discussion from a legal or theoretical perspective (Bierlein, 2007; Cooley, 2006; Gatter, 1999; Gentry, 1995; Hayes, et al., 2003; Hoffman, 1994; Kovach, 2000; Perlman, 2001; Pope & Waldman, 2007; Simms-Taylor, 1994; Stoller, 2008). Others have proposed models based on their work in the medical environment (Buchanan, et al., 2002; Caplan & Bergman, 2007; Currie, 1998; Dubler, 2005; Dubler, 2007; Dubler & Liebman, 2004; Hyman, 2004; Kellett, 1987; Liebman & Marcus, et al. 1995; Watkins, Sacajiu, & Karasz, 2007). Overall, there is substantial support for the use of mediation in end-of-life disputes but there is a lack of consensus on how this dispute resolution strategy should be implemented. In addition, characteristics of the healthcare system make it particularly challenging to introduce new methods of conflict management.

Mediation. Mediation is a structured form of dispute resolution that uses an impartial facilitator - the mediator - to help the parties reach a decision that is mutually satisfactory. The mediation process is voluntary and private. The mediator does not have the authority to render a decision or force participants to accept a settlement. Mediation sessions are generally less adversarial than other forms of
dispute resolution. While the parties come to mediation with different needs and opinions, they are not treated as competitors. Instead, the mediator works to decrease anger and build trust between the parties by helping them communicate more effectively, generate options, and evaluate alternatives. Mediation can be particularly effective when a dispute is caused by insufficient or erroneous information and when the parties are in an ongoing relationship. Mediation is widely and successfully used to settle labor disputes, small claims lawsuits, and family law issues. However, mediation has not been generally well accepted in healthcare.

**Mediation for end-of-life disputes.** Those who advocate using mediation in end-of-life disputes point to many positive aspects of the process. "Over time, parties in an unresolved conflict become more adversarial, more polarized in their positions, less likely to identify common goals and less able to communicate or cooperate. As a result, the conflict between them becomes more difficult to resolve" (Gatter, 1999, p. 1109). Mediation can interrupt the escalation of hostility between family members or between the family and the healthcare team by restructuring communication. The mediator can identify when the conflict is based on inadequate information and misinterpretations - the greatest sources of conflict in end-of-life care. In addition, the mediator can act as an educator and "translator" ensuring that the parties truly understand one another (Hoffman, 1994). One of mediation's greatest strengths is its ability to neutralize the imbalances of power between the family and the healthcare professionals or among members of the treatment team. The mediator "levels the playing field" by establishing and enforcing ground rules, using everyday language, and bringing the focus back to the family as the experts on the patient (Dubler, 2005; Dubler & Liebman, 2004; Stoller, 2008). Re-balancing the power helps the parties build a better relationship so they can work in partnership to evaluate and choose treatment options. Because the mediation is a controlled encounter, individuals are often more comfortable expressing anger, frustration and grief; families particularly appreciate having a safe environment in which their feelings are acknowledged and respected and they get more time with their physicians (Dubler & Liebman, 2004; Hoffman, 1994; Kovach, 2000).
Care-based challenges to using traditional mediation. Some authors see problems with using classic mediation in end-of-life disputes. Confidentiality is a fundamental element of non-medical mediation. However in a bioethical mediation, the final agreement usually involves decisions about treatment that must be recorded in the medical record and accessed by other team members who were not part of the mediation. Therefore, strict confidentiality is limited to information not relevant to direct patient care (Caplan & Bergman, 2007; Dubler & Liebman, 2004). It may also not be clear whether the parties are covered under the same standards of privilege that are used in non-medical mediations; this lack of clarity about privilege may inhibit the honest exchange of information. Another hallmark of mediation is that the parties can generate creative options for resolving their differences. In end-of-life disputes, there may be medical care options but they are limited by the condition of the patient, the state of medicine, bioethical principles, and legal constraints (Bierlein, 2007; Dubler & Liebman, 2004; Hoffman, 1994); the mediator is expected to make these constraints explicit. In addition, many end-of-life disputes must be addressed quickly because of the critical status of the patient: there is little time for mediation participants to generate and evaluate multiple options.

In most non-medical mediations, all the interested stakeholders participate. However, in end-of-life disputes, the "person with the greatest stake, the patient, is often not at the table." (Dubler & Liebman, 2004, p. 28). When the patient cannot speak on her or his own behalf, family members, surrogates, and healthcare providers must be able to represent the patient's interests. Unfortunately, within the healthcare setting the patient may become "invisible" (Robson, 2003). Healthcare professionals often presume they can represent the best interests of the patient and surrogates and families may have difficulty separating their own needs from those of the patient. With this interpersonal dynamic in place, it can be difficult to generate acceptance of a dispute resolution technique such as mediation that relies on the participation of all of the stakeholders.

An additional burden on the mediator is to determine whether the patient, if present, the family, and/or the surrogate have the capacity to make the decisions
being discussed in mediation. It is not uncommon for people to be so stressed by end-of-life decision-making that they become temporarily incompetent (Hoffman, 1994). Accommodations to classic mediation may not only be recommended but utterly essential. While some of the parties (patients) may be bed-ridden, have serious disabilities, or be experiencing overwhelming grief, others (physicians) may be dealing with this conflict in between cases in the operating room or after a long, hard night on call. In some situations, the parties' views are so entrenched that mediation may not be the correct method of dispute resolution. For example, when a surrogate has strong, religious beliefs that care must be continued even in the face of apparent futility, mediation is unlikely to generate mutually satisfying decisions about terminating life-sustaining treatment (Pope & Waldman, 2007).

**Organizational challenges to using traditional mediation.** Some elements of classic mediation seem well suited to addressing end-of-life disputes; other components are more problematic. There are additional systems-based challenges to using traditional mediation in healthcare. The healthcare industry runs 24/7. Decision-making tends to be hierarchical. The physician is the team leader who works autonomously and often feels solely responsible for the quality of care a patient receives. This attitude is well developed during medical school and residency and reinforced by the healthcare system (Gerardi, 2004-2005). There is a prevailing attitude that it is up to physicians and others in authority to handle conflicts.

Ironically, although it is acknowledged that conflict management should be part of the curriculum for healthcare providers, it is rarely taught (Saulo & Wagener, 2000) and awareness of less adversarial, alternative dispute resolution approaches is quite low (Gerardi, 2004-2005, p. 876). In addition, the emphasis on evidence based medicine and the reliance on clinical practice guidelines leave little room or support for brainstorming and collaborative option generation which are key elements in most mediation sessions (Robson, 2003). Members of the healthcare team never feel they have enough time to complete their work. Consequently, they develop "process intolerance" and drive to move quickly to solutions (Gerardi, 2004-2005). In this context, it is difficult for providers to see the potential for mediation to help with
problem solving and compromise solutions (Dauer, 2005). Alternative dispute resolution strategies such as mediation may, in fact, be seen as a threat to the physician's power and autonomy or a sign of failure (Gerardi, 2004-2005; Lebed & McCauley, 2004-2005).

The assumption that an outsider must be used to mediate conflicts has been a significant barrier to implementing alternative dispute resolution programs in the healthcare system. "The health care industry, although famous for its penchant for new technology and clinical care advances, is highly resistant to change in "non-clinical" practices and the acceptance of ‘outsiders’ into the community of caregivers" (Lebed & McCauley, 2004-2005, p. 916). This means that dispute resolution practitioners who are not also involved in the healthcare field may be rejected by providers who believe that only fellow healthcare professionals can understand their problems (Robson, 2003). So, although attorneys frequently serve as mediators in other settings, they are not the most appropriate mediators for end-of-life conflicts. In addition, bringing in an attorney to mediate may send the message that the problem at hand is more a legal than a communication or clinical care issue and heighten rather than reduce tension and conflict.

In healthcare there is a very real tension between balancing the mediator's neutrality with her credibility. "In addition, external mediators, used to working in less crisis-driven environments may be insensitive to the real-time in which health care conflict occurs and the short timeframe available in which to address it" (Dauer, 2005, p. 1048). Scheduling challenges are tremendous as are the logistics of including all of the relevant parties. An additional barrier to using outside mediators is that funds for outsourcing to dispute resolution professionals are limited. Mediators who work effectively in other settings may fail to appreciate the unique challenges of mediating in a medical environment (Buchanan, et al., 2002). In addition, those who get too focused on a narrow definition of neutrality miss the potential benefit of using mediation strategies as a structured methodology to improve end-of-life care, reduce conflict in the intensive care setting, and improve the ethical climate by enhancing
communication and understanding among patients, families, and members of the healthcare team.

To better address the needs of patients and families, Sims-Taylor has suggested that at the time of admission a hospital-provided mediator-counselor approach the family. This early intervention is intended to be subtle, informal and private and to proactively address potential problems from misunderstandings (Sims-Taylor, 1994). If this first step is unsuccessful, Sims-Taylor suggests, "the hospital could have a small contingent of counselor-mediators...that could serve to formally mediate disputes" (Sims-Taylor, 1994, p. 367). If mediation proves unsuccessful, the conflict would be referred to a multi-disciplinary ethics committee for non-binding adjudication. Medical social workers, who have received advanced training in mediation and bioethics, would be well-suited to fulfill the mediator-counselor role that Sims-Taylor suggested.

**Social work qualifications as a “counselor-mediator.”** Studies have shown that social workers were family members' first choice when they wanted assistance discussing issues surrounding end-of-life decisions; social workers are more likely to be involved in these decisions than any other members of the treatment team (Huff, et al., 2008). Core skills of medical and hospice social workers include: providing people with the information needed to understand the natural course of an illness as well as the decisions they are likely to face; helping families deal with their emotional reactions to the information they receive; and helping patients and families understand and plan for the time when death becomes imminent (Huff, et al., 2008). A social worker uses skillful interviewing techniques and a systems perspective to elucidate tensions, values differences, and misunderstandings. In other words, the medical social worker is attuned to the needs of the patient and family in the context of illness, death and the healthcare environment. Medical social worker interventions are usually short term; these sessions are designed for problem solving not addressing behavioral or personality issues (DeAngelo, 2000).

In her research, Parsons found that family conflict resolution was one of the five most frequent interventions of home health care agency social workers.
Therefore, she notes, "the role of mediator is not new to social work. Social work is (in fact) often viewed as mediation between clients and their environments" (Parsons & Cox, 1989, p. 123). In another study, social workers said they perceived their primary role as advocates for patients and families and as arbitrators and mediators between patients and families and the hospital (Stein & Sherman, 2005).

Social workers are also trained in ethics and are active participants on many ethics committees. The National Association of Social Workers promotes the integration of principles of bioethics into professional practice: "Social workers are expected to be familiar with common and complex bioethical considerations and with legal issues such as the right to refuse treatment; proxy decision-making; and withdrawal or withholding of treatment" (Stein & Sherman, 2005). Csikai (2004) found that ethics committees look to social workers to act as a liaison between the patient, family and healthcare team; present family beliefs and values; help promote communication; investigate facts of the case from all parties; and facilitate discussions.

In summary, social workers are already key members of the healthcare team particularly when issues involve communication with the patient and family. Long sessions with patients and families are an expected part of social work practice. Therefore, social workers may be more likely than other team members to have the flexibility to schedule and facilitate end-of-life dispute resolution sessions. Because medical social workers know the culture and language of healthcare, they are prepared to be "translators" and communication consultants. In many settings, social workers are already respected members of ethics committees. Acting as a mediator would be a natural extension of social worker skills, responsibilities on the healthcare team, and involvement on ethics committees.

**Social Work Mediators as Adjuncts to the Ethics Committee**

*Communication consultants at the end of life: A conceptual model.* Social workers are often active participants in end-of-life discussions. In this conceptual model, medical social workers would receive additional training to enhance their
skills in addressing and mitigating conflict that arises in the context of end-of-life care. The training (which is discussed in greater detail below) would include content on bioethics, conflict management, advance directives, and capacity assessment. In addition, social workers would be taught a structured approach for facilitating difficult end-of-life conversations and mediating end-of-life disputes. The trained social workers would form a team or network of "communication consultants" (CC) affiliated with the ethics committee.

Social workers in the emergency department, on the medical and surgical floors and in the critical units would be expected to be proactive in identifying potential end-of-life conflicts and ethical dilemmas. In addition, other clinical staff would be encouraged to make automatic referrals for social work intervention if a terminal patient did not have a living will or designated surrogate or patients and families faced significant communication challenges because of literacy issues, language barriers, or physical disabilities. Any member of the treatment team could request the services of a communication consultant; a physician referral would not be required.

After receiving training, a medical social worker might use mediation as a methodology to clarify differing views and expectations and develop consensus on treatment decisions. Or, one hospital social worker might choose to call in another social worker (acting as a communication consultant) to facilitate a meeting with the family. This second option would be the better choice if the social worker wished to remain an advocate for the patient or family or a new, impartial consultant would bring a needed, fresh perspective. The social worker might ask another CC to co-facilitate a session if the family was particularly large or the issues unusually complex. A communication consultant could "mediate" discussions among family members, clinical team members, or between the patient/family and healthcare providers. A CC might also be used to facilitate end-of-life family meetings to improve the efficiency and effectiveness of the process and relieve some of the burden on physicians.
The consultation process. An invited communication consultant would review the patient's chart and gather information from the clinical team. Speaking with the patient (if possible), family members and any surrogate decision-makers would be a standard, essential part of the process. Assessment would focus in particular on communication issues. Healthcare team members would be invited to participate in a consult as needed although a treating physician would always be present if treatment choices were being made. As Hoffman (1994) suggested, a member of the ethics committee could offer advice prior to the mediation or be present at the session as an interested party.

The primary goal of the consult would be to share information about values, diagnosis, prognosis, and treatment options. Misunderstanding would be addressed. Choices would be presented and evaluated. Priorities would be established. Patient and family wishes and needs would be expressed and medical constraints explained. If possible, the CC would help the parties reach mutually agreeable decisions about care. Communication consultations would be considered confidential meetings. Decisions reached in these sessions would be documented in the patient's chart only if needed for patient care and with the knowledge of family and staff. If the consultation did not lead to an agreement, the issue could be referred to the ethics committee for their deliberation. The original social worker, not the CC would maintain the ongoing relationship with the patient and family.

As members of the clinical team, a specially trained social worker/communication consultant would also act as front line resources on ethical concerns. If unable to answer a question from the staff, she or he would contact the ethics committee for advice. A social worker/communication consultant would also be expected to model - and thus informally teach - excellent interviewing and patient education techniques. Finally, it is hoped that the social worker/communication consultant would inform the ethics committees of systems issues that are leading to ethical issues and unnecessary conflict that can lead to a more negative ethical climate.
Advantages of the communication consultant model. The model:

- Addresses these goals of the ethics committee: resolve conflict; improve patient care; increase patient satisfaction; and educate clinical staff, patients and families about bioethics.
- May be a more acceptable approach than traditional consults through the ethics committee. This model may be less threatening to clinicians because it is integrated in to clinical practice. Communication consultants will have the skills of a facilitator who is already familiar with the language and culture.
- Is minimally invasive: it trades the pure neutrality of an external neutral for a less intrusive, more flexible response. It preserves patient privacy during very emotional times.
- May increase patient and family satisfaction because it increases face time with clinicians and improves communication. It is less formal and remote than traditional ethics committee consultation and includes the family in the process when possible.
- May help the institution meet the Joint Commission’s requirement that hospitals provide conflict resolution strategies. The communication consultant acts as a role model for mediation and other alternative dispute resolution skills.
- Is practical and economical: it builds on and enhances the skills of existing staff. It requires minimal financial and personnel investment. It could use float or on-call staff in the communication consultant role.
- May be an alternative that could be used by smaller hospitals without funds to support a staff ethicist or for hospice/home care and rural health care facilities which might not have easy access to ethics committees or other conflict resolution resources. Social workers from one nursing home, for example, could be "on-call" as a communication consultant for other facilities. Or, state organizations, such as Midwest Care Alliance, could provide a "communication consultant" as a service to its members. In a healthcare
system such as OhioHealth, a social worker/communication consultant at one of the hospitals might respond to a facilitation request at one of the other hospitals.

- Provides a mechanism for gathering data about system problems thus opening up the possibility of changing and improving practice.
- Extends the educational efforts of the ethics committee by creating opportunities to explain and discuss ethical principles in the context of actual clinical practice. It provides the ethics training required for licensed social workers.
- Allows the ethics committee to be the ethics experts. It acknowledges that it is difficult for an ethics committee representative to be a neutral party.
- Draws on mediation skills to provide safe, efficient, structured communication that empowers patients and increases their participation in the medical decision making. It supports patient-centered care and focuses on creating a plan of action that respects the interests and needs of patients, families, and healthcare providers.
- Becomes part of end-of-life treatment focusing on good communication rather than on conflict.

**Similarities with and differences from other medical social work roles.**

**Discharge planner.** Medicare defines discharge planning as "a process used to decide what a patient needs for a smooth move from one level of care to another". The discharge planner, who is often a social worker, is responsible for making sure that the plan of care is safe and appropriate. A discharge plan is a short-term strategy to get a patient out of the hospital to another level of care. Discharge planning may occur at the end-of-life if a patient moves from acute care to hospice, skilled nursing or home care. Discharge planning generally involves an assessment of patient and caregiver needs, patient and family education, a review of insurance coverage and community resources, and various steps in setting up alternative care. Discharge planning usually goes smoothly and is well managed by the discharge planner.
However, if healthcare team members felt that there was significant conflict in the planning process - for example, family members were fighting discharge because they felt that aggressive inpatient care should be continued - they might request assistance from the communication consultant. If disagreements were resolved during the consults and the family and the team agreed to a plan of care, the discharge planner would help implement the plan.

Like the discharge planner, the CC would need to understand the patient's diagnosis and prognosis and the treatment plan. In addition, the CC would assess the patient's and family's understanding of the situation and their emotional, physical, and financial resources. Unlike the discharge planner, the CC would be more focused on how values differences and communication breakdowns are preventing effective decision-making.

**Counselor.** Brief, supportive, time-limited psychotherapy has specific goals. The intervention is intended to help clarify the source of the conflict and focus on specific issues or problems that are currently pressing. It may have an educational focus but usually does not aim to uncover deeply held or long-standing conflicts. In family therapy, only one member may be experiencing symptoms; however, the whole family is included in treatment because they are impacted by the problem or conflict. A therapist looks for ways to reinforce the family's strengths and problem-solving behaviors (Gabel, 2003). When social workers do counseling in a healthcare setting, they often use this model.

Like a counselor who uses time-limited psychotherapy, the CC would help to bolster problem-solving skills. The CC would do this by helping the patient and family articulate their needs and understand what the healthcare team is recommending and why. In addition, the CC would help team members listen to patients and families and present painful news in a way that is easier to comprehend. Unlike a counselor, the CC would not try to address long-term relationship issues nor be expected to "cure" unhealthy coping strategies.
Similarities with and differences from traditional mediation.

A comparison of mediation and counseling. As noted earlier, mediation is a structured form of dispute resolution that uses an impartial facilitator - the mediator - to help the parties reach a decision that is mutually satisfactory. There are many commonalities between mediation and counseling. In both, conflict is central, and participants want to change an undesirable situation. In both, the third party is expected to be neutral, non-judgmental, and supportive to both sides. Similarly, these approaches foster appropriate expression of feelings and emotion relevant to the situation. However, "mediation proceeds from the stated problem, which is often related to a substantive issue or resource, backward to positions that are personal and emotional in nature. The psychotherapist commonly starts with the ‘interests’ of the client, which are personal and emotional in nature, before going to more substantive resource-based issues" (Gabel, 2003, p. 323). Mediation, generally, is more focused on tangible outcomes than on resolution of disturbing feelings. And, mediation is more heavily weighted to achievement of a specific, concrete, detailed agreement about a problem or conflict; improved relationship among the parties in the future is usually secondary. "The mediator is not wedded to, or a subscriber to, various theoretical orientations related to communication or to mental health…(The mediator) uses techniques from any field that seem appropriate to foster the type of relationship that is helpful in achieving the ultimate goal of mediation" (Gabel, 2003, p. 327).

A comparison of traditional mediation and the CC model. Like a mediator, the communication consultant would use a structured format to facilitate the healthy exchange of information and emotions. In addition, like a mediator, the CC's goal would be to help parties come to mutually satisfying decisions. Unlike the classic mediator, the CC would not be a strictly neutral third party. In fact, the CC would be a clearly identified member of the healthcare team, providing consultation much like other specialists do in medicine. In addition, the CC would provide education on healthcare jargon, hospital procedures, treatment constraints, and ethical principles. Even more important, the CC would identify power imbalances and work actively to "level the table". The CC would help parties explore possible choices - but always
within the context of the healthcare environment and the condition of the patient. This "limited range of outcomes challenges a traditional benefit associated with mediation" (Bierlein, 2007, p. 81). The CC would work from the perspective that communication breakdown is the underlying cause of most conflict at the end of life. The CC would be flexible in working just with families, just with team members or with families and providers depending upon where the conflict is occurring. Therefore, the philosophical presumption is that providing a safe environment for a thorough and thoughtful exchange of information would mitigate conflict in all but the most intractable values disputes.

Addressing concerns about neutrality and mediation ethics. Purists hold that a mediator must be neutral. In other words, he or she must not have feelings, values, agendas or relationships that might consciously or unconsciously favor one party over another. It is this belief in the neutral third party that has led many to say that mediators in bioethical disputes must be from outside the healthcare system. In reality, there is substantial discussion about what mediators can and cannot do and still remain "neutral" and "ethical" (McCorkle, 2005; Cobb & Rifkin, 1991; Taylor, 1997).

While the CC would use mediation skills when facilitating end-of-life discussions, she or he will not be a "mediator" and held to a theoretical level of neutrality that could not, in fact, be achieved. However, the CC would be expected to meet other ethical standards. The CCs would always disclose to the parties that they are social workers, employed by the healthcare facility, and working short term as consultants; they would not continue if any of the parties found this a conflict of interest. In addition, when working as communication consultants, the social workers would not provide counseling, discharge planning or other social work services. As with all medical encounters, the communication consults would be confidential. The CC would not conduct a consult if the parties were unable to participate meaningfully. Party self-determination would be respected and the CC would ensure that no one dominated the discussions, prevented others from making their own decisions. Of particular concern, the CC would ensure that non-participating third
parties (such as an unconscious patient) would not be harmed by any agreements reached (Hoffman, 2003).

In many respects, the CC would be more like an organizational ombudsman than a mediator. An ombudsman is expected to be fair and even-handed, have no personal stake in the outcome, and be objective in the assessment of the facts and analysis of the situation. While the ombudsman could help individuals identify, construct and evaluate options, he or she no formal power to make, change, or impose a decision (Gadlin & Pino, 1997). While an ombudsman is an employee, he is, nevertheless, working independently. He develops credibility because he is open-minded. He treats individuals equitably - not according to their status - as a sign of respect.

**Implementing a communication consultation program.**

*Support needed from the ethics committee.* For this model to work, the ethics committee must be committed to being more proactive than reactive. Rather than serving primarily as a consultative or adjudicative body, the committee must embrace new goals of preventing and minimizing conflict. In addition, the committee would acknowledge that many ethics conflicts are the result of poor communication rather than intractable differences in values. The committee must offer social workers extended training in bioethics and ethical decision-making frameworks. Training would require a coordinated effort between the ethics committee and the department of social services. Finally, the committee must treat the trained social workers as adjunct members of the ethics committee who serve as front line conflict managers in end-of-life disputes. Since this is a new approach for the ethics committee and a new role for social workers, the committee would need to obtain buy-in from healthcare team members and supplemental funding from administration. The new program is meant to enhance conflict management services; the committee itself remains the expert on bioethics and the final advisory body when ethical issues cannot be resolved by early intervention.

*Support needed from social services.* To support this effort, the department of social services must envision an enhanced role for its staff. While the skills to
become a communication consultant are complementary with current social work competencies, the department must endorse, and perhaps secure funding for, the additional training needed to take on these new responsibilities. Continuing education, occasional meetings with the ethics committee, and communication consultation sessions would also require time that would be taken away from other responsibilities. In addition, the model requires that social workers must have the flexibility to respond when called in by colleagues to assist with end-of-life discussions and disputes.

**Suggested content for communication consultant training.** Training for the communication consultants should be standardized so that these specialists will be seen as providing competent, consistent service. How the content is packaged and presented will depend on the learning needs of the social workers, the time available for training and the availability of materials and instructors. Below is a recommendation of core content.

Knowledge acquired through readings, lectures, and self-assessment tools:

- Self-assessment: attitudes toward death; attitudes toward conflict
- Core content in:
  - End-of-life issues; cultural factors in end-of-life decision-making; physical aspects of dying; stages of grief
  - Recommended steps and questions for end-of-life conversations
  - Sources of conflict in healthcare
  - Advance directives - living wills and healthcare power of attorney; role of healthcare surrogate; Medical Orders for Life Sustaining Treatment
  - Low health literacy; plain language communication principles; learning needs assessments
  - Religious and cultural values impacting care decisions
  - Bioethical principles
  - Mediation ethics
  - Assessment of decision making capacity of patient, family or surrogate
Skills acquired through watching videos and demonstrations, doing role playing exercises, class room discussions, and shadowing others:

- Handling highly charged conversations; dealing with conflict
- Talking about highly emotional issues (e.g. death)
- Conducting interested based negotiations
- Balancing power while maintaining respect
- Adapting communication to the needs of the ill, disabled and elderly
- Maintaining impartiality; disclosing of interests
- Deciding who should participate in a communication consult
- Making a referral to the ethics committee; working with ethics committee members or ethics consultant
- Conducting a communication consult session according to the structured model
- Maintaining confidentiality within the constraints of patient care
- Charting agreements according to institutional guidelines
- Communicating consult decisions to other members of the treatment team
- Making referrals for ongoing follow up as needed (for example, to pastoral care, legal, customer service)

**Evaluation of a communication consult service.** The objectives of the communication consult are to improve communication about end-of-life issues and reduce conflict in end-of-life decision-making. To be effective, the process must be timely and efficient. It must respect the needs of patients, families and healthcare providers. Because it will divert resources from other activities there must be value added from this effort. It is hypothesized that this approach would:

- Increase patient and family satisfaction versus usual care because it would help improve communication by clarifying information and choices. The consultation process would provide in-person assistance to patients and families who require timely, and time intensive, assistance.
- Increase staff satisfaction by making it easier to conduct end-of-life conversations and make end-of-life decisions in partnership with families.
The communication consult would achieve this by acting as a “liaison with patients and families” as suggested in this study.

- Improve the ethical climate in the critical care unit by decreasing conflict. The communication consult process would do this by providing another resource for resolving team disputes or disputes between clinicians and families. The communication consult will be an alternative to traditional, hierarchical decision making.
- Improve the communication skills of other healthcare team members as they observe the communication consultation process.
- Extend the educational efforts of the ethics committee by training social workers who can, in turn, provide real time information and assistance when dilemmas arise.
- Provide the ethics committee with more information on inadequately addressed ethical issues.
- Make it easier for the ethics committee to respond proactively to problems which could become ethical disputes.
- Complement the skills and resources of an all volunteer ethics committee
- Extend the ethics committee’s presence in the critical care setting.

Interviews and satisfaction surveys could be used to gather information after the implementation of a pilot program. It might also be possible to determine whether the program had an impact on the use of life-sustaining treatment (Schneiderman, et al. 2003) or on the number of referrals to palliative medicine or hospice from inpatient care.

_Potential barriers to implementation._ Challenges to implementing this program may come from various points in the healthcare system. There is a prevailing attitude that it is up to physicians to handle their own conflicts; consequently, doctors may look at the communication consults as a threat to their power or autonomy (Lebed & McCauley, 2004-2005). Physicians may also want to maintain full control over end-of-life conversations. Nurses may resent that social workers are being given
an additional responsibility particularly one which may impact patient care. The ethics committee may not be comfortable using "adjunct" staff or in adopting a more proactive approach to conflict. Some ethics committee members may feel this role must be held by a physician or bioethicist despite research showing that consultations have been successfully conducted by many disciplines. Many view social workers as strictly "discharge planners" and may be unable to accept this new role. Social workers themselves may be reluctant to learn new skills or take on added responsibility. Patients and families may be hesitant to discuss personal issues even in a structured, confidential format.

From a practical standpoint, it may be difficult to find the resources and time to train the communication consultants. Even when they are trained, social workers may find it difficult to juggle their schedules to provide consultations. Marketing the program will be critical particularly since staff are likely used to handling issues on their own. Even as a pilot project, the communication consultation process will require buy-in from diverse stakeholders and a commitment of time, energy and financial resources.

Decisions about end-of-life care are complex and highly emotional. Each participant brings a unique set of values, knowledge, and responsibilities to the discussion. Misunderstandings are common, and it can be difficult to resolve differences in an expedient, respectful way. The proposed model acknowledges the complexity of resolving disputes in the healthcare environment and builds on existing strengths in the system - and in social work practice - to improve end-of-life conversations and decisions. The changes required to implement the communication consultation process might provoke resistance from those committed to current practice. For others, the model may present an opportunity to manage conflict proactively, to further a positive partnership between patients, families and the healthcare team, and to address the needs identified in this study.
Limitations

This study has a number of limitations. It was conducted in only one healthcare system in the Midwest. The primary purpose of the research was to gather data to direct planning and evaluation efforts for this multi-hospital healthcare system. Responses of participating staff and ethics committee members may also help inform the work of other committees nationally. However, the data collected may not reflect the experiences of similar professionals in other hospital systems, from other parts of the country, or employed by other types of healthcare practices. Replication of this study in other regions or in different healthcare models (e.g., the Veterans Administration or Kaiser Permanente) would partially address this concern.

The study included only staff working in or affiliated with the critical care units. Other healthcare staff (e.g., employees working in home health or skilled nursing) may have different views about the support needed from an ethics advisory committee. In an effort to address a limitation in earlier research and give voice to a broader spectrum of healthcare providers who might use ethics committee services, this research tried to include as many different disciplines as possible. However, this meant that many of the sample sizes were very small. Small sample sizes raise additional concerns about validity, and differences between samples, even if statistically significant, must be interpreted with caution. A repeated study with larger, randomly generated samples of participants would strengthen the research and address validity concerns, as would the inclusion of a broader selection of clinical staff.

There are also limitations in the external and content validity of the concept maps that were generated in this study. The methodology limited the conceptual domain by confining brainstorming responses through the carefully constructed focus prompt (Robinson & Trochim, 2007). Working closely with an advisory team to develop the final focus helped ensure that the wording generated the information that was most meaningful to participants and end users. Consequently, because the ideas generated were purposefully constrained by the wording of the focus prompt, there are intrinsic limitations on how broadly the findings can be generalized.
The concept mapping process limited the final number of brainstormed ideas for rating and sorting. And, some suggestions were excluded because they were not consistent with OhioHealth standards of practice. Consequently, the statements included in the rating and sorting steps did not represent a complete inventory of potential ways an ethics advisory committee might support the work performed in the critical care setting. This issue could be addressed by replicating the study (Donnelly, Donnelly, Grohman, 2005) and comparing the ideas generated. In this study, there was no opportunity to explore why statements were included. This limitation could be partially overcome if participants (or a sub-set of participants) could be assembled for interpretive sessions to discuss individual items and their meaning or relevance (Johnsen, Biegel, & Sharfran, 2000). The Director and a research specialist from the OhioHealth Medical Education department have already discussed exploring topics further with focus groups of interns and residents. Another method for addressing this problem would be to pose the focus question during in-depth interviews (Robinson & Trochim, 2007) and compare this information with the generated statements. This type of qualitative research could also be conducted by researchers at OhioHealth, Ohio State or elsewhere.

Using a web-based tool had both advantages and disadvantages. By using an online application for the brainstorming, it was possible to gather data asynchronously from geographically dispersed settings. In addition, the online tool helped decrease participant burden because individuals could complete the brainstorming at their own convenience and pace. Employees working on the night shifts could be included as could staff who might not be attending regular staff meetings. Participants might also have been more candid than they would have been in an in-person brainstorming session where they might have been reluctant to express opinions in front of co-workers or managers (Petrucci & Quinlan, 2007). Nevertheless, some potential respondents may not have wanted to take the time to access the survey website. Future studies could collect data from participants by phone, regular mail or during staff meetings (Donnelly, Donnelly, Grohman, 2005; Vishwanath & Scamurra, 2007). Each method of data collection introduces bias into
Rosas and Kane (2012) contend that a larger number of raters increases the inter-rater reliability estimates. It was hoped that participants would find the online rating survey convenient and easy to access thus facilitating data collection from a larger sample of participants. The research advisory team hoped to have 100 usable Impact rating surveys (the most the software system licensing agreement would permit), but even after three and a half weeks and the inclusion of a third hospital, only 84 were usable in the remaining analysis. The lower than hoped for response rate could have been due to the time consuming nature of the task (which took 30-40 minutes of careful attention), difficulty accessing the survey from the OhioHealth’s email system, competition with other staff surveys, resistance from supervisors, or other demands in the work place. Although an incentive (a $5.00 gift voucher to the cafeteria) was offered, the gift was a small one and may not have seemed adequate for the time required to participate.

Rosas and Kane (2012) found that there is often a higher rate of rating survey completion if the surveys are distributed during in-person sessions in which personal encouragement can be given by the researcher. This recruitment approach was not feasible for this study, but in the future the health system may want to gather additional rating data from selected staff members and do this during more personal, in-person gatherings. Alternatively, future researchers might send participants paper and pencil rating sheets to overcome the reluctance of some participants to do the work online. In either case, sampling bias is introduced.

The sorting task was also a very time consuming process. To include as many ethics advisory committee members and clinicians as possible, sorting was offered online to Non EAC staff at two hospitals; some EAC members also did this step online. However, other researchers have found that sorting can be more challenging for participants to do online than in person. A short training video introducing this task was used to explain the sorting activity. The assumption was that the video would make the process easier to understand but this assumption has not been empirically tested. In addition, the sorting step can take up to 45 minutes to complete.
which adds to the participant burden and may have led to fewer completed sorts or compromised the quality of the sorting that was submitted.

Caution must be used in making inferences about the number of clusters, their content and their labels (Bedi & Alexander, 2009) which rely on significant researcher judgment in addition to the statistical analysis. The interpretation session was used to reduce this researcher-introduced bias. However, other groups might have chosen a different cluster solution or selected other cluster labels. Any data collected in this study should be considered qualitative and formative rather than objective and confirmatory.

Further Research

Many opportunities for future research were mentioned throughout this chapter. In addition, other issues are worthy of attention. At OhioHealth, as elsewhere, patients and families rarely access the services of ethics committees despite struggling with ethical and moral dilemmas, particularly at the end of life. In fact, this study indicated that ethics committees might have a positive impact on care by being a liaison between clinicians and families who are in distress. Further research is needed to determine why families are not accessing committee services themselves, what support they wish the committee could offer, and how committees can work in partnership with clinical staff to assist families who are making difficult decisions.

The conceptual model to use social workers as “communication consultants” might be one avenue for meeting family needs and connecting clinicians, families and the ethics committees. This model also might help improve ethical climate in a critical area unit by helping reduce conflict and ease the stress of end-of-life decision making. Hopefully, ethics committees will endorse this approach and work in close partnership with hospital administrators and departments of social service to pilot this model. After the model has been implemented, hospitals could measure whether patients and families are more satisfied with the care they receive and staff are feeling more supported and thus less ethically and morally stressed. It may also be possible
to measure cost savings if this intervention is successful in resolving ethical and moral issues proactively.

It was posited that a clinical ethics committee could play a role in creating a more positive ethical environment. The results of this study seem to indicate that Non EAC staff see opportunities for the committees to provide resources, training, and support which may improve the ethical environment. However, there is no hard data from this study to show that any of these interventions will, in fact, have this outcome. Scales which have been validated with nurses (Olson, 1995) are available to measure ethical climate in healthcare settings. Ethics committees could measure the current ethical climate in a work unit, implement one or some of the suggested activities, and then re-assess the ethical climate to determine if the services made a positive difference. In a similar way, validated scales (Corley et al., 2001; Schwenzer & Wang, 2006) could be used to measure levels of moral distress. A selected intervention (such co-sponsoring staff training in “The 4A’s to Rise Above Moral Distress” mentioned on page 179) could be piloted and then levels of moral distress could be measured again. Other variables might also be considered such as rate of staff turnover (Filopova, 2011; O’Donnell et al. 2008; Porter, 2010) or staff satisfaction before and after the intervention.

This study asked participants to make suggestions about committee activities and then speculate how much positive impact the activity could have on staff and care in the critical care setting. Consequently, the data generated in this research serves merely as a starting point for further exploration. Suggestions that were rated as having a potentially high positive impact could be implemented and then actual impact could be measured. Ideally, an intervention group could be compared to a usual practice control group. For example, Schneiderman et al. (2003) used a randomized controlled trial to measure the impact of an ethics consultation on number of days in the hospital, in the intensive care unit, or on non-beneficial life sustaining treatment. Similar metrics could be used to evaluate the value of some of the interventions suggested in this study.
A Summary of Suggestions for Ethics Committee Practice

The primary purpose of this exploratory study was to provide data which could help a large healthcare system improve its ethics committee services. However, as detailed earlier in this chapter, the findings have potential implications for other ethics committees as well. Some of the suggestions emerging from the study (e.g., “Provide education about basic ethical principles”) reflect traditional committee practice. Others point to new directions for ethics committee efforts. The following list summarizes the findings, observations, and recommendations presented above.

• The findings in this study affirm that ethics committees are looked to as a resource for education about ethics principles as many professionals feel they do not get a sufficient grounding in bioethics through their formal education. In addition, staff members want specific information on laws and ethical standards related to end-of-life care.

• Staff members want education on communicating more effectively with patients, families, and healthcare team members. In particular, staff members want help developing skills which will help them deal more successfully with conflict. This education could be provided by the ethics committee or some other department working in partnership with the committee.

• Because education remains such a vital function of the ethics committee, committees should purposefully recruit members with expertise in professional education who can help propose, design, oversee and evaluate staff development efforts. These individuals might work as a sub-committee of the full committee and need not be involved in clinical consults.

• Committees should develop close ties with human resources, medical and nursing education, social services, and pastoral care which can co-sponsor ethics related education. Ethics committees should advocate for funds to
provide seminars, workshops and ethics education days that could be discipline specific or broadly applicable.

- Ethics education should be offered in a variety of modalities (e.g., in team meetings, seminars, online, or in print) to reach more staff, more effectively.

- Staff members want the ethics committee to identify role models who practice high quality, ethical decision-making. Role models can help providers in the critical care setting understand how to approach ethical dilemmas and when to come to the committee for additional support and guidance. Identifying role models may also serve as a form of staff development as practitioners learn by example in the context of their work environment.

- Most staff members do not turn to the ethics committee as their first resource when they encounter a conflict or ethical dilemma. In this study more than 36% of respondents turned to supervisors first for advice on ethical concerns. Therefore, committees should provide ethics education targeted specifically for supervisors, helping them become more comfortable and proficient in assisting other staff untangle troubling situations.

- Staff members want the ethics committee to develop clear, specific hospital policies that will help them know in advance their legal and ethical obligations to both the hospital and patients and families.

- Staff members would like the ethics committee to develop simple resources such as a card with easy to understand definitions of code status or a screening tool to be used at admission to identify situations that might become ethically challenging. Regional ethics organizations (e.g., the Bioethics Network of Ohio) might consider developing these tools and sharing them with member organizations.
• Staff members want specific guidelines and education on when and how to access the ethics committee and what to expect from the consultation process. Similarly, staff want the services of the ethics committee to be well known and contact information for the committee widely available.

• Active outreach by the ethics committee and better accessibility can support staff and the work they do in the critical care units. Staff members want explicit permission to request a consultation. Personal outreach by the ethics committee may help develop trust so that clinicians feel comfortable requesting assistance when a crisis occurs.

• Staff members want “face time” with members of the committee; they want a bioethicist or a representative from the ethics committee to be visible and present in clinical activities.

• When a full consultation is needed, clinicians want the ethics committee to respond and meet promptly and make decisions quickly. In addition, staff members want the committee to get opinions from the clinicians directly involved in the care of the patient; staff want a voice in ethical deliberations.

• Staff members want more transparency from the ethics committee about how recommendations are reached. While ethics committee decisions do not set precedent, they nevertheless offer insight that can be applied in future situations. HIPAA and medical liability concerns may make it challenging to provide follow up to the healthcare team. In addition, communication with all clinicians involved in a patient’s care may be difficult. However, the ethics committee should consider developing mechanisms for giving feedback to the team such as debriefing sessions offered on several occasions in order to reach practitioners who work nights or irregular hours. Clinicians who are affiliated with the critical care unit (e.g., respiratory therapy, dietetics) should be included in the follow up communication.
• Staff members would like the ethics committee to communicate with clinicians through the medical record.

• Personnel working in critical care expressed a desire for the ethics committee to help them identify and network with appropriate resources in the system. This networking function could potentially be done by social medical workers.

• Staff members suggested that the ethics committee advocate for hospital resources that would help identify and address potential ethical issues proactively (e.g., a social worker in the emergency department 24 hours a day).

• Staff members want the ethics committee to ensure that “whatever decisions are made are grounded in the best interests of the patient” and are consistent with ethical practice, state laws, and hospital policies.

• Critical care staff often find discussion of end-of-life issues time consuming and difficult. Participants suggested that the ethics committee or a committee representative meet directly with families who are struggling with end-of-life decisions. This intervention could support staff and potentially improve patient and family satisfaction.

• Staff members want the ethics committee – or some other hospital service – to intervene to reduce tension and conflict between clinicians, patients and families. Many ethics committees already use family conferences very effectively to improve communication between staff and patients and families. In addition, ethics committees should consider collaborating with departments such as social work and palliative medicine to provide counseling and conflict resolution services.
• Staff members want the ethics committee to mediate between staff members who are in disagreement on how to approach an ethical dilemma.

• Ethics committee members should be required to have training in negotiation, mediation, and alternative dispute resolution.

• Ethics committees should consider the facilitation of ethical and moral support to be one of their primary functions. Staff working in the critical care unit have strong feelings about distressing ethical situations, particularly those that can occur when caring for critically ill patients. These concerns may lead to burnout or a desire to be relieved from care. Ethics committee should play a role in providing or securing emotional support for troubled staff. Support may come from pastoral care, social work, peer to peer support groups, or the opportunity to talk in a “safe space” such as a confidential ethics committee meeting. By adding the provision of ethical and moral support to their primary functions, ethics committees can potentially reduce the prevalence of moral distress which can lead to burnout, staff turnover, and less effective patient care.

• Ethics committees should actively look for opportunities to dovetail with other hospital initiatives. While committees may have limited resources to provide their own programming, they can advocate for services and provide consultation to hospital departments thus leveraging their unique expertise and influence.

• Ethics committees should be multi-disciplinary. Over representation from administrators, managers and physicians may skew a committee’s perspective and severely limit its ability to be responsive to the needs of front line staff. A purposeful, representative mix of clinicians and administrators is recommended. All disciplines want and need a voice in ethical deliberations and program planning.
• Clinicians want the opportunity to shape the committee’s work with feedback. Ethics committees should have a mechanism for soliciting suggestions from administration, ancillary staff, and clinicians.

• There are multiple opportunities for medical social workers to support ethical practice. First, because of their expertise in family dynamics and community resources, social workers should be members of ethics committees. Second, with their expertise in counseling, social workers should be involved in planning and providing interventions to address moral distress. Based on their advanced training, social workers are able to assist with staff education, particularly on the topic of communicating with patients and family members. Potentially, social workers might also act as “communication consultants” providing a proactive, conflict prevention intervention for staff members and families. Ethics committees and departments of medical social services should seek out opportunities for collaboration.

**Conclusion**

The findings in this study indicate that healthcare practitioners want help in addressing ethical and moral concerns, and they look to the clinical ethics committee as a potential resource. Many of the suggestions affirm that the committee’s traditional functions of education and hospital policy development continue to be important. In addition, the study results emphasized the importance of ethics committees being visible and present in clinical activities: staff want consultation provided in a more immediate and personal way than is usually done in the traditional ethics committee model. Of particular interest is that this research points to other activities that ethics committees might undertake or endorse, particularly in ensuring that staff get sufficient ethical and moral support. By operationalizing the traditional and suggested functions with specific activities, the results of this study should make it easier for ethics committees to plan, create objectives, conduct research and evaluate performance. While the primary purpose of this study was to help a
particular healthcare system improve the work of its ethics committees, it is hoped that the findings will prompt other committees to re-examine how they are approaching practice. In addition, this research indicated a number of ways in which medical social workers could help support the work of clinical ethics committees and address the needs of staff, patients and families. The suggested roles for social workers build on the profession’s expertise and leverage existing hospital resources.

Meeting the full spectrum of suggested activities is currently beyond the resources of almost all ethics committees. Expecting a group of volunteers to fulfill the diverse roles suggested in this research may be unrealistic. Yet, clearly, staff want and need help around ethical dilemmas. In fact, staff members are looking for an active, vibrant service that can offer ethics education, assist in developing hospital policies, offer personal and immediate consultation to clinicians and family members, and help overcoming moral distress. In the interest of better patient care and a stronger, more emotionally healthy workforce, it may be time for hospitals to begin dedicating personnel and substantially more resources to support these important efforts. With endorsement from the American Medical Association, the American Society for Bioethics and Humanities, or the Joint Commission, ethics services could be broadened and strengthened to better match the increasingly complex ethics issues healthcare staff, patients, and families face every day. Applying the lessons learned in this study would help direct resources and would be a major step in the right direction.
References


Torjuul, K., & Sorlie, V. (2006). Nursing is different than medicine: Ethical


Appendix A: Recruitment and Reminder Emails
Recruitment and Reminder Email for Brainstorming - Ethics Advisory Committee
Members

Email subject line: Please participate in study of Ethics Advisory Committees

Dear Ethics Advisory Committee member,

OhioHealth, through the Office of Mission and Ministry, and The Ohio State University are collaborating on a study to explore how ethics advisory committees could support the critical care staff and the work they do. In particular, we are interested in how committee activities might have an impact on care.

As a member of an ethics advisory committee, your perspective and input are very important to this project.

This study will be conducted in several stages, and you can participate in one or more. The first phase of the study is a brainstorming process which will be done confidentially, online and take about 10 minutes to complete. You can access the survey directly by clicking on this link: http://OhioHealthEthics.com/ or by typing the link name OhioHealthEthics.com into your browser.

To thank you for your participation, we would like to give you a $2.00 voucher that you can use at the hospital cafeteria. Instructions for getting your voucher appear at the end of the survey.

Results of this study will be shared with the ethics advisory committees once the study is completed. We hope that insights from this research will help committees become even more effective in supporting critical care clinicians.

We encourage you to contribute your ideas to this important effort. Thank you for all that you do for the ethics committee.

Corey Perry, M.Div., J.D
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu
Recruitment and Reminder Email for Brainstorming for Critical Care Staff

Email subject line: Interested in ethics? Work in critical care?

OhioHealth, through the Office of Mission and Ministry, and The Ohio State University are collaborating on a study to explore how ethics advisory committees could support you and the work you do in the critical care setting. In particular, we are interested in how committee activities might have an impact on care.

As someone who works in a critical care unit, your perspective and input are very important to this project.

This study will be conducted in several stages, and you can participate in one or more. The first phase of the study is a brainstorming process which will be done confidentially, online and take about 10 minutes to complete. You can access the survey directly by clicking on this link: http://OhioHealthEthics.com/ or by typing the link name (OhioHealthEthics.com) into your browser.

To thank you for your participation, we would like to give you a $2.00 voucher that you can use at the hospital cafeteria. Instructions for getting your voucher appear at the end of the survey.

Results of this study will be shared with the hospital community once the study is completed. We hope that insights from this research will help ethics advisory committees become even more effective in supporting the essential work you provide in the critical care unit.

We encourage you to contribute your ideas to this important effort. Thank you for all that you do for the patients who come to OhioHealth.

Corey Perry, M.Div., J.D.
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu
Dear Colleagues,

Several weeks ago, you and your colleagues in the Ethics Advisory Committees at Riverside Methodist Hospital and Doctors Hospital were asked to participate in a research study being conducted by the Office of Mission & Ministry at OhioHealth and The Ohio State University. This study is exploring how the ethics advisory committees at each campus could support the staff and the work they do in the critical care units. Many of you responded and offered suggestions. Suggestions were also submitted by critical care clinicians.

Now we need your opinions. We would like you to rate each brainstormed idea along two dimensions. First, we would like you to rate how much positive impact the proposed activities might have on the care provided in the units. Second, we want you to let us know how well the ethics committee in your hospital is currently fulfilling the suggested tasks. Final results of this research will be shared with ethics advisory committees and used for planning and prioritizing committee functions.

We want your candid feedback. You can access the survey directly by clicking on this link: go.osu.edu/OhioHealthEthics or by typing the link name go.osu.edu/OhioHealthEthics into your browser. Once you enter the survey, you will be asked to create a profile with a user name and password only you will know. This will allow you to start your survey and return later if you need more time to complete your responses. We do not want you to provide your name or contact information, and all responses will be kept confidential. Your data will be protected with a code to reduce the risk that other people can view the responses.

As an expression of our appreciation, each respondent will be offered a $5.00 voucher for the cafeteria. We recognize that it will take time for you to respond to these suggestions and – while this gift certainly will not compensate you for your time – we hope it will express our gratitude that you have assisted us in this vital research. Just follow the directions at the end of the survey to receive your voucher.

Again, thank you for your time and effort in this study.
Corey Perry, M.Div., J.D.
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu or 614-754-8303.
Email subject line: Express your opinion about the Ethics Committees

Dear Colleagues,

Several weeks ago, you and your coworkers in the critical care units at Riverside Methodist Hospital and Doctors Hospital were asked to participate in a research study being conducted by the Office of Mission & Ministry at OhioHealth and The Ohio State University. This study is exploring how the Ethics Advisory Committees at each campus could support you and the work you do in the critical care units. Many of you responded and offered suggestions. Suggestions were also submitted by ethics committee members.

Now we need your opinions. We would like you to rate each brainstormed idea along two dimensions. First, we would like you to rate how much positive impact the proposed activities might have on the care provided in the unit. Second, we want you to let us know how well the ethics committee in your hospital is currently fulfilling the suggested tasks. Final results of this research will be shared with ethics advisory committees and used for planning and prioritizing committee functions.

We want your candid feedback. You can access the survey directly by clicking on this link: go.osu.edu/OhioHealthEthics or by typing the link name go.osu.edu/OhioHealthEthics into your browser. Once you enter the survey, you will be asked to create a profile with a user name and password only you will know. This will allow you to start your survey and return later if you need more time to complete your responses. We do not want you to provide your name or contact information, and all responses will be kept confidential. Your data will be protected with a code to reduce the risk that other people can view the responses.

As an expression of our appreciation, each respondent will be offered a $5.00 voucher for the cafeteria. We recognize that it will take time for you to respond to these suggestions and – while this gift certainly will not compensate you for your time – we hope it will express our gratitude that you have assisted us in this vital research. Just follow the directions provided in the survey to receive your voucher.

Again, thank you for your time and effort in this study.

Corey Perry, M.Div., J.D.
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu or 614-754-8303.
Email subject line: Reminder! We need your input on the work of the ethics committees.

Colleagues,

We need your opinion about the current performance of your hospital’s ethics committee and about the potential impact of activities the committee may undertake. It is not too late to express your views!

The survey will close after 100 responses or on Thursday, February 14th at midnight, whichever comes first. Don’t miss out on this opportunity to give your input. If you have started this activity but haven’t had a chance to finish, there is still time to provide your viewpoint.

You can access the survey directly by clicking on this link: go.osu.edu/OhioHealthEthics or by typing the link name go.osu.edu/OhioHealthEthics into your browser. Remember, we don’t want you to give us your name or contact information, and all responses will be kept confidential. In appreciation of your time and energy, we are offering a $5.00 voucher which you can use at the hospital cafeteria. Instructions for getting your voucher appear at the end of the survey.

This study being conducted by the Office of Mission & Ministry at OhioHealth in collaboration with The Ohio State University.

Sincerely,
Corey Perry, M.Div., J.D.
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

If you have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu
Email subject line: Oops. Wrong email sent. We do want YOUR opinion on ethics committees

Dear Colleagues,

We apologize for the confusion. Our last email was unclear. We want and need input from Marion General critical care staff.

Several weeks ago, your colleagues in the critical care units at Riverside Methodist Hospital and Doctors Hospital brainstormed ideas on how the ethics committees could support the staff and the work they do in the units. Suggestions were also submitted by members of the Ethics Committees.

Now we need your opinions. We would like you to rate each brainstormed idea along two dimensions. First, we would like you to rate how much positive impact the proposed activities might have on the care provided in the critical care unit. Second, we want you to let us know how well the ethics committee in your hospital is currently fulfilling the suggested tasks. Final results of this research will be shared with ethics advisory committees and used for planning and prioritizing committee functions.

We want your candid feedback. You can access the survey directly by clicking on this link: go.osu.edu/OhioHealthEthics or by typing the link name go.osu.edu/OhioHealthEthics into your browser. Once you enter the survey, you will be asked to create a profile with a user name and password only you will know. This will allow you to start your survey and return later if you need more time to complete your responses. We do not want you to provide your name or contact information, and all responses will be kept confidential. Your data will be protected with a code to reduce the risk that other people can view the responses.

As an expression of our appreciation, each respondent will be offered a $5.00 voucher for the cafeteria. We recognize that it will take time for you to respond to these suggestions and – while this gift certainly will not compensate you for your time – we hope it will express our gratitude that you have assisted us in this vital research. Just follow the directions provided in the survey to receive your voucher.

Again, thank you for your time and effort in this study.
Corey Perry, M.Div., J.D.
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

This research study is being conducted by the Office of Mission & Ministry at OhioHealth and The Ohio State University.

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu or 614-754-8303.
Email subject line: Oops. Wrong email sent. We do want YOUR opinion on ethics committees

Dear Colleagues,

We apologize for the confusion. Our last email was unclear. We want and need input from Marion General critical care staff.

Several weeks ago, your colleagues in the critical care units at Riverside Methodist Hospital and Doctors Hospital brainstormed ideas on how the ethics committees could support the staff and the work they do in the units. Suggestions were also submitted by members of the Ethics Committees.

Now we need your opinions. We would like you to rate each brainstormed idea along two dimensions. First, we would like you to rate how much positive impact the proposed activities might have on the care provided in the critical care unit. Second, we want you to let us know how well the ethics committee in your hospital is currently fulfilling the suggested tasks. Final results of this research will be shared with ethics advisory committees and used for planning and prioritizing committee functions.

We want your candid feedback. You can access the survey directly by clicking on this link: go.osu.edu/OhioHealthEthics or by typing the link name go.osu.edu/OhioHealthEthics into your browser. Once you enter the survey, you will be asked to create a profile with a user name and password only you will know. This will allow you to start your survey and return later if you need more time to complete your responses. We do not want you to provide your name or contact information, and all responses will be kept confidential. Your data will be protected with a code to reduce the risk that other people can view the responses.

As an expression of our appreciation, each respondent will be offered a $5.00 voucher for the cafeteria. We recognize that it will take time for you to respond to these suggestions and – while this gift certainly will not compensate you for your time – we hope it will express our gratitude that you have assisted us in this vital research. Just follow the directions provided in the survey to receive your voucher.

Again, thank you for your time and effort in this study.
Corey Perry, M.Div., J.D.
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

This research study is being conducted by the Office of Mission & Ministry at OhioHealth and The Ohio State University.

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu or 614-754-8303.
Email subject line: Please participate in Ethics Advisory Committees’ study

Dear Ethics Advisory Committee member,

OhioHealth, through the Office of Mission and Ministry, and The Ohio State University are collaborating on a study to explore how ethics advisory committees could support the critical care staff and the work they do. In particular, we are interested in how committee activities can have a positive impact on care.

As a member of an ethics advisory committee, your perspective and input are very important to this project.

This study is being conducted in several stages, and you can participate in one or more. The first phase of the study was a brainstorming process. The second was a rating activity. This third phase is called “sorting.” During this part of the research, you are asked to organize the brainstormed suggestions into groups of conceptually similar ideas. This sorting activity is an interesting process. In fact, it may help you think more critically about the work you do as a member of an ethics advisory committee.

The sorting activity will be done online. You can access the survey directly by clicking on this link https://www.conceptsystemsglobal.com/EAC/sort or by copying and pasting this link into your browser. When you access the survey, you will be asked to create a user name and password that is known only to you. If you participated in the rating activity, you can use your existing log-in credentials. By setting up this secure log-in, you can start this activity, save your work, and return at a later time to complete your sorting. We will work to make sure that no one sees your survey responses without approval. But, because we are using the Internet, there is a chance that someone could access your online responses without permission. Your data will be protected with a code to reduce the risk that other people can view the responses.

To thank you for your participation, we would like to give you a $10.00 voucher that you can use at the hospital cafeteria. Information about how to get your voucher appears at the end of the survey.

A summary of this research will be shared with the Joint Ethics Advisory Committee and each ethics advisory committee once the study is completed. We hope that insights from this research will help committees become even more effective in supporting critical care clinicians.

We encourage you to contribute your ideas to this important effort. Thank you for all that you do for the ethics committee.
Corey Perry, M.Div., J.D.
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu
Email subject line: Your perspective on ethics consultation is needed

Dear clinician,

We are interested in how ethics committee activities could have a positive impact on care.

OhioHealth, through the Office of Mission and Ministry, and The Ohio State University are collaborating on a study to explore how clinical ethics advisory committees could support you and the work you do in the critical care setting. **As a clinician, your perspective and input are very important to this project.**

This study is being conducted in several stages. The first phase of the study was a brainstorming process. The second was a rating activity.

This third phase is called “sorting.” During this part of the research, we are asking you to organize the brainstormed suggestions into groups of conceptually similar ideas. This sorting activity is an interesting process. In fact, it may help you think more critically about the kind of support you need from an ethics advisory committee and provide insight that will help ethics committees with future planning and evaluation efforts.

The sorting activity is done online. You can access the survey directly by clicking on this link [https://www.conceptsystemsglobal.com/EAC/sort](https://www.conceptsystemsglobal.com/EAC/sort) or by copying and pasting this link into your browser. When you enter the survey, you will be asked to create a user name and password that is known only to you. By setting up this secure log-in, you can start this activity, save your work, and return at a later time to complete your sorting. You will not be asked to provide your name or contact information. We will work to make sure that no one sees your survey responses without approval. But, because we are using the Internet, there is a chance that someone could access your online responses without permission. Your data will be protected with a code to reduce the risk that other people can view the responses.

To thank you for your participation, we would like to give you a $10.00 voucher that you can use at the hospital cafeteria. Information on how to get your voucher appears at the end of the survey.
A summary of this research will be shared with the OhioHealth community once the study is completed. We hope that insights from this research will help committees become even more effective in supporting critical care clinicians.

We encourage you to contribute your perspective to this important effort. Thank you for all that you do on behalf of the patients who come to OhioHealth.

Corey Perry, M.Div., J.D.
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu or 614-754-8303.
Email subject line: Reminder! Help us sort it out.

You recently received an invitation to participate in a study we hope will improve the services of the ethics advisory committees and the support they provide to clinicians in the critical care setting.

We are still accepting input from critical care staff and ethics committee members. In this phase of the research, “sorting,” we are asking you to organize suggestions into groups of conceptually similar ideas. It is not too late to offer your insight on how the ethics committees could potentially function. If you have started sorting, you still have time to finish this activity. The sorting phase of this study will close on Friday, March 1st or whenever we have 50 completed “sorts,” whichever comes first.

The sorting activity is done online. You can access the sorting activity directly by clicking on this link https://www.conceptsystemsglobal.com/EAC/sort or by copying and pasting this link into your browser. When you enter the survey, you will be asked to create a user name and password that is known only to you. By setting up this secure log-in, you can start this activity, save your work, and return at a later time to complete your sorting. Remember, we won’t ask you to give us your name or contact information. The data is being collected through a secure online survey. Your data will be further protected with a code to reduce the risk that other people can view the responses.

As an expression of our appreciation for your time and effort, we are offering participants a $10.00 voucher to the cafeteria.

Corey Perry, M.Div., J.D.
System Director of Clinical Ethics
OhioHealth, Office of Mission and Ministry

Kathy Raffel, M.S.W., M.B.A., Ph.D. (candidate)
Doctoral Student
The Ohio State University, College of Social Work

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu or 614-754-8303.
Appendix B: Staff Meeting Announcements
Brainstorming Staff Announcement

A Study of How Clinical Ethics Committees Can Support the Staff and Their Work in the Critical Care Settings

OhioHealth, through the Office of Mission and Ministry, and Ohio State are collaborating on a study about the clinical ethics committees serving the OhioHealth system. The first part of this study is focusing specifically on Doctors Hospital and Riverside Methodist. Because you work in critical care, you are being asked to participate in this research. Your perspective and input are very important to this project.

This study will be conducted in several stages, and you can participate in one or more. The first phase of the study is a brainstorming process which will be done confidentially, online and take about 10 minutes to complete. In this online activity, you will be asked to make suggestions on ways the ethics committees could support you and the work you do in the unit.

You can access the survey directly by clicking on this link: http://OhioHealthEthics.com. I will leave a copy of this announcement so that you can access this information after the meeting. You may also receive an email about the study. The email will contain a direct link to the survey.

To thank you for your participation, the research team would like to give you a $2.00 voucher that you can use at the hospital cafeteria.

Results of this study will be shared with the hospital community once the study is completed. The research team hopes that insights from this research will help ethics advisory committees become even more effective in supporting the essential work we provide in the critical care unit.

You are encouraged to contribute your ideas to this important effort.

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu
Rating Staff Announcement

Please participate in a study about ethics committee services

OhioHealth, through the Office of Mission and Ministry, and Ohio State are collaborating on a study about the clinical ethics committees serving the OhioHealth system. As someone who works in critical care, you are being asked to participate in this research.

This study is being conducted in several stages, and you can participate in one or more. In fact, many of you may have contributed ideas during the first stage, Brainstorming, which was conducted in December. In this next phase of the research, you are being asked to rate the ideas that were suggested by clinicians and members of ethics advisory committees. Rating will be done for each suggestion. First, you will be asked to rate how much positive impact the proposed activities might have on the care provided in the units. Second, you will be asked to rate how well the ethics committee in this hospital is currently fulfilling the suggested tasks. Your perspective and input are very important to this project.

To participate in the rating activity, you will go to an online survey. You can access the survey directly by clicking on this link: go.osu.edu/OhioHealthEthics. I will leave a copy of this announcement at YYYYY so that you can access this information after the meeting. You may also receive an email about the study. The email will contain a direct link to the survey. When you log in, you will be asked to set up a user name and password that will be known only to you. Once you have set up your log-in access, you can start the survey, stop, and then return later to complete the ratings. The researchers do not want you to provide your name and contact information. Your opinions will be kept confidential. Your data will also be protected with a code to reduce the risk that other people can view the responses.

To thank you for your participation, the research team would like to give you a $5.00 voucher that you can use at the hospital cafeteria.

Results of this study will be shared with the hospital community once the study is completed. The research team hopes that insights from this research will help ethics advisory committees become even more effective in supporting the essential work we provide in the critical care unit.

You are encouraged to contribute your ideas to this important effort.
If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu

Sorting Staff Announcement

OhioHealth, through the Office of Mission and Ministry, and Ohio State are collaborating on a study about the clinical ethics committees serving the OhioHealth system. As someone who works in critical care, you are being asked to participate in this research. The study is exploring how ethics advisory committees could support us and the work we do in the critical care setting. In particular, they are interested in how committee activities can have a positive impact on care.

As a clinician in a critical care setting, your perspective and input are very important to this project.

This study is being conducted in several stages. The first phase of the study was a brainstorming process. The second was a rating activity. These phases of the study are now completed.

This third phase is called “sorting.” During this part of the research, you are asked to organize the suggestions that were brainstormed into groups of similar ideas. This sorting activity is an interesting process. In fact, it may help you think more critically about the kind of support you need from an ethics advisory committee and provide insight that will help the committee with future planning and evaluation efforts.

The sorting activity is done online. I will leave a copy of this announcement at (......) so that you can access this information after the meeting and copy down the URL (https://www.conceptsystemsglobal.com/EAC/sort). You may also receive an email about the study. The email will contain a direct link to the survey. When you log in, you will be asked to set up a user name and password that only you will know. Once you have set up your secure log-in access, you can start sorting, stop, and then return later to complete the sorting. You will not be asked to provide your name and contact information. The researchers will work to make sure that no one sees your survey responses without approval. But, because you will be using the Internet, there is a chance that someone could access your online responses without permission. Your data will be protected with a code to reduce the risk that other people can view the responses.

To thank you for your participation, the research team would like to give you a $10.00 voucher that you can use at the hospital cafeteria.
A summary of this research will be shared with the OhioHealth community once the study is completed. The research team hopes that insights from this research will help ethics advisory committees become more effective in supporting the essential work we provide in the critical care unit.

You are encouraged to contribute your ideas to this important effort.

If you should have specific questions about the process or the study itself, please contact Kathy Raffel at raffel.11@osu.edu
Appendix C: Thank You Vouchers
Appendix C: Thank You Vouchers

OhioHealth

Thank you for your participation in the Ethics Advisory Committee Study. This coupon authorizes up to $2.00 off your purchase.

Courtesy Meal Ticket

This coupon may be redeemed at the Riverside and Broadway Café or Doctors Café.

This coupon has no cash value. Only one coupon per person.

71050-551100
OhioHealth

Thank you for your participation in the Ethics Advisory Committee Study. This coupon authorizes up to $5.00 off your purchase.

Courtesy Meal Ticket

This coupon may be redeemed at the Riverside and Broadway Café, Doctors Café, or Skylight Café at Marion.

This coupon has no cash value.
Only one coupon per person.

71050-551100
Thank you for your participation in the Ethics Advisory Committee Study. This coupon authorizes up to $10.00 off your purchase.

**Courtesy Meal Ticket**

This coupon may be redeemed at the Grant Central Station, The Bistro at Grady, Waterfall Café at DMH or Skylight Café at Marion.

This coupon has no cash value. Only one coupon per person.

71050-651100
Appendix D: Consent Forms
Consent for Online Brainstorming

**Study Title:**
How could clinical ethics committees support the staff and work in critical care settings?

**Researchers:** Kathleen Raffel, Mo Yee Lee (Ohio State)
Corey Perry (OhioHealth)

**Sponsors:**
This study is being conducted by the College of Social Work, Ohio State University and the Office of Clinical Ethics & Faith Group Relations at OhioHealth. *This study has not received any grant or federal funding.*

**This is a consent form for research participation.**
It contains important information about this study and what to expect if you decide to participate.

**Your participation is voluntary.**
Please consider the information carefully. Feel free to contact the researcher listed below if you have any questions before making your decision whether or not to participate.

**What is the purpose of this study?**
The purpose of this study is to gather information which may help clinical ethics committees do a better job of supporting the work of clinicians working in the critical care settings. You are being asked to participate in this study because you serve on an Ethics Advisory Committee at OhioHealth or you are a clinician who works in a critical care setting.

**What will I be asked to do?**
The research method being used for this study is Concept Mapping. Data for this study will be collected in three phases. This consent form is for your participation in the first stage, “Brainstorming”.

During brainstorming, you can contribute your ideas about the work of clinical ethics committees through this online survey. The ideas generated in this stage of the research will be used in other phases which will be conducted at a later time. You will also be asked some demographic information after you have finished providing your brainstorming suggestions.
How much time will this activity take?
Completing this brainstorming survey will take approximately 15 minutes. If you finish the survey and think of other ideas later, you can re-enter the survey. You may stop doing the survey and leave the study at any time. If you stop, you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your relationship with OhioHealth.

What are the potential benefits of participating in this study?
By participating in this study you have the opportunity to express your opinions about ethics committee activities. Your views could potentially improve the support and services ethics committees provide clinicians in the critical care setting.

What are the potential risks of participating in this study?
The level of risk for participating in this study is minimal. The focus of this study is on program improvement.

How is my personal information protected?
The data is being collected through a secure online survey and you will not be asked to identify yourself. We will work to make sure that no one sees your survey responses without approval. But, because we are using the Internet, there is a chance that someone could access your online responses without permission. Your data will be protected with a code to reduce the risk that other people can view the responses.

If you consent to participate in this study, the study staff will be authorized to use your responses to carry out the purposes of the research. Organizations that may also review research records for quality assurance include groups such as:

• OhioHealth Institutional Review Board #2
• The Ohio State University’s Institutional Review Board or Office of Responsible Research Practices
• Sponsor (drug manufacturer, etc.)
• The U.S. Food and Drug Administration (FDA) and other government agencies.
• The Department of Health and Human Services Office of Human Subject Research Protections
• The Centers for Medicare and Medicaid Services (CMS)
• CIGNA (the financial agent for CMS)
• OhioHealth Research and Innovation Institute Office of Regulatory Compliance

Will I receive compensation?
To thank you for participation, you will be offered a $2.00 voucher which can be redeemed at an OhioHealth cafeteria. Information on how to get your certificate will be provided at the end of the survey. You may collect a voucher even if you do not answer all the survey questions.
Who has reviewed this study?
Institutional Review Boards responsible for human subjects research at both The Ohio State University and OhioHealth have reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

Whom do I contact if I have questions?
For questions, concerns, or complaints about the study, or if you believe you were harmed by participation, you may contact Dr. Mo Yee Lee at the College of Social Work at The Ohio State University at 614-292-9910.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251 or Dr. Randall Franz, Chairman of the OhioHealth Institutional Review Board # 2 at (614) 566-9345 or Customer Service at (614) 566-5708.

Providing Consent:
I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study. I am not giving up any legal rights by consenting to participate. Because I am completing the consent form online as part of an electronic survey, I understand that I will not be given a copy of this form but may produce a screen print from my computer or request a copy from the researchers.

By clicking on the “Next” button at the bottom of this page, you are indicating that you have voluntarily agreed to participate in this research. You will not receive a printed copy of this consent but you can print these pages from the Internet if you wish.
Consent for Online Rating

**Study Title:**
How could clinical ethics committees support the staff and work in critical care settings?

**Researchers:** Kathleen Raffel, Mo Yee Lee (Ohio State), Corey Perry (OhioHealth)

**Sponsors:**
This study is being conducted by the College of Social Work, Ohio State University and the Office of Clinical Ethics & Faith Group Relations at OhioHealth. This study has not received any grant or federal funding.

This is a consent form for research participation.
It contains important information about this study and what to expect if you decide to participate.

Your participation is voluntary.
Please consider the information carefully. Feel free to contact the researcher listed below if you have any questions before making your decision whether or not to participate.

**What is the purpose of this study?**
The purpose of this study is to gather information which may help clinical ethics committees do a better job of supporting the work of clinicians working in the critical care settings. You are being asked to participate in this study because you serve on an Ethics Advisory Committee at OhioHealth or you are a clinician who works in a critical care setting.

**What will I be asked to do?**
The research method being used for this study is Concept Mapping. Data for this study will be collected in three phases. This consent form is for your participation in the “Rating” activity.

During the first stage of the study, participants brainstormed ideas in response to the prompt:  
*Something specific ethics committees could do to support staff and the work they do in the critical care setting is…*

During rating, you can express your opinion through this online survey about the ideas suggested. You will also be asked to provide some demographic information.
How much time will this activity take?
Completing this rating activity will take 30-45 minutes. You can save your work and return to complete the ratings at a later time. You may also leave the study at any time. If you do not complete the rating questions, you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your relationship with OhioHealth or Ohio State University.

What are the potential benefits of participating in this study?
By participating in this study you have the opportunity to express your opinions about ethics committee activities. Your views could potentially improve the support and services ethics committees provide clinicians in the critical care setting.

What are the potential risks of participating in this study?
The level of risk for participating in this study is minimal. The focus of this study is on program improvement.

How is my personal information protected?
The data is being collected through a secure online survey and you will not be asked to identify yourself. We will work to make sure that no one sees your survey responses without approval. But, because we are using the Internet, there is a chance that someone could access your online responses without permission. Your data will be protected with a code to reduce the risk that other people can view the responses.

If you consent to participate in this study, the study staff will be authorized to use your responses to carry out the purposes of the research. Organizations that may also review research records for quality assurance include groups such as:

- OhioHealth Institutional Review Board #2
- The Ohio State University’s Institutional Review Board or Office of Responsible Research Practices
- Sponsor (drug manufacturer, etc.)
- The U.S. Food and Drug Administration (FDA) and other government agencies.
- The Department of Health and Human Services Office of Human Subject Research Protections
- The Centers for Medicare and Medicaid Services (CMS)
- CIGNA (the financial agent for CMS)
- OhioHealth Research and Innovation Institute Office of Regulatory Compliance

Will I receive compensation?
To thank you for participating, you will be offered a $5.00 voucher which can be redeemed at an OhioHealth cafeteria. Information on how to get your certificate will be provided at the end of the survey. You may collect a voucher even if you do not answer all the survey questions.
Who has reviewed this study?
Institutional Review Boards responsible for human subjects research at both The Ohio State University and OhioHealth have reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

Whom do I contact if I have questions?
For questions, concerns, or complaints about the study, or if you believe you were harmed by participation, you may contact Dr. Mo Yee Lee at the College of Social Work at The Ohio State University at 614-292-9910.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251 or Dr. Randall Franz, Chairman of the OhioHealth Institutional Review Board # 2 at (614) 566-9345 or Customer Service at (614) 566-5708.

Providing Consent:
I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study. I am not giving up any legal rights by consenting to participate. Because I am completing the consent form online as part of an electronic survey, I understand that I will not be given a copy of this form but may produce a screen print from my computer or request a copy from the researchers.

By clicking on the “Accept” button at the bottom of this page, you are indicating that you have voluntarily agreed to participate in this research.
Study Title:  
How could clinical ethics committees support the staff and work in critical care settings?

Researchers:  Kathleen Raffel, Mo Yee Lee (Ohio State), Corey Perry (OhioHealth)

Sponsors:  
This study is being conducted by the College of Social Work, Ohio State University and the Office of Clinical Ethics & Faith Group Relations at OhioHealth. This study has not received any grant or federal funding.

This is a consent form for research participation.  
It contains important information about this study and what to expect if you decide to participate.

Your participation is voluntary.  
Please consider the information carefully. Feel free to contact the researcher listed below if you have any questions before making your decision whether or not to participate.

What is the purpose of this study?  
The purpose of this study is to gather information which may help clinical ethics committees do a better job of supporting the work of clinicians working in the critical care settings. You are being asked to participate in this study because you serve on an Ethics Advisory Committee at OhioHealth or you are a clinician who works in a critical care setting.

What will I be asked to do?  
The research method being used for this study is Concept Mapping. Data for this study will be collected in three phases. This consent form is for your participation in the “Sorting” activity.

During the first stage of the study, participants brainstormed ideas in response to the prompt:  

Something specific ethics committees could do to support staff and the work they do in the critical care setting is…

During sorting, you will group these brainstormed ideas into piles in ways that make the most sense to you and then provide a short label for each grouping. You will also be asked to provide some demographic information.
How much time will this activity take?
Completing the sorting process will take 30-45 minutes. You can save your work and return to complete the sorting at a later time. You may also leave the study at any time. If you do not complete the sorting process, you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your relationship with OhioHealth or Ohio State University.

What are the potential benefits of participating in this study?
By participating in this study you have the opportunity to express your opinions about ethics committee activities. Your views could potentially improve the support and services ethics committees provide clinicians in the critical care setting.

What are the potential risks of participating in this study?
The level of risk for participating in this study is minimal. The focus of this study is on program improvement.

How is my personal information protected?
The data is being collected through a secure online survey and you will not be asked to identify yourself. We will work to make sure that no one sees your survey responses without approval. But, because we are using the Internet, there is a chance that someone could access your online responses without permission. Your data will be protected with a code to reduce the risk that other people can view the responses.

If you consent to participate in this study, the study staff will be authorized to use your responses to carry out the purposes of the research. Organizations that may also review research records for quality assurance include groups such as:

- OhioHealth Institutional Review Board #2
- The Ohio State University’s Institutional Review Board or Office of Responsible Research Practices
- Sponsor (drug manufacturer, etc.)
- The U.S. Food and Drug Administration (FDA) and other government agencies.
- The Department of Health and Human Services Office of Human Subject Research Protections
- The Centers for Medicare and Medicaid Services (CMS)
- CIGNA (the financial agent for CMS)
- OhioHealth Research and Innovation Office of Regulatory Compliance

Will I receive compensation?
To thank you for participation, you will be offered a $10.00 voucher which can be redeemed at an OhioHealth cafeteria. Information on how to get your certificate will be provided at the end of the survey. You may collect a voucher even if you do not answer all the survey questions.
Who has reviewed this study?
Institutional Review Boards responsible for human subjects research at both The Ohio State University and OhioHealth have reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

Whom do I contact if I have questions?
For questions, concerns, or complaints about the study, or if you believe you were harmed by participation, you may contact Dr. Mo Yee Lee at the College of Social Work at The Ohio State University at 614-292-9910.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251 or Dr. Randall Franz, Chairman of the OhioHealth Institutional Review Board # 2 at (614) 566-9345 or Customer Service at (614) 566-5708.

Providing Consent:
I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study. I am not giving up any legal rights by consenting to participate. Because I am completing the consent form on-line as part of an electronic survey, I understand that I will not be given a copy of this form but may produce a screen print from my computer or request a copy from the researchers.

By clicking on the “Accept” button at the bottom of this page, you are indicating that you have voluntarily agreed to participate in this research.
Consent for In-person Sorting and Rating

**Study Title:**
How could clinical ethics committees support the staff and work in critical care settings?

**Researchers:** Kathleeen Raffel, Mo Yee Lee (Ohio State)
Corey Perry (OhioHealth)

**Sponsors:**
This study is being conducted by the College of Social Work, Ohio State University and the Office of Clinical Ethics & Faith Group Relations at OhioHealth. This study has not received any grant or federal funding.

This is a consent form for research participation.
It contains important information about this study and what to expect if you decide to participate.

Your participation is voluntary.
Please consider the information carefully. Feel free to contact the researcher listed below if you have any questions before making your decision whether or not to participate.

What is the purpose of this study?
The purpose of this study is to gather information which may help clinical ethics committees do a better job of supporting the work of clinicians working in the critical care settings. You are being asked to participate in this study because you serve on an Ethics Advisory Committee at OhioHealth or you are a clinician who works in a critical care setting.

What will I be asked to do?
The research method being used for this study is Concept Mapping. Data for this study was collected in several phases.

During the first stage of the study, participants brainstormed ideas in response to the prompt:

*Something specific ethics committees could do to support staff and the work they do in the critical care setting is…*

During the second phase of data collection, participants provide opinions about the potential positive impact of ethics committee activities on the care provided in the critical care settings and an assessment of how well the committees are currently fulfilling suggested tasks. In this phase of data collection, participants will also organize the data. Whether or not you
participated in the brainstorming phase of this study, we need your consent to participate in this activity.

**How much time will this activity take?**
The interpretation session will last approximately 75 minutes.

**What are the potential benefits of participating in this study?**
By participating in this study you have the opportunity to express your opinions about ethics committee activities. Your views about the study findings could potentially improve the support and services OhioHealth clinical ethics committees provide clinicians in the critical care setting.

**What are the potential risks of participating in this study?**
The level of risk for participating in this study is minimal. The focus of this study is on program improvement.

**How is my personal information protected?**
Neither the written transcription nor the summary will link you personally with specific statements. However, you will be listed as a participant on the meeting summary. If you consent to participate in this study, the study staff will be authorized to use your responses to carry out the purposes of the research. Organizations that may also review research records for quality assurance include groups such as:

- OhioHealth Institutional Review Board #2
- The Ohio State University’s Institutional Review Board or Office of Responsible Research Practices
- Sponsor (drug manufacturer, etc.)
- The U.S. Food and Drug Administration (FDA) and other government agencies.
- The Department of Health and Human Services Office of Human Subject Research Protections
- The Centers for Medicare and Medicaid Services (CMS)
- CIGNA (the financial agent for CMS)
- OhioHealth Research and Innovation Office of Regulatory Compliance

**Will I receive compensation?**
You will be mailed a $5.00 voucher which you can redeem at an OhioHealth cafeteria.

**Who has reviewed this study?**
An Institutional Review Boards responsible for human subjects research at both The Ohio State University and OhioHealth have reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.
Whom do I contact if I have questions?
For questions, concerns, or complaints about the study, or if you believe you were harmed by participation, you may contact Dr. Mo Yee Lee at the College of Social Work at The Ohio State University at 614-292-9910.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251 or Dr. Randall Franz, Chairman of the OhioHealth Institutional Review Board # 2 at (614) 566-9345 or Customer Service at (614) 566-5708.

Providing Consent:
I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study. I am not giving up any legal rights by signing this form. I will be given a copy of this form.

________________________________________  ______________________________________
Printed name of person obtaining consent                Signature of person obtaining consent

________________________________________  ______________________________________
Printed name of person obtaining consent                Signature of person obtaining consent

AM/PM
Date and time

Investigator/Research Staff
I have explained the research to the participant before requesting the signature above. There are no blanks in this document. A copy of this form has been given to the participant.
Consent for Interpretation of Maps Session

**Study Title:**
How could clinical ethics committees support the staff and work in critical care settings?

**Researchers:** Kathleen Raffel, Mo Yee Lee (Ohio State)  
Corey Perry (OhioHealth)

**Sponsors:**
This study is being conducted by the College of Social Work, Ohio State University and the Office of Clinical Ethics & Faith Group Relations at OhioHealth. This study has not received any grant or federal funding.

This is a consent form for research participation.
It contains important information about this study and what to expect if you decide to participate.

**Your participation is voluntary.**
Please consider the information carefully. Feel free to contact the researcher listed below if you have any questions before making your decision whether or not to participate.

**What is the purpose of this study?**
The purpose of this study is to gather information which may help clinical ethics committees do a better job of supporting the work of clinicians working in the critical care settings. You are being asked to participate in this study because you serve on an Ethics Advisory Committee at OhioHealth or you are a clinician who works in a critical care setting.

**What will I be asked to do?**
The research method being used for this study is Concept Mapping. Data for this study was collected in three phases. This consent form is for your participation in a fourth activity, “Interpretation of Maps.”

During the first stage of the study, participants brainstormed ideas in response to the prompt: **Something specific ethics committees could do to support staff and the work they do in the critical care setting is…**

During the second phase of data collection, participants provided opinions about the positive impact of ethics committee activities on the care provided in the critical care settings and an assessment of how well the committees are currently fulfilling suggested tasks. In the third
phase of data collection, participants organized the data. Whether or not you participated in earlier phase of this study, we need your consent to participate in this activity.

In this activity, “Interpretation of Maps,” you will be instructed on how to interpret and utilize the graphical output of the study data. You will also be asked for your observations about the study findings and their implications for ethics committee activities. The interpretation session will be recorded and the recording will be transcribed. The transcription will be given to the System Director of Clinical Ethics who oversees the ethics advisory committees. The researcher will create a summary of the meeting. We would like your permission to use quotes from the session in either the executive summary or in other publications. Quotes will not be attributed to a particular individual.

**How much time will this activity take?**
The interpretation session will last approximately two and a half hours. You may leave this session at any time. If you do not complete the session, you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your relationship with OhioHealth or Ohio State University.

**What are the potential benefits of participating in this study?**
By participating in this study you have the opportunity to express your opinions about ethics committee activities. The information presented in the maps can help ethics committees plan and evaluate their services. Your views about the study findings could potentially improve the support and services OhioHealth clinical ethics committees provide clinicians in the critical care setting.

**What are the potential risks of participating in this study?**
The level of risk for participating in this study is minimal. The focus of this study is on program improvement.

**How is my personal information protected?**
Neither the written transcription nor the summary will link you personally with specific statements. However, you will be listed as a participant on the meeting summary. If you consent to participate in this study, the study staff will be authorized to use your responses to carry out the purposes of the research. Organizations that may also review research records for quality assurance include groups such as:

- OhioHealth Institutional Review Board #2
- The Ohio State University’s Institutional Review Board or Office of Responsible Research Practices
- Sponsor (drug manufacturer, etc.)
- The U.S. Food and Drug Administration (FDA) and other government agencies.
- The Department of Health and Human Services Office of Human Subject Research Protections
- The Centers for Medicare and Medicaid Services (CMS)
• CIGNA (the financial agent for CMS)
• OhioHealth Research and Innovation Office of Regulatory Compliance

Will I receive compensation?
To thank you for participation, you will be given refreshments during the session. You will also receive a copy of the written summary of the meeting.

Who has reviewed this study?
An Institutional Review Boards responsible for human subjects research at both The Ohio State University and OhioHealth have reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

Whom do I contact if I have questions?
For questions, concerns, or complaints about the study, or if you believe you were harmed by participation, you may contact Dr. Mo Yee Lee at the College of Social Work at The Ohio State University at 614-292-9910.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251 or Dr. Randall Franz, Chairman of the OhioHealth Institutional Review Board #2 at (614) 566-9345 or Customer Service at (614) 566-5708.

Providing Consent:
I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study. I am not giving up any legal rights by signing this form. I will be given a copy of this form.

__________________________________________________________________________          ___________________________________________________________________
Printed name of subject                      Signature of subject

__________________________________________________________________________          ___________________________________________________________________
Date and time

Investigator/Research Staff
I have explained the research to the participant before requesting the signature above. There are no blanks in this document. A copy of this form has been given to the participant.

__________________________________________________________________________          ___________________________________________________________________
Printed name of person obtaining consent         Signature of person obtaining consent
Appendix E: Instructions for Brainstorming, Sorting and Rating and Demographic Questions for In-person Sorting and Rating
Content of first page of online “Brainstorming” survey

Welcome.

We would like your perspective on how the clinical ethics committees at OhioHealth can support the staff and their work in the critical care settings.

Data will be collected in three phases: brainstorming, rating and sorting. In this first part of the study, brainstorming, you can contribute your ideas through this online survey.

It usually takes between 10 and 15 minutes for people to brainstorm and answer the 2 demographic questions. If you finish this survey and think of other ideas later, you can enter the survey again.

Your participation in all aspects of this activity is voluntary and your responses will be kept confidential.

As a token of appreciation for your contribution, we are offering you a $2.00 voucher which you can redeem at an OhioHealth hospital cafeteria. At the end of the survey, you will find information on how to get your gift.

After providing your consent to participate on the next page, you can begin sharing your ideas. Thank you.

This study is being conducted by:

OhioHealth Clinical Ethics & Faith Group Relations
Ohio State University, College of Social Work

If you have any questions about this research, contact Kathy Raffel at raffel.11@osu.edu or by calling 614-754-8303.

Consent Form: See Appendix D for the consent form.

Note 2: After consenting to participate, clinicians and ethics committee members were directed to separate pages in the survey so that the instructions could be
addressed to each group personally. Both groups responded to the same focus prompt. All the collected data was combined before the next phases of the study.

**Brainstorming instructions (clinicians)**

A multi-disciplinary clinical ethics committee serves each of the hospitals in the OhioHealth system. The mission of the ethics committees is to assist patients, families and health care team members sort through the ethical aspects of making difficult health care decisions.

Ethical issues are often complex, involving medical, nursing, legal, psychological, moral and social dimensions. Ethical dilemmas may prompt feelings of uncertainty and distress or even lead to conflict.

Below is a brainstorming prompt. As you respond to this prompt, think about your personal experiences as a clinician working in a critical care setting. Consider as many situations as you can in which you have struggled with an ethical dilemma. Please respond with ideas that reflect something that might help you or others in your unit.

Complete the following sentence and type your ideas in the space provided. You can respond as many times as you want, but please keep each statement brief and on a separate line.

_Something specific ethics committees could do to support staff and the work they do in the critical care setting is..._

**Brainstorming instructions (ethics advisory committee members)**

Multi-disciplinary, clinical ethics committees serve each of the hospitals in the OhioHealth system. The mission of the ethics committees is to assist patients, families and health care team members sort through the ethical aspects of making difficult health care decisions.

Ethical issues are often complex, involving medical, nursing, legal, psychological, moral and social dimensions. Ethical dilemmas may prompt feelings of uncertainty and distress or even lead to conflict.

Below is a brainstorming prompt. As you respond to this prompt, think about your personal experiences as a member of an ethics advisory committee. Consider as
many situations as you can. Please spend a moment to think of ideas that may point to new directions for the ethics committee’s work supporting the critical care units.

Complete the following sentence and type your ideas in the space provided. You can respond as many times as you want, but please keep each statement brief and on a separate line.

*Something specific ethics committees could do to support staff and the work they do in the critical care setting is...*

**Demographic questions**

For this study, we hope to reach a diverse mix of critical care clinicians and ethics committee members. Your answers to the two questions below will let us know whether the brainstormed ideas reflect a multi-disciplinary perspective.

**All demographic information will be kept confidential.** If you wish to remain anonymous and are concerned that answering a particular questions will identify you, please choose "No answer" for that question.

When finished, select the *Submit* button to continue to the Thank You page or *Exit and clear survey* to exit without having any of your brainstormed ideas or responses recorded.

1) Where is your **primary place of employment?** (choose one)
   - Doctors Hospital
   - Doctors Hospital ICU or critical care unit
   - Riverside Methodist Hospital
   - RMH 4 Blue ICU
   - RMH 5 Blue Cardiac ICU
   - RMH 6 Blue Neuro Critical Care
   - OhioHealth system
   - OhioHealth corporate offices
   - Someplace other than OhioHealth
   - No answer

2) What is your **primary professional role?** (choose one)
   - Administrator/manager
   - Attending Physician - medical specialty
   - Attending Physician - surgical specialty
   - Attorney
Chaplain or pastoral care
Dietician
Nurse
Occupational therapist
Pharmacist
Physical therapist
Resident or intern - medical specialty
Resident or intern - surgical specialty
Respiratory therapist
Social Worker
Other
No answer

“Thank you page” content

Thank you for sharing your suggestions.

After the first of the year, everyone who was invited to Brainstorm will be invited to rate the brainstormed ideas. We encourage you to participate in this aspect of the research as well.

To show our appreciation for your contribution, we would like to offer you a small gift: a $2.00 voucher which can be used at the hospital cafeteria. To get your voucher, please click on this link http://ohiohealthethics.com/71050-2.pdf. You will be taken to a web page which is not part of this survey. On this new page, you will have access to a pdf of the voucher which you can print and then use at the cafeteria.

Again, thank you for contributing to this effort. If you have any questions or concerns about this research, contact Kathy Raffel at raffel.11@osu.edu or by calling 614-754-8303.
First Page of Online “Rating” Survey – Introduction to the Project

Welcome,

This study is exploring what functions the clinical ethics committees could have at OhioHealth. The study is being conducted in several phases. In the first phase, completed in December, participants brainstormed ideas for how ethics advisory committees could support staff and the work they do in the critical care settings. You may have even contributed some of these ideas yourself.

We now need your candid feedback. We would like you to respond to each of the brainstormed ideas on two dimensions: how much positive impact that activity might have on the care provided in the critical care units and how well it is currently being done. Final results of this research will be shared with ethics advisory committees and used for planning and prioritizing committee functions.

This activity will take between 30 and 40 minutes to complete. If you cannot do all the ratings at one sitting, you can save your work and return later to finish.

Participation in all aspects of this activity is voluntary and responses will be kept confidential.

As a token of appreciation, we are offering you a $5.00 voucher that you can redeem at an OhioHealth hospital cafeteria. When you have completed the rating process, you will be given information on how to get your gift.

After providing your consent to participate and answering a few demographic questions, you can begin rating the brainstormed ideas.

This study is being conducted by:
OhioHealth, Clinical Ethics & Faith Group Relations
The Ohio State University, College of Social Work

If you have any questions about this research, contact Kathy Raffel at raffel.11@osu.edu or by calling 614-754-8303.
Registration Page Instructions

Please create a non-identifying user name and password. By registering, you will be able to start your work, save it and return later to complete it.

Complete ONLY the first three (3) lines of this form. Please DO NOT provide the other information that is requested on this registration page.

Consent Form: See Appendix D for the consent form.

Home Page Content for Online Rating Survey

In the first phase of this study, participants brainstormed almost 100 different ideas for how ethics advisory committees could support staff and the work they do in the critical care settings. In this part of the study, you will be rating each brainstormed idea twice. First, you will rate each activity based on how much positive impact you think it could have on the care provided in the critical care setting. After you have completed these ratings, you will rate each activity on how well you think it is currently being done.

Information from your individual ratings will be averaged with other participants’ ratings to give us a better understanding of how participants overall view each of the ideas. Your completion of both rating scales is very important to understanding how ethics committees might function more effectively at OhioHealth.

This activity will take between 30 and 40 minutes to complete. If you cannot do all the ratings at one sitting, you can save your work and return later to finish.

As a token of appreciation for participating in this study, we are offering you a $5.00 voucher that you can redeem at an OhioHealth hospital cafeteria. Please note, if the Thank You page does not appear after you complete the rating activity, you can access your thank you gift by clicking on the link in the Project Messages window which appears in the upper right hand corner of this window or by contacting Krista Clouser at KCLOUSE2@OhioHealth.com or 614-544-4399.

If you have any questions about this research, contact Kathy Raffel at raffel.11@osu.edu or by calling 614-754-8303.
Project Message content

If you were unable to get your voucher through the Thank You Page after completing both ratings, please click on this link: www.ohiohealthethics.com/71050-5.pdf. You will be taken to a web page which is not part of this survey. On this new page, you will have access to a pdf of the voucher that you can print and then use at the cafeteria.

Demographic Questions

For this study, we hope to reach a multi-disciplinary mix of participants who have varying experiences with clinical ethics consultation services. Your answers to the questions below will let us know how the rating results reflect various perspectives at OhioHealth.

All demographic information will be kept confidential. If you wish to remain anonymous and are concerned that answering a particular questions will identify you, please choose “No answer” for that question.

Only one response can be marked for each question. When finished with each question, select the Continue button to continue or Cancel to exit.

1) Where is your primary place of employment? (choose one)
   Doctors Hospital
   Doctors ICU
   Riverside Methodist Hospital
   RMH 4 Blue ICU
   RMH 5 Blue Cardiac ICU
   RMH 6 Blue Neuro Critical Care
   Marion General
   OhioHealth Corporate Offices
   OhioHealth system
   Someplace other than OhioHealth
   No answer

2) When you have questions about an ethical dilemma involving your clinical work, who is the first person you usually consult? (choose one)
   My direct supervisor
My program director
A more senior resident
A co-worker at OhioHealth
A colleague outside of OhioHealth
My team (in a team meeting)
An individual member of an ethics advisory committee
A clinical ethics advisory committee
A member of the pastoral care department
My spiritual advisor
My spouse or partner
Another family member
A close friend
Other
No one

3) Are you now, or have you ever been, a member of a clinical ethics advisory committee?
   No, never
   No at OhioHealth but yes at another institution
   Yes, at OhioHealth only
   Yes, at OhioHealth and another institution

4) What is your primary professional role? (choose one)
   Administrator/manager
   Attending Physician - medical specialty
   Attending Physician - surgical specialty
   Attorney
   Case Manager
   Chaplain or pastoral care
   Dietician
   Nurse
   Occupational therapist
   Pharmacist
   Physical therapist
   Resident or intern - medical specialty
   Resident or intern - surgical specialty
   Respiratory therapist
   Social Worker
   Speech Language Pathologist
   Other
   No answer
5) How many years have you worked in healthcare? (numerical)

6) What is your race? (choose one)
   - African American/Black
   - Asian or Pacific Islander
   - Caucasian/White
   - Hispanic or Latino
   - Native American
   - Bi-racial or Multi-racial
   - No answer

7) Over your entire career, how many times have you been involved in a patient care or clinical issue that has been brought to a clinical ethics advisory committee?
   - Never
   - 1-3 times
   - 4-6 times
   - 7 or more times

8) Over your entire career, how many times have you personally brought an issue to a clinical ethics advisory committee
   - Never
   - 1-3 times
   - 4-6 times
   - 7 or more times

Rating Instructions – Rating Question #1:

For each statement, please click on the number between 1 and 5 which best reflects your answer to the question:

How much positive impact could this activity have on the care provided in the critical care setting?

Use the following scale:

Impact Rating
1 = Very small positive impact when compared to the rest
2 = Some positive impact when compared to the rest
3 = Moderate positive impact when compared to the rest
4 = Large positive impact when compared to the rest
5 = Very large positive impact when compared to the rest

Keep in mind we are looking for relative importance. Please use all values on the rating scale to make distinctions. Do your best to rate each statement. However, if you cannot rate an idea, please skip this statement and go on to the next.

When you hit "Save Rating Information" your responses will be saved even if you were unable to rate some of the items.

Rating Instructions – Rating Question #2

In the second rating task, you will rate each of the brainstormed ideas again. For each statement, please click on the number between 1 and 5 which best reflects your answer to the question:

How well does the ethics committee currently perform this activity or task?

Use the following scale:

**Performance Rating**

1 = Very Poorly when compared to the rest
2 = Poorly when compared to the rest
3 = Adequately when compared to the rest
4 = Well when compared to the rest
5 = Extremely well when compared to the rest

Keep in mind we are looking for relative performance. Please use all values on the rating scale to make distinctions. Do your best to rate each statement. However, if you cannot rate an idea, please skip this statement and go on to the next.

When you hit "Save Rating Information" your responses will be saved even if you were unable to rate some of the items.

“Thank You” Page Content

(Note: This page appeared each time a set of statements had been rated, not only when the participant completed both tasks.)
If you have finished one rating task but not the other, you can find the link to the second rating task in the sidebar to the left.

If you have now completed both ratings, thank you.

We know that participating in this study took a substantial commitment on your part. Please know that your opinions will play a role helping OhioHealth ethics committees evaluate their current services and plan future activities.

We would like to offer you a small gift - a $5.00 voucher that you can use at an OhioHealth cafeteria. While this gift will certainly not compensate you for your time, we hope it will express our gratitude that you have assisted us in this vital research.

To get your voucher, please click on this link www.ohiohealthethics.com/71050-5.pdf You will be taken to a web page which is not part of this survey. On this new page, you will have access to a pdf of the voucher that you can print and then use at the cafeteria. If you should encounter any difficulties printing your voucher, contact Krista Clouser at 544-4399 or KCLOUSE2@OhioHealth.com for assistance.

Again, thank you for contributing to this effort.
Sorting Introduction and Instructions

First page of online “Sorting” activity – Introduction to the Project

Welcome.

OhioHealth wants to know how clinical ethics committees can best support the staff and work in the critical care settings. This online activity will help the committees plan how they will fulfill this important role.

To begin the survey, click on the "Self-Register" link below and complete only the three required fields. If you have registered for an earlier phase of this study, you can use your existing user name and password.

This study is being conducted by:

OhioHealth, Clinical Ethics & Faith Group Relations
Ohio State University, College of Social Work

If you have any questions about this research, contact Kathy Raffel at raffel.11@osu.edu or by calling 614-754-8303.

Registration page instructions

Please create a non-identifying user name and password. By registering, you will be able to start you work, save it and return later to complete it.

Complete ONLY the first three (3) lines of this form. Please DO NOT provide the other information that is requested on this registration page.

Consent Form: See Appendix D for the consent form.

Home page Content for Online Sorting Activity

This study is exploring what functions the clinical ethics committees could have at OhioHealth. The study is being conducted in several phases. In the first phase, ethics committees and clinical staff brainstormed ideas for how ethics advisory committees could support the staff and the work they do in the critical care settings. We now invite you to help us understand how the ideas fit together. This creative part of the study is called "sorting." Your sorting data will make an important contribution to
understanding how ethics committees might function.

There are two links below. It is important that you complete the information requested in each link in the following order:

**Demographics:** For this study, we hope to reach a diverse mix of critical care clinicians and ethics committee members. Your answers to the three demographic questions will let us know whether the sorting results reflect a multi-disciplinary perspective. After you answer these questions, you will be brought back to this page where you can link to the sorting activity.

**Sorting:** This activity will take 30 to 40 minutes to complete. If you cannot sort all of the suggestions at one sitting, you can save your work and return to finish with the username and password you have just created in registration. You will not need to complete the demographic information a second time.

Participation in all aspects of this activity is voluntary and responses will be kept confidential.

As a token of appreciation, we are offering you a $10.00 voucher which you can redeem at an OhioHealth hospital cafeteria. At the end of the sorting activity, you will find information on how to get your gift.

If you have any questions about this research, contact Kathy Raffel at raffel.11@osu.edu or by calling 614-754-8303.

**Demographic Questions**

All demographic information will be kept confidential. If you wish to remain anonymous and are concerned that answering a particular questions will identify you, please choose "No answer" for that question.

Only one response can be marked for each question. When finished with each question, select the *Continue* button to continue or *Cancel* to exit.

1) **Where is your primary place of employment?** (choose one)
   - Doctors Hospital
   - Dublin Methodist
   - Grady Memorial
   - Grant Medical Center
   - Marion General
OhioHealth Community Based Services
OhioHealth Corporate Offices
Someplace other than OhioHealth
No answer

2) Are you now, or have you ever been, a member of a clinical ethics committee? (choose one)
   No, never
   No at OhioHealth but yes at another institution
   Yes, at OhioHealth only
   Yes, at OhioHealth and another institution

3) What is your primary professional role? (choose one)
   Administrator/manager
   Attending Physician - medical specialty
   Attending Physician - surgical specialty
   Attorney
   Chaplain or pastoral care
   Dietician
   Nurse
   Occupational therapist
   Pharmacist
   Physical therapist
   Resident or intern - medical specialty
   Resident or intern - surgical specialty
   Respiratory therapist
   Social Worker
   Other
   No answer

Sorting Instructions

This part of the study asks you to reflect on ideas brainstormed by OhioHealth critical care staff and ethics committee members. We are asking your help in understanding how these ideas fit together. In the sorting process, we want you to organize the ideas into piles in a way that makes the most sense to you as they relate to the work of the clinical ethics committees. Group the ideas based on how similar in meaning they are to each other.

GETTING STARTED:
These instructions will explain how to complete the online sorting process. You can read these instructions below or view a video demonstration of the sorting process.

To see the video, please click on the following link: www.go.osu.edu/SurveyInstructions Please note these instructions refer to a different research study, but the sorting process is the same.

Note that the instruction box itself can be enlarged by dragging the arrows on the sides of the box to the desired size. It can also be minimized and moved out of the way by clicking on the arrow in the upper right hand corner of the box and dragging it to the desired location. When finished with the instructions, click the X in the upper right hand corner of the box. You can always return to the instructions by going to the instructions button on the tool bar and clicking on the question mark tab.

At the top of the column on the left side of the screen you will see the project focus prompt:

*Something specific ethics committees could do to support staff and the work they do in the critical care setting is...*

In an earlier part of the study, participants brainstormed ideas to complete this sentence. Beneath the focus prompt is the list of ideas (or Statements) that were suggested. Before you begin sorting these statements, you may find it helpful to read through this list. Once you are ready to begin organizing, click on the “Create a pile” tab from the toolbar. A “New pile” window will appear. You are asked to name this pile, but for now, just click on OK. You will assign your own names to the piles after you have sorted all of the statements.

Now, return to the list of brainstormed ideas. Start with the statement at the top of the column. Click on this idea and drag it to the Unnamed Pile 1 box. When the green dotted line appears, drop the statement into the pile.

Go to the next statement in the list and read it carefully. If the statement seems similar in meaning to the first statement, drag it into the existing pile just like you did the first one. If the statement does not seem similar, create a second pile. Leave this pile unnamed for now as well. Drag the second statement into this second pile box. The pile boxes can be moved around by dragging the box title bar to the desired location.

Go to the next statement at the top of the column and continue this process until all of the statements have been sorted. Any idea can be moved from one pile to
another by clicking on the statement and dragging it to the desired pile box.

Remember, do not group the ideas according to how important they are or how you would rank them on some area of priority. Rating of ideas is done in another part of this assessment. Do not create any “miscellaneous” or “junk” piles. An idea may be put alone as its own pile if you think it is unrelated to the other ideas or stands alone. If you have statements left over that you can’t place, put each one in its own pile. Make sure that every idea is placed somewhere. Do not leave any ideas unsorted. You need to create a minimum of two piles.

Once all of the ideas have been sorted, it is time to name each pile. Look through the ideas you have sorted together and decide on a very short label that describes the contents of each pile. When ready, click on Edit pile name in the toolbar and re-label each pile with the name you have chosen to reflect its contents. Even single-card piles need to have a name.

You may be prompted during your sort to save your work. We recommend you do so. Saving your work is essential if you cannot finish all of the sorting at one sitting.

Once all the statements have been sorted and the piles named, a “Save and Finish” button will appear in the left column. This button will not appear until you have sorted all of the statements. Once you click on this button, you will be exited from the sorting screen and taken to the “Thank You” page.

“Thank You” Page Content

Thank you for sorting the brainstormed ideas. We know that participating in this study took a substantial commitment on your part. Please know that your opinions will play a role in helping OhioHealth ethics committees evaluate their current services and plan future activities.

We would like to offer you a small gift - a $10.00 voucher which can be used at the hospital cafeteria. While this gift will certainly not compensate you for your time, we hope it will express our appreciation for your contribution.

To get your voucher, please click on this link http://www.ohiohealthethics.com/71050-10.pdf. You will be taken to a web page which is not part of this survey. On this new page, you will have access to a pdf of the voucher which you can print and then use at the cafeteria. If you should encounter any difficulties printing your voucher, contact Krista Clouser at 544-4399 or KCLOSE2@OhioHealth.com for assistance.
Again, thank you for contributing to this effort.

If you have any questions or concerns about this research, contact Kathy Raffel at raffel.11@osu.edu or by calling 614-754-8303.
Appendix E4  In Person Sorting Instructions and Recording Form

Task 2 - Instructions for Sorting and Recording

Step 1 - Sorting the Task Statement Cards. Enclosed in your package is a deck of cards with one statement per card. Each card has a statement and an ID number. We would like you to group the statements into piles in a way that makes sense to you, following these guidelines:

- Group the statements for how similar in meaning they are to one another. Do not group the statements according to how important they are, how high a priority they have, etc. Another part of the process will ask you how important you believe each idea is.

- There is no right or wrong way to group the statements. You will probably find that you could group the statements in several sensible ways. Pick the arrangement that feels best to you.

- You cannot put one statement into two piles at the same time. Each statement must be put into only one pile.

- People differ on how many piles they wind up with. In most cases, anywhere from 10 to 20 piles usually works out well.

- A statement may be put alone as its own pile if you think it is unrelated to all the other statements or if it stands alone as a unique idea. Do not have any piles of "miscellaneous" statements.

- Make sure that every statement is put somewhere. Do not leave any statements out.

Step 2 - Recording the Results. You also have in this packet a Sort Recording Sheet for recording the results of your groupings. On that sheet, please write the results as described below. An example of how to record a pile is shown in the first box on the Sort Recording Sheet.

- Pick up any one of your piles of statements. It does not matter what order the piles are recorded in.

- Quickly scan the statements in this pile, and write down a short phrase or title that describes the contents of the pile on the line provided after Pile Title or Main Topic in the first available box on the Sort Recording Sheet.

- In the space provided under the pile name, write the statement identification (ID) number of each card in that pile. Separate the numbers with commas. When you finish with the pile, put it aside so you don’t mistakenly record it twice.

- Move on to your next pile and repeat the three steps above, recording the statement numbers in the next available box on the Sort Recording Sheet. Continue in this way until all your piles have been named and recorded.

- Your Sort Recording Sheet has room for you to record up to 20 piles or groups of cards. As mentioned above, any number of piles (usually 10 to 20) is fine. If you have more than 20 piles, continue recording your results on a blank sheet of paper and be sure to attach this extra sheet to the ones provided.

- Please write legibly and clearly. Most of the errors that find their way into the program and results are made at this stage and are due to data that is hard to read.

When you have completed all of the piles, please go on to Task 2 - Sorting... 
© 2011 Concept Systems, Incorporated

Structuring p. 5
Sort Recording Sheet

This sheet is to be used for Task 1, Step 2 - Recording the Results. Specific directions for recording your sorts are included in the Instructions for Task 1 - Sorting and Recording. Remember that you do not have to have as many piles as there are boxes on this sheet. The space is provided to allow for variability among participants in the way they group the items. The first box (Example Pile) is filled out to serve as a guide for you.

Example Pile Title or Main Topic: Program Management
Record here the identifying number of each item in this pile, separating the ID numbers with commas.
1, 4, 29, 43, 12

Start recording your sorts here:

Pile Title or Main Topic: _________________________
Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _________________________
Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _________________________
Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _________________________
Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _________________________
Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _________________________
Record here the identifying number of each item in this pile, separating the ID numbers with commas.

Pile Title or Main Topic: _________________________
Record here the identifying number of each item in this pile, separating the ID numbers with commas.
In-person Demographic Questions for Sorting and Rating

For this study, we hope to reach a multi-disciplinary mix of participants who have varying experiences with clinical ethics consultation services. Your answers to the questions below will let us know how the rating results reflect various perspectives at OhioHealth.

All demographic information will be kept confidential. If you wish to remain anonymous and are concerned that answering a particular question will identify you, please choose “No answer” for that question.

Only one response can be marked for each question.

1) Where is your primary place of employment? (choose one)
   _____Doctors Hospital
   _____Doctors ICU
   _____Riverside Methodist Hospital
   _____RMH 4 Blue ICU
   _____RMH 5 Blue Cardiac ICU
   _____RMH 6 Blue Neuro Critical Care
   _____OhioHealth Corporate Offices
   _____OhioHealth system
   _____Someplace other than OhioHealth
   _____No answer

2) When you have questions about an ethical dilemma involving your clinical work, who is the first person you usually consult? (choose one)
   _____My direct supervisor
   _____My program director
   _____A more senior resident
   _____A co-worker at OhioHealth
   _____A colleague outside of OhioHealth
   _____My team (in a team meeting)
   _____An individual member of an ethics advisory committee
   _____A clinical ethics advisory committee
   _____A member of the pastoral care department
   _____My spiritual advisor
   _____My spouse or partner
3) Are you now, or have you ever been, a member of a clinical ethics advisory committee?
   ______ No, never
   ______ No at OhioHealth but yes at another institution
   ______ Yes, at OhioHealth only
   ______ Yes, at OhioHealth and another institution

4) What is your primary professional role? (choose one)
   ______ Administrator/manager
   ______ Attending Physician - medical specialty
   ______ Attending Physician - surgical specialty
   ______ Attorney
   ______ Case Manager
   ______ Chaplain or pastoral care
   ______ Dietician
   ______ Nurse
   ______ Occupational therapist
   ______ Pharmacist
   ______ Physical therapist
   ______ Resident or intern - medical specialty
   ______ Resident or intern - surgical specialty
   ______ Respiratory therapist
   ______ Social Worker
   ______ Speech Language Pathologist
   ______ Other
   ______ No answer

5) How many years have you worked in healthcare? (numerical________)

6) What is your race? (choose one)
   ______ African American/Black
   ______ Asian or Pacific Islander
   ______ Caucasian/White
   ______ Hispanic or Latino
   ______ Native American
[305x75]307

_____Bi-racial or Multi-racial
_____No answer

7) Over your entire career, how many times have you been involved in a patient care or clinical issue that has been brought to a clinical ethics advisory committee?
   _____Never
   _____1-3 times
   _____4-6 times
   _____7 or more times

8) Over your entire career, how many times have you personally brought an issue to a clinical ethics advisory committee
   _____Never
   _____1-3 times
   _____4-6 times
   _____7 or more times
Appendix F: List of Statements with Supporting Brainstormed Suggestions
List of Statements with Supporting Brainstormed Suggestions

1. Use simulations and role playing exercises to teach staff about potential ethical situations that could arise in the clinical setting

   7      Provide opportunity to participate/view "role play" encounters with patients/families
   95     Run simulations to prepare us for potential ethical issues that could arise in the clinical setting
  225    Develop a simulated ethical dilemma

2. Identify when difficult clinical situations or difficult families require debriefing for staff and make a referral to get this going

   1      Help staff debrief about difficult clinical situations, families
  176    Support meetings for staff after ethics cases to "debrief"
  206    Follow-up with critical care staff in small groups where the outcome of an ethics decision was not beneficent to the patient or to staff
  237    Support Staff by identifying when a case requires a debriefing for staff and doing the referral to get this rolling

3. Come to staff meetings periodically to increase associate of ethics committee resources and provide opportunities to dialogue about ethics

   26A    Come to periodic staff meetings to allow for dialogue about ethics
   26B    Come to periodic staff meetings to increase associate awareness of the resources available to them through the ethics committees

4. Ensure that whatever decisions are made are grounded in the best interests of the patient

   14B    Be an advocate for the patient
   30     A more patient centered response which can be enforced. This may or may not include code status changes, moving a patient from critical care to a lower level of care, moving the patient to a lower level care facility.
   130    Act as an unbiased opinion in making medical decisions in the best interest of the patient, even if the best interest is comfort care only
   194    Have a clear vision of what is the right thing to do without prolonging the suffering of a pt
   217    Actually enforce the true meaning of ethics when the need arises for a patient instead of the committee appearing to wash their hands of a situation because of a difficult family member
12 Be supportive of the patient's quality of life (excerpt to preserve anonymity)

5. Provide information to all staff on how to contact the committee to discuss an issue or ask a question without generating a full consult

85 More and more often, our patient's stories are complex with a multitude of factors (family, religion, legal, moral, etc). Not only do patients and family members struggle with life and death decisions, but we as nurses do as well. Nursing is by far the job I was made for, but I have to say that ethical dilemmas have been a challenge for me. Being able to see a familiar face and know not only the patient's interest, but mine as well, is being considered would be helpful

189 Have contact people that the nursing staff and ICU attendings are aware of

213 Have a specific contact person available to the clinical staff. Aside from having an "ethics hotline" number available to me I do not have an ethics member available to me should I have a question or concern regarding a specific patient

234 Provide a handout/information sheet at the start of the ICU rotation with a contact person from the ethics committee

6. Be physically present to review the case with the social worker and nursing staff when patients appear to have been either abused or neglected by their caregivers

178 Be physically present to review the case with the social worker and nursing staff when patients appear to have been either abused or neglected by their caregivers

7. Decide who should be the decision maker when family is estranged and friends are sincerely involved with the patient

142 Decide who should be the decision maker when family is estranged and friends are sincerely around the patient

8. Provide education and training to staff on when they are permitted to be relieved from a case for ethical reasons

110 Make sure clinical staff understand when they are permitted to withdraw from a case for ethical reasons

9. Mediate between staff members who are in disagreement on how to approach an ethical dilemma

79 Provide mediation for staff who are in disagreement on how to approach an ethical dilemma

149 Serve as liaison between nursing, house staff and medical staff in discussing ethical issues
10. Provide opportunities for employees to be able to talk to someone about their feelings when dealing with critically ill patients

48 Provide more opportunities for employees to be able to talk to someone about emotional feelings when dealing with critically ill patients

85 More and more often, our patient's stories are complex with a multitude of factors (family, religion, legal, moral, etc). Not only do patients and family members struggle with life and death decisions, but we as nurses do as well. Nursing is by far the job I was made for, but I have to say that ethical dilemmas have been a challenge for me. Being able to see a familiar face and know not only the patient's interest, but mine as well, is being considered would be helpful

125 Have discussions with clinicians about specific patient scenarios and what difficulties they encountered and what stresses they are dealing with as far as outcomes

185 Assist staff with adjustments to their own stresses in dealing with difficult families

229 Provide emotional support and education for staff members

244 Have a support team talk with health care staff

11. Provide information sheets at the start of the ICU experience with examples of commonly encountered ethical dilemmas that may arise

233 Provide a handout/information sheet at the start of the ICU rotation with examples of commonly encountered situations

12. Provide a newsletter to staff on current events and hot topics in bioethics

209 Educate staff on current events in the ethics community

225B Publish a newsletter with information about new developments in bioethics

13. Provide support for staff who wish to be relieved from a case for ethical reasons

139 Personally, there have been times when I just want to refuse to continue to administer death prolonging therapies (excerpt to preserve anonymity)

14. Communicate with front line staff about the situation and the status of the ethics consult

23 Communicate more with staff

89 Offer information to clinicians caring for a client as to what is going on with the situation. Sometimes knowing the process that is being taken helps to relieve stress for those caring for the client. It also helps to get rid of misinformation that may be spread about the situation
15. Provide thorough, concise recommendations when consulted

62 Provide thorough, concise recommendations when consulted

16. Work with pastoral care, nursing, and/or social work to establish daily rounds in the waiting rooms to talk with families about issues like life support or code status

137 Perhaps a twice a day round in the waiting room from the chaplains, nursing and/or social work to specifically to talk about issues like life support, code status etc -- to both explain, educate and support decision making

17. Automatically become involved anytime family members make a decision that appears to be inconsistent with patient's Living Will

111 Step in when patient has a living will that says patient does not to live on a vent but the family wants to keep going
119 Ensure that living wills are followed

18. Provide practical tools staff can use with family members to provide answers and guidance with common ethical dilemmas

24 Increase practical education and tips to associates to help them deal with the challenges they face
90 Give staff tools to use with family members when a patient is involved with an ethics situation. How can we as clinicians educate those involved in the situation
232 Recognize common ethical dilemmas and assist with scripted answers towards families

19. Provide clear information on how to get the ethics committee involved

53 Educate more on the process of reporting ethical issues
77B Give information on how to approach the ethics committee
86 Educate staff on what steps needed in order to get ethics involved if they feel they should
97 Educate staff on the process of consulting ethics and what's all involved

20. Provide education on the types of cases that are appropriate for an ethics consult versus questions that should go to legal or human resources

236 Intermittent education on types of cases that are appropriate Ethics consults, vs questions that appropriately go to Legal, HR, etc

21. Create flow charts showing the decision trees for common ethical dilemmas
Discuss logically and in a flow-sheet form all the pros and cons to the ethical dilemma

22. Give guidance to staff on how to deal with family members who wish to continue with treatment that is deemed futile

To provide guidance on dealing with patients who have family members who wish to continue medical care that is deemed futile
Give guidance on end of life care in various situations

23. Work with palliative care to assist with pain management, goals of care and end-of-life decisions

Work with palliative care to assist with pain management, goals of care and end of life decisions
Coordinate care with the palliative care team

24. Become involved in cases where families are struggling with the issue of whether or not to place a feeding tube

Assist families with the decision as to placement of a feeding tube. It would seem the decision would be better made at the initial stage rather than the family being presented with the decision to withdraw nutrition

25. Create a safe haven where staff can discuss distressing ethical concerns

It is very uncomfortable when such topics come up either as a part of patient care (which it has) or just in general conversation. The lack of respect for my opposing viewpoint (whether I voice it or not) is distressing (excerpt to preserve anonymity)

26. Involve clinical nutrition in ethics consults when there are issues related to nutrition and hydration

Needs to include more disciplines than just the attending physician. Realize these are difficult situations, but it is evident that multidisciplinary notes are not reviewed for issues related to nutrition and hydration as it relates to ethical decision making. Clinical Nutrition is an under recognized, under utilized aspect of the patients medical care

27. Help staff connect with pastoral care if staff’s personal religious beliefs are being challenged

Provide chaplain support to nursing if personal religious beliefs may be challenged
28. Help family members understand their legal and ethical rights

243 Help family understand the laws and ethics to help them understand their rights

29. Conduct unit-based meetings to discuss ways in which the committee could be best utilized

215 Conduct unit based educational opportunities to advise staff of ways in which the committee could best be utilized

30. Make it clear that any critical care staff member can request an ethics consult

93B Increased awareness among critical care staff of who can order the consult
211 For nurses and practitioners to know the purpose of ethics committees, at this time I feel that a lot of staff feel it is the MD's responsibility to involve ethics when concerning patients and patients care, when it should be open and encouraged for all staff. There should be emphasis placed on the fact that the ethics committee is not only for malpractice or negligence but can be utilized by nursing (amongst others) for advice and information and assistance with issues concerning family issues
240 Support that anyone may request an ethics consult.. not just the manager or attending

31. Be available to meet with family members of gravely ill patients so they have the opportunity to discuss end-of-life decisions before a crisis arrives

47 Speak with family members directly regarding issues
115 Be willing to meeting with families that are in crisis
184 Meet with struggling families to give bedside staff the gift of time
191 Help with end of life issues when families are reluctant to make these decisions
199 Support family during difficult decisions regarding focus of care for loved ones
208 Visit all families of poor prognosis patients at some point to discuss code status changes/options
220 Helping families deal with difficult decisions
221 Help family's deal with decision on prolonging life measures
228 Meet with families for end of life decisions
241 Help with family making the right decision for end of life care
242 Help family members in their decision making for the care of their loved ones

32. Educate staff on OhioHealth’s approach to futile treatment

175 Education to staff on end-of-life issues, like advance directives, futile treatment

33. Maintain an informational website for families to help them prepare for discussions with critical care staff

69 A informational website to direct families to visit after or in preparation for family discussions
34. Educate staff about State of Ohio laws related to care of terminally ill patients

- Provide education about State of Ohio law in regards to frequently seen ethical consults (i.e. withdrawing vent/nutrition, etc)
- Educate staff on the legalities of decisions made for withdrawal of care by physicians as it contradicts family wishes in the terminal patient
- Educate the nursing staff about the role of ethics and their importance in legal situations. For example, if a patient has a terminal illness and staff consults ethics because a family is in disagreement with the level of care being ordered for the patient

35. Create a screening tool to be used at admission to identify situations that may become ethically difficult

- I was recently made aware of a screening tool UCLA is developing to screen on admission for situations that have the potential to become ethically difficult situations later in care. If OhioHealth could utilize something like this it would be especially beneficial, and could probably decrease such dilemmas as much as possible

36. Inform customer service that the ethics committee has been called in to consult on care of a particular patient

- Having customer service be aware of patients, families that the ethic committee is involved with so they do not get anxious when family comes to them with problems

37. Round daily on the critical care unit to discuss ethical issues related to patient care

- Be more visible in daily clinical activities

38. Survey staff regularly on what the ethics committee can do to support the work in the critical care units

- Ask questions like this on a regular basis. People often have concerns that they don't feel warrant a call to an ethics committee and probably don't end up being asked

39. Inform critical care staff of what to expect from an ethics consult and how the consults affect care

- Educate on the follow-up that will occur with ethical issues
- Increased awareness among critical care staff of what is involved in an ethics consult
- Increased awareness of what to expect from an ethics consult
Feedback to critical care staff as to how often ethics consultations are done and how they effect outcomes

40. Be visible and present in clinical activities, including on "off shifts"

   28  Be visible and present more often
   177 Higher visibility with information posted about different topics in units
   218 Make themselves more visible. I know many critical care nurses would utilize the ethics committee more, but they often forget when it's appropriate or how to properly get ahold of them
   223 Be visible on "off" shifts

41. Get opinions from staff directly involved in care of the patient

   10  Offer support and intervene for clinical staff who have constant interaction with families. Even though medical staff speak to families, the bedside nurse has primary interaction with families
   88  For clinicians (nurses, doctors, etc.) that are working with a patient involved, get their opinion of what they believe is best for the patient. This needs to be done separate from everyone else. Sometimes getting the opinion of those caring for the person helps to clear some of the grey area associated with ethics
   164 Ask for opinions and statements from staff involved in the care of the patient
   203 Invite "interested parties" i.e. staff who have been involved in an ethics situation, to be a part of the ethics committee's discussion about the values conflict of that situation

42. When a situation arises where an ethics committee consult may be indicated, provide information on how prior cases have been resolved

   64  When a situation arises where an ethics committee is indeed indicated, it would be helpful to hear from the ethics committee on options and prior similar situations

43. Ensure that whatever decisions are made are grounded in the best interests of the patient

   14B  Be an advocate for the patient
   30  A more patient centered response which can be enforced. This may or may not include code status changes, moving a patient from critical care to a lower level of care, moving the patient to a lower level care facility.
   130 Act as an unbiased opinion in making medical decisions in the best interest of the patient, even if the best interest is comfort care only
   194 Have a clear vision of what is the right thing to do without prolonging the suffering of a pt
Actually enforce the true meaning of ethics when the need arises for a patient instead of the committee appearing to wash their hands of a situation because of a difficult family member.

Be supportive of the patient's quality of life (excerpt to preserve anonymity).

Be available to assist staff communicate with families when it feels like neither side is understanding the other.

Discuss the families needs (with staff) if they are not being met.

They are sometimes needed to help a physician interact with families and patients.

Help staff communicate with families in difficult decisions.

Serve as a liaison between the hospital and patients/families when dealing with ethical issues.

Help staff and families frame difficult issues so decisions become easier.

Be proactively involved from the beginning of every critically ill patient's stay not just when consulted.

Proactive rounds rather than reactive interventions.

We only see the ethics committee members when there is a crisis and we are at what seems to be a desperate crossroads between the family and the medical staff. I feel that at this point the physicians and nurses often do not feel supported.

Getting involved in difficult cases earlier. It can be difficult to deal with situations when it is a week or two into the case rather than being involved from the beginning.

Be proactive by rounding to identify and address questions early.

Be more involved from the beginning of a patients stay, not just when consulted.

Be a more upfront and proactive presence. Currently, this is a last resort when there is conflict between the medical staff and family decision makers. Yet, families are being asked to make decisions, about which they have no prior knowledge or reference points, daily.

Seek out opportunities to get involved to help out with tough patient families or dicey decision making.

Offer a summary of the ethics committee meeting to explain the process and reasoning behind its decisions.

Offer a summary and/or transcript of the meeting to explain the process and various reasonings behind its decisions.

When an ethical dilemma has not been handled in an ideal way, have non-committee staff participate in committee review of the dilemma.

Facilitate and/or provide performance improvement training (to nursing, house staff, medical staff) when ethical considerations have not been handled in an ideal way.
48. Help identify the primary contact for the patient

41 Help with who the primary contact for a patient is

49. Talk with physicians and staff about the decision making behind the conclusions reached in an ethics consult

112 Debrief physicians/residents on decision making behind conclusions reached regarding the particular ethics issue at hand
145 Training staff on the process, procedure, and outcomes of ethics consults will be helpful. Simply leaving a note in the patient's chart isn't always helpful

50. Provide articles to staff presenting research, case studies or expert opinion on ethical issues and dilemmas

193 Provide articles such as statements of expert opinion or research articles or case studies, to be read by staff, for background education in ethical issues and dilemmas
197 Be a resource. Make available different articles (could be on e-source) that relate to their current job

51. Meet with staff one on one to understand what might be learned from a particular case

204 Review past cases with staff in order to learn what the staff person learned from their involvement in that case. This could be done by a questionnaire or better, by a one to one interview

52. Help families realize staff are there to help them and the patient not to judge them or the patient or "kill off" their family member

101 Help families realize staff are there to help them and the patient not to judge them or "kill off" their family member

53. Provide online learning describing specific situations, common problems and their resolution

118 Provide learning (written, oral, or online) of specific situations or common themes and their resolution
194A OhioHealth University online education about the Ethics committee, who are the members, what education and training in ethics has each member received
54. Provide periodic in-service training by reviewing cases or situations and discussing how these might be approached

40    Review cases and ask questions that help to probe
60    Instruct and educate staff on situations that may arise
80    A lecture series may help to address some of the most common ethical dilemmas that may arise during a shift, such as how to address code status in a sick patient, determining if a patient is competent to refuse treatment, etc
166   Periodically give the staff some in-service training by presenting a situation they might encounter in their work which would require them to make some decisions which would have an ethical consequence
193A  Offer a series of ethics lectures for clinicians

55. Help explain in layman's terms the rationale physicians have for withdrawal of care

13    Be as specific as possible explaining to the family the rationale the physicians have for withdrawal of care when this is not desired but is the appropriate decision for the patient
136   When they are asked "What do you want us to do" they don't know what we mean--we aren't speaking the same language! and they struggle with what is the "right" decision. They fear they are "killing" their family member if they refuse treatment or withdraw support, yet they don't want to be causing suffering

56. Provide peer to peer support groups for staff dealing with difficult ethical issues

16    Provide support groups for staff to attend
52    Provide support groups on how to make appropriate ethical choices
152   Provide and/or facilitate peer to peer emotional support when dealing with difficult ethical issues

57. Hear from all sides of the ethical dilemma in a private setting before discussing with the entire committee

32    Hear from both sides of the ethical dilemma in a private setting before discussing with the entire group

58. Offer inservices to staff to study and discuss interesting ethical cases from beginning to end

133   Share interesting ethical decisions with others to learn from them
205   Inservice with groups of critical care staff and other clinical staff for the purpose of studying a case from beginning to end in order to discuss/learn from the process between Pt/family and staff and ethics committee and learn how the parties involved
arrived at a resolution. This could be in the case where the resolution was contentious and where it was peaceful.

59. Assist in developing a policy on when family members can be at the bedside during a code

A number of physicians still are not willing to allow families to be at the bedside during resuscitation... even when they are in no way interfering with care. Some even yell, "Get them out of here!" Presence with a loved-one at the time of death seems morally and ethically the right thing to do. Could we not get this codified in a system-wide policy?

60. Meet with families of patients whose treatments are considered futile to assist them in understanding why treatments are considered futile

Assist with end of life discussions when it has been deemed futile and the family wants everything done (excerpt to preserve anonymity)

Help families realize that what we're doing is futile care

Help families realize care is futile and that the patient is suffering

Help the family to make a decision that the patient would make if they could, not what the family wants

Provide active ethics counseling to patient and families faced with end of life issues especially with regards to futility of care

With situations where care may be futile

61. Be physically present to review the case with the social worker and nursing staff when patients appear to have been either abused or neglected by their caregivers

Be physically present to review the case with the social worker and nursing staff when patients appear to have been either abused or neglected by their caregivers

62. When requested, meet with families that seem to be at odds with the medical staff

Assist families that seem to be at odds with the medical staff re: care

when situations arouse with families vs bedside nurses, have the floor committee actual meet and follow up personally with family (excerpt to preserve anonymity

63. Help staff distinguish between a bioethical dilemma and a disagreement about physician’s care plan

Educate on what is considered a true ethical dilemma using actual patient examples not obscure made up ones

320
Help staff to have a clearer method for identifying the ethical question at stake. This can help distinguish situations from "peer review" of other clinicians or second guessing the physician's care plan. Many times, I was asked to intervene for ethics when in fact it was a placement problem (Example: ESRD who could no longer do outpatient dialysis).

64. Make services of the ethics committee well known and contact information for the ethics committee widely available

- Have easy access for reporting
- Make what you can offer the medical staff more well known
- Make contact information more available
- Make their presence better known, especially in the critical care setting
- Inform the staff that there is an ethics committee. Many of the staff I questioned do not know there is a committee. They do not know what the role of the ethics committee is or how to contact them

65. Have a process in place to assist staff when care decisions need to be made and there is no decision maker

- Develop a better process to withdraw care on patients that do not have family
- There needs to be a better process in place to assist staff when there is no family

66. Communicate with patients and families about the availability of the clinical ethics committee

- Increase patient and family awareness of OhioHealth's commitment to ethical care to strengthen their trust of the associates caring for them

67. Have a regular article in newsletter or hospital's print publication providing information on the committee's functions and how to access committee services

- Do a newsletter every so often as to what the ethics committee role is and what is new in their field. Include maybe the processes involved when the ethics committee is contacted. Who serves on this committee? Doctors? Lawyers? Nurses?
- Staff education/reminders of EAC availability, function, and how to access, with set regularity i.e. an article in the Lamp x1, followed by the contact info(email, pager, ext#) on same page#, each publication of the Lamp. This may create an involuntary memorization of the info for when the staff member happens across an opportunity to utilize the EAC. We are generally creatures of habit, and most people are not in the habit of utilizing an EAC even when needed.

68. Provide regular staff education on ethical standards and issues related to critical care
69. Identify and acknowledge best practice, high-quality, ethical decision making

   153A Identify examples of best practices of high quality ethical decision making and acknowledge them in attempt to reinforce positive behavior and provide an example to peers

70. Meet with families who are in crisis about decision making for the care of their loved ones

   47 Speak with family members directly regarding issues
   115 Be willing to meeting with families that are in crisis
   184 Meet with struggling families to give bedside staff the gift of time
   199 Support family during difficult decisions regarding focus of care for loved ones
   220 Helping families deal with difficult decisions
   242 Help family members in their decision making for the care of their loved ones

71. Facilitate provision of appropriate support when staff are showing signs of burnout

   19 Addressing provider burnout and emotions related to difficult events
   238 Identify when individual staff members are showing signs of burnout and somehow prompt appropriate support

72. Provide lectures to staff on current events and hot topics in bioethics

   22 Hold a quarterly meeting addressing the important issues involved in ethics
   41 Consider trends that might stand out and address the challenges of these trends by discussion
   216 Provide a resident lecture regarding current/hot topics in ethics at DH

73. Provide a pamphlet for patients and families on the principles and values underlying the work of the ethics committee

   155 Somehow make the ethics committee's presence known to patients and families...not necessarily the committee's work and processes, but what the ethic committee stands to uphold. Perhaps develop an educational piece that supplements the patients bill of
rights highlighting the fact that our goal is to honor the dignity and worth of each individual, respect the patient's right to make their own healthcare decisions and/or dictate who speaks on their behalf in the event they are not able to make their own decisions, etc.

74. Have the ethics committee communicate with front line staff through the medical record

163B Work transparently with effective communication to the front line staff directly involved in the care of the patient and their loved ones
224 Communicate with all disciplines what the status is with a particular patient

75. Encourage brown bag discussion of day to day ethical concerns

114 Most ethical concerns should continue to be brought up in our lunchtime meetings. I think once we start talking it brings out alot of problems that most of us deal with from day to day

76. Educate staff on what treatments physicians may refuse to provide

45 Why is it that when a surgeon tells a patient or family that there is nothing further to do for his patient that's the end and treatment stops. When an intensivist in a critical care unit tells a patients family there is nothing further to do they are frequently disregarded

77. Acknowledge individuals who demonstrate high quality ethical decision making so they can serve as a role models for peers

153B Identify champions of high quality ethical decision making and acknowledge them in attempt to reinforce positive behavior and provide an example to peers

78. Provide education about basic ethical principles

2 Provide education about basic ethical principles

79. Be easily available 24/7 to clarify ethical standards and for difficult decisions, such as withdrawing care

37 Make sure that they are available 24/7 as issues sometimes arise in the middle of the night.
43 Be prepared and ready to come "put out the fires" on short notice! Resources and family/health care personnel/patient relationships depend on it
61 Be available on any notice for dilemmas that might occur
Being more available and present in the day to day operations of our unit. As a night shift RN, I find that many situations could benefit from having a professional in the field of ethics

Increased availability for consults
Be available at all times for difficult situations
Be easily available
Be available to clarify ethical standards regarding end of life and other ethical issues
Be responsive and available to the needs of our patients 24/7
Be available for difficult decisions such as family's desire to withdraw care, vs. prolong treatments on a patient with a terminal or very poor prognosis
Be there when we need you

Provide resources to help staff “untangle” themselves when they are conflicted ethically about a patient they are caring for

Provide resources to help nurses 'untangle' themselves from conflictual situations that distract from their clinical caregiving and cause emotional duress
Provide “counseling” to staff when they are conflicted about a patient they are caring for
Provide support to staff when the nurses and doctors have conflicting emotions and concerns that conflict with the families' and patient's wishes to treatment

Educate residents on how to approach families and explain code status in layman's terms

Make a 3x5 hand-out for interns on how to appropriately have code status discussions. Specifically, suggested phrasing and a list of "do no say..." like...."do not ask if the family wants everything done
I witness the house staff asking patients/families on admission about code status, and it is the rare one that expresses the question clearly and understandably to the person who is coming into the situation without a clue. So the house staff needs training, or better training, on how to approach and explain this to laypeople

Provide clear guidelines on when it is appropriate to get the ethics committee involved

Navigating hierarchy in healthcare system
Give information on when to approach the ethics committee
Help the nursing staff to better understand when it is appropriate to get ethics involved.
Some cases the nurse may think ethics is needed but the medical teams are hesitant
87 Educate staff on the criteria for getting ethics involved. Ethics may not be brought in due to ignorance of the staff as to what can constitute an ethics situation. Also, staff may believe ethics should be involved, but there is no legal justification for it. Knowing the criteria would be very helpful

127 Education for providers on the role of ethics committees and how they should be incorporated into practice

147 Better inform hospital staff about the purpose, process and importance of ethics committee/consultations

173 Have information meeting on what the ethics committee actually does and how often they meet

192 Provide clear standards that must be met prior to needing an ethics committee's involvement in patient care

83. Provide staff education on advance directives such as living will, healthcare power of attorney

4 Provide education on differences between living will, DPOA

84. Respond and meet promptly and make decisions quickly

71A End of life decisions need to be made quicker
105 Meet promptly as needed during difficult patient/ethical situations and involve staff members as appropriate
163A Work quickly
222 Become involved more quickly
227 Respond more quickly

85. Round regularly on the critical care unit to discuss ethical issues related to patient care

31 Round with the hospital staff when a specific case of ethical dilemma comes up
57 Ethics rounding
123 Round in the unit and assist where obvious dilemmas are
169 Round to talk with staff
182 Make rounds to remind staff that ethics help is available
128 Have a representative from the ethics team meet with one of the members of the critical care teams to regularly discuss ethical issues related to patient care
174 Have someone round regularly on the unit to assess ethics situations

86. Provide clear, easy to access definitions of code status (e.g., DNR-CC)

172 Give clearer definitions to code status of patients. DNR-CC, CCA .... can be confusing during critical moments of care

87. Provide staff with a card listing the chain of medical decision makers in families
68. Have a card listing the chain of medical decision makers in families when one is needed

88. Have staff members come to ethics committee meetings to present different ethical dilemmas they have encountered in practice

196. Committee receive education from a staff member who would present different encounters they have on a regular basis

89. Assist in developing a policy on dealing with disruptive families

212. Assisting with families. An ethics group/committee should be in place for the protection of staff as well as patients. Critical care nurses, as well as other specialties, are constantly abused by patient families, whether it includes not following unit rules, or nursing direction or making decisions. It would be a huge assist if there were protocols in place that would help to deal with sideline family issues so that the nurses can spend their time providing patient care

90. Provide training in crucial conversations and communication skills

17. Training in crucial conversations - e.g. discussing goals of care

109. Teach communication skills as many so called ethics issues are cleared up with better communication

91. Offer education on spiritual and religious concerns that may impact patient and family decision making

157. Offer education that includes spiritual/religious concerns. Very often this is at the heart of communication problems between staff and patients. The value system for decision-making from a religious standpoint is vastly different that a scientific or outcomes-based approach.

27. Provide faith based information. Offer this for all the different religions. For example if you are catholic it would be nice if there was information available to tell you what the laws and believes are on withdrawing etc. This would be good for family and staff. I KNOW OUR CHAPLINS DO A GREAT JOB!! But some people may feel more at ease if the information was in pamphlet form. I know I would want to know what the bible says when I was attempting to decide what is the best thing to do.

92. Be a liaison with the legal department when there are problems with guardianship

74. Be a liaison to use with the legal department when there are problems with guardianship
93. Provide staff education on how to deal with unrealistic, angry or difficult patients and families

6  Provide staff education on how to deal with the difficult/angry patient
35 Education-dealing with difficult patients, families
132 Provide resources/classes/etc on how to best deal with unrealistic and difficult families

94. Provide chart notes (exclusively available to physicians) to help with documentation

183 Provide chart notes (limited to members of medical staff) to assist caregivers with documentation

95. Have a medical social worker in ER 24 hours a day

146 Have a medical social worker in the ER 24 hours a day

Suggestions which were not used because they were outside the purview of the clinical ethics committee or not permissible by hospital policy (n = 4):

65 Ethics committees should be able to say when care is futile
98 It is inhuman, to think that I've had to ask for raises when switching to higher paying jobs when the job post as a higher pay (excerpt to preserve anonymity)
99 Making sure the entitlements promised are given to those they are promised too. Instead of a working asking for them over & over
170 Keep and share a log of previous cases and their outcomes after the committee had met

Suggestions which were not used because the wording was vague, unclear, confusing or just a comment rather than a suggestion (n = 12):

20 Balancing financial and legal considerations which too often dominate decision making
29 I'm not at all certain ethics consults do much to change the course of treatment and care for critically ill and dying patients. My sense is the greater weight of these decisions favor concerns for legal consequences rather than the most appropriate medical care and support. Too often, the result is a protracted critical care stay resulting in the same likely outcome (death). My belief is we do not add benefit or quality to the patient's life, mislead and offer unrealistic expectations to the family, add appreciably to the stress of physicians and staff who experience the frustration of managing a terminally ill patient, and drive costs up significantly.
41 Consider trends that might stand out and address the challenges of these trends by discussion
As a PSA I don't have any involvement with ethical issues so I don’t have any recommendation at this time

Working with case manager and social worker to present ethical dilemma in an organized fashion

We place a very heavy emphasis on the legal aspects rather than moral and ethical factors and I do not have an answer for how to change. Short of tort reform favorable to the moral and ethical side of the equation, I doubt little will change. The new government health care may force changes as hospitals have to live with smaller reimbursements and higher penalties

The committee serves not only in a guidance and decision making capacity but also and frankly more importantly in an educational capacity

Legal NOK is refusing to withdraw life-sustaining treatment because they will forfeit the patient's income: e.g., monthly Social Security checks. Not sure how that can be resolved

Have a clear vision of what is the right thing to do without prolonging the suffering of a pt

Education to the management team with follow up on the impact it had on their team.

Be more supportive of staff and family members as well as patients need

Be more supportive of staff, family members as well as staff needs
Appendix G: Impact and Performance Ratings by Statement and Cluster for Non EAC Staff, EAC Members and All Participants
Table 37

Impact Ratings by Statement and Cluster for Non EAC Staff, EAC Members and All Participants

Note: The scale used in the Impact rating was:

**Impact**: 1 = Very small positive impact; 2 = Some positive impact; 3 = Moderate positive impact; 4 = Large positive impact; and 5 = Very large positive impact

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>81</td>
<td>Educate residents on how to approach families and explain code status in layman's terms</td>
<td>4.27</td>
<td>4.21</td>
<td>4.26</td>
</tr>
<tr>
<td>19</td>
<td>Provide clear information on HOW to get the ethics committee involved</td>
<td>4.26</td>
<td>4.26</td>
<td>4.26</td>
</tr>
<tr>
<td>5</td>
<td>Provide information to all staff on how to contact the committee to discuss an issue or ask a question without generating a full consult</td>
<td>4.17</td>
<td>4.21</td>
<td>4.18</td>
</tr>
<tr>
<td>32</td>
<td>Educate staff on OhioHealth's approach to futile treatment</td>
<td>4.08</td>
<td>3.89</td>
<td>4.04</td>
</tr>
<tr>
<td>20</td>
<td>Provide education on the types of cases that are appropriate for an ethics consult versus questions that should go to legal or human resources</td>
<td>4.05</td>
<td>4.11</td>
<td>4.06</td>
</tr>
<tr>
<td>39</td>
<td>Inform critical care staff of what to expect from an ethics consult and how the consults affect care</td>
<td>4.05</td>
<td>3.68</td>
<td>3.96</td>
</tr>
<tr>
<td>93</td>
<td>Provide staff education on how to deal with unrealistic, angry or difficult patients and families</td>
<td>4.00</td>
<td>3.53</td>
<td>3.89</td>
</tr>
<tr>
<td>34</td>
<td>Educate staff about State of Ohio laws related to care of terminally ill patients</td>
<td>3.97</td>
<td>3.89</td>
<td>3.95</td>
</tr>
<tr>
<td>18</td>
<td>Provide practical tools staff can use with family members to provide answers and guidance with common ethical dilemmas</td>
<td>3.91</td>
<td>3.89</td>
<td>3.90</td>
</tr>
<tr>
<td>83</td>
<td>Provide staff education on advance directives such as living will, healthcare power of attorney</td>
<td>3.90</td>
<td>4.21</td>
<td>3.98</td>
</tr>
<tr>
<td>90</td>
<td>Provide training in crucial conversations and communication skills</td>
<td>3.85</td>
<td>3.89</td>
<td>3.86</td>
</tr>
</tbody>
</table>

Continued
Table 37 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Provide information sheets at the start of the ICU experience with examples of commonly encountered ethical dilemmas that may arise</td>
<td>3.75</td>
<td>3.05</td>
<td>3.60</td>
</tr>
<tr>
<td>8</td>
<td>Provide education and training to staff on when they are permitted to be relieved from a case for ethical reasons</td>
<td>3.70</td>
<td>3.32</td>
<td>3.61</td>
</tr>
<tr>
<td>76</td>
<td>Educate staff on what treatments physicians may refuse to provide</td>
<td>3.63</td>
<td>3.72</td>
<td>3.65</td>
</tr>
<tr>
<td>78</td>
<td>Provide education about basic ethical principles</td>
<td>3.61</td>
<td>3.74</td>
<td>3.65</td>
</tr>
<tr>
<td>54</td>
<td>Provide periodic in-service training by reviewing cases or situations and discussing how these might be approached</td>
<td>3.56</td>
<td>3.42</td>
<td>3.53</td>
</tr>
<tr>
<td>91</td>
<td>Offer education on spiritual and religious concerns that may impact patient and family decision making</td>
<td>3.53</td>
<td>3.84</td>
<td>3.60</td>
</tr>
<tr>
<td>68</td>
<td>Provide regular staff education on ethical standards and issues related to critical care</td>
<td>3.44</td>
<td>3.63</td>
<td>3.48</td>
</tr>
<tr>
<td>21</td>
<td>Create flow charts showing the decision trees for common ethical dilemmas</td>
<td>3.35</td>
<td>3.47</td>
<td>3.38</td>
</tr>
<tr>
<td>58</td>
<td>Offer inservices to staff to study and discuss interesting ethical cases from beginning to end</td>
<td>3.32</td>
<td>3.47</td>
<td>3.36</td>
</tr>
<tr>
<td>12</td>
<td>Provide a newsletter to staff on current events and hot topics in bioethics</td>
<td>3.29</td>
<td>3.00</td>
<td>3.23</td>
</tr>
<tr>
<td>53</td>
<td>Provide online learning describing specific situations, common problems and their resolution</td>
<td>3.25</td>
<td>2.79</td>
<td>3.14</td>
</tr>
<tr>
<td>1</td>
<td>Use simulations and role playing exercises to teach staff about potential ethical situations that could arise in the clinical setting</td>
<td>3.20</td>
<td>3.63</td>
<td>3.30</td>
</tr>
<tr>
<td>50</td>
<td>Provide articles to staff presenting research, case studies or expert opinion on ethical issues and dilemmas</td>
<td>3.16</td>
<td>3.00</td>
<td>3.12</td>
</tr>
<tr>
<td>67</td>
<td>Have a regular article in newsletter or hospital's print publication providing information on the committee's functions and how to access committee services</td>
<td>3.11</td>
<td>3.26</td>
<td>3.15</td>
</tr>
<tr>
<td>72</td>
<td>Provide lectures to staff on current events and hot topics in bioethics</td>
<td>3.02</td>
<td>3.05</td>
<td>3.02</td>
</tr>
</tbody>
</table>

**Cluster average**

<table>
<thead>
<tr>
<th></th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.67</td>
<td>3.62</td>
<td>3.66</td>
</tr>
</tbody>
</table>

**Standard deviation**

<table>
<thead>
<tr>
<th></th>
<th>0.37</th>
<th>0.42</th>
<th>0.37</th>
</tr>
</thead>
</table>

Continued
<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #2: Guidance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Give guidance to staff on how to deal with family members who wish to continue</td>
<td>4.34</td>
<td>4.16</td>
<td>4.30</td>
</tr>
<tr>
<td></td>
<td>with treatment that is deemed futile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>Provide clear, easy to access definitions of code status (e.g., DNR-CC)</td>
<td>4.29</td>
<td>4.42</td>
<td>4.32</td>
</tr>
<tr>
<td>82</td>
<td>Provide clear guidelines on when it is appropriate to get the ethics committee</td>
<td>4.21</td>
<td>4.21</td>
<td>4.21</td>
</tr>
<tr>
<td></td>
<td>involved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>87</td>
<td>Provide staff with a card listing the chain of medical decision makers in families</td>
<td>3.77</td>
<td>3.89</td>
<td>3.80</td>
</tr>
<tr>
<td>89</td>
<td>Assist in developing a policy on dealing with disruptive families</td>
<td>3.67</td>
<td>3.21</td>
<td>3.56</td>
</tr>
<tr>
<td>42</td>
<td>When a situation arises where an ethics committee consult may be indicated,</td>
<td>3.61</td>
<td>3.42</td>
<td>3.57</td>
</tr>
<tr>
<td></td>
<td>provide information on how prior cases have been resolved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Offer a summary of the ethics committee meeting to explain the process and</td>
<td>3.61</td>
<td>3.42</td>
<td>3.57</td>
</tr>
<tr>
<td></td>
<td>reasoning behind its decisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Create a screening tool to be used at admission to identify situations that</td>
<td>3.48</td>
<td>2.95</td>
<td>3.36</td>
</tr>
<tr>
<td></td>
<td>may become ethically difficult</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Assist in developing a policy on when family members can be at the bedside</td>
<td>3.35</td>
<td>2.89</td>
<td>3.36</td>
</tr>
<tr>
<td></td>
<td>during a code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>Encourage brown bag discussion of day to day ethical concerns</td>
<td>3.02</td>
<td>3.36</td>
<td>3.07</td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td>3.74</td>
<td>3.58</td>
<td>3.70</td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td>0.41</td>
<td>0.52</td>
<td>0.42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #3: Liaison with patients &amp; families</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Provide thorough, concise recommendations when consulted</td>
<td>4.43</td>
<td>4.37</td>
<td>4.42</td>
</tr>
<tr>
<td>62</td>
<td>When requested, meet with families that seem to be at odds with the medical staff</td>
<td>4.35</td>
<td>4.16</td>
<td>4.30</td>
</tr>
<tr>
<td>60</td>
<td>Meet with families of patients whose treatments are considered futile to assist</td>
<td>4.34</td>
<td>3.74</td>
<td>4.20</td>
</tr>
<tr>
<td></td>
<td>them in understanding why treatments are considered futile</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued
Table 37 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Be available to meet with family members of gravely ill patients so they have the opportunity to discuss end-of-life decisions before a crisis arrives</td>
<td>4.25</td>
<td>3.89</td>
<td>4.17</td>
</tr>
<tr>
<td>70</td>
<td>Meet with families who are in crisis about decision making for the care of their loved ones</td>
<td>4.22</td>
<td>3.68</td>
<td>4.10</td>
</tr>
<tr>
<td>7</td>
<td>Decide who should be the decision maker when family is estranged and friends are sincerely involved with the patient</td>
<td>4.17</td>
<td>3.47</td>
<td>4.01</td>
</tr>
<tr>
<td>52</td>
<td>Help families realize staff are there to help them and the patient not to judge them or the patient or &quot;kill off&quot; their family member</td>
<td>4.00</td>
<td>3.63</td>
<td>3.91</td>
</tr>
<tr>
<td>17</td>
<td>Automatically become involved anytime family members make a decision that appears to be inconsistent with patient's Living Will</td>
<td>4.00</td>
<td>3.95</td>
<td>3.99</td>
</tr>
<tr>
<td>2</td>
<td>Identify when difficult clinical situations or difficult families require debriefing for staff and make a referral to get this going</td>
<td>3.95</td>
<td>4.21</td>
<td>4.01</td>
</tr>
<tr>
<td>28</td>
<td>Help family members understand their legal and ethical rights</td>
<td>3.91</td>
<td>3.53</td>
<td>3.82</td>
</tr>
<tr>
<td>55</td>
<td>Help explain in layman's terms the rationale physicians have for withdrawal of care</td>
<td>3.87</td>
<td>3.95</td>
<td>3.89</td>
</tr>
<tr>
<td>66</td>
<td>Communicate with patients and families about the availability of the clinical ethics committee</td>
<td>3.80</td>
<td>3.47</td>
<td>3.73</td>
</tr>
<tr>
<td>16</td>
<td>Work with pastoral care, nursing, and/or social work to establish daily rounds in the waiting rooms to talk with families about issues like life support or code status</td>
<td>3.74</td>
<td>3.32</td>
<td>3.64</td>
</tr>
<tr>
<td>24</td>
<td>Become involved in cases where families are struggling with the issue of whether or not to place a feeding tube</td>
<td>3.65</td>
<td>3.42</td>
<td>3.60</td>
</tr>
<tr>
<td>48</td>
<td>Help identify the primary contact for the patient</td>
<td>3.31</td>
<td>3.11</td>
<td>3.27</td>
</tr>
</tbody>
</table>

*Cluster average*  | 4.0 | 3.73 | 3.94 |

*Standard deviation*  | 0.29 | 0.34 | 0.29 |

Continued
Table 37 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Communicate with front line staff about the situation and the status of the ethics consult</td>
<td>4.14</td>
<td>4.16</td>
<td>4.14</td>
</tr>
<tr>
<td>6</td>
<td>Be physically present to help bedside personnel better assess emerging ethical issues</td>
<td>3.74</td>
<td>3.68</td>
<td>3.73</td>
</tr>
<tr>
<td>85</td>
<td>Round regularly on the critical care unit to discuss ethical issues related to patient care</td>
<td>3.59</td>
<td>3.21</td>
<td>3.50</td>
</tr>
<tr>
<td>40</td>
<td>Be visible and present in clinical activities, including on &quot;off shifts&quot;</td>
<td>3.48</td>
<td>3.26</td>
<td>3.43</td>
</tr>
<tr>
<td>37</td>
<td>Round daily on the critical care unit to discuss ethical issues related to patient care</td>
<td>3.40</td>
<td>2.74</td>
<td>3.25</td>
</tr>
<tr>
<td>74</td>
<td>Have the ethics committee communicate with front line staff through the medical record</td>
<td>3.26</td>
<td>2.89</td>
<td>3.17</td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td><strong>3.6</strong></td>
<td><strong>3.2</strong></td>
<td><strong>3.54</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td><strong>0.28</strong></td>
<td><strong>0.48</strong></td>
<td><strong>0.32</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Ensure that whatever decisions are made are grounded in the best interests of the patient</td>
<td>4.42</td>
<td>4.21</td>
<td>4.37</td>
</tr>
<tr>
<td>84</td>
<td>Respond and meet promptly and make decisions quickly</td>
<td>4.23</td>
<td>4.05</td>
<td>4.19</td>
</tr>
<tr>
<td>44</td>
<td>Be available to assist staff communicate with families when it feels like neither side is understanding the other</td>
<td>4.13</td>
<td>4.42</td>
<td>4.20</td>
</tr>
<tr>
<td>61</td>
<td>Be physically present to review the case with the social worker and nursing staff when patients appear to have been either abused or neglected by their caregivers</td>
<td>4.11</td>
<td>3.32</td>
<td>3.93</td>
</tr>
<tr>
<td>79</td>
<td>Be easily available 24/7 to clarify ethical standards and for difficult decisions, such as withdrawing care</td>
<td>3.94</td>
<td>4.26</td>
<td>4.01</td>
</tr>
<tr>
<td>95</td>
<td>Have a medical social worker in ER 24 hours a day</td>
<td>3.92</td>
<td>3.26</td>
<td>3.76</td>
</tr>
<tr>
<td>23</td>
<td>Work with palliative care to assist with pain management, goals of care and end-of-life decisions</td>
<td>3.85</td>
<td>3.72</td>
<td>3.82</td>
</tr>
</tbody>
</table>

Continued
Table 37 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #5: Liaison with system</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92</td>
<td>Be a liaison with the legal department when there are problems with guardianship</td>
<td>3.82</td>
<td>3.63</td>
<td>3.78</td>
</tr>
<tr>
<td>26</td>
<td>Involve clinical nutrition in ethics consults when there are issues related to nutrition and hydration</td>
<td>3.39</td>
<td>3.05</td>
<td>3.31</td>
</tr>
<tr>
<td>36</td>
<td>Inform customer service that the ethics committee has been called in to consult on care of a particular patient</td>
<td>3.26</td>
<td>2.74</td>
<td>3.14</td>
</tr>
<tr>
<td>33</td>
<td>Maintain an informational website for families to help them prepare for discussions with critical care staff</td>
<td>3.19</td>
<td>2.42</td>
<td>3.01</td>
</tr>
<tr>
<td>45</td>
<td>Be proactively involved from the beginning of every critically ill patient's stay not just when consulted</td>
<td>2.86</td>
<td>2.42</td>
<td>2.76</td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td>3.75</td>
<td>3.46</td>
<td>3.69</td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td>0.46</td>
<td>0.68</td>
<td>0.49</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #6: Outreach &amp; accessibility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Have a process in place to assist staff when care decisions need to be made and there is no decision maker</td>
<td>4.26</td>
<td>41.6</td>
<td>4.23</td>
</tr>
<tr>
<td>64</td>
<td>Make services of the ethics committee well known and contact information for the ethics committee widely available</td>
<td>4.15</td>
<td>4.32</td>
<td>4.19</td>
</tr>
<tr>
<td>30</td>
<td>Make it clear that any critical care staff member can request an ethics consult</td>
<td>4.11</td>
<td>4.11</td>
<td>4.11</td>
</tr>
<tr>
<td>63</td>
<td>Help staff distinguish between a bioethical dilemma and a disagreement about physician's care plan</td>
<td>3.94</td>
<td>3.68</td>
<td>3.88</td>
</tr>
<tr>
<td>69</td>
<td>Identify and acknowledge best practice, high-quality, ethical decision making</td>
<td>3.82</td>
<td>3.84</td>
<td>3.83</td>
</tr>
<tr>
<td>3</td>
<td>Come to staff meetings periodically to increase associate awareness of ethics committee resources and provide opportunities to dialogue about ethics</td>
<td>3.69</td>
<td>3.84</td>
<td>3.73</td>
</tr>
<tr>
<td>29</td>
<td>Conduct unit-based meetings to discuss ways in which the committee could be best utilized</td>
<td>3.60</td>
<td>3.42</td>
<td>3.56</td>
</tr>
</tbody>
</table>

Continued
Table 37 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Provide resources to help staff &quot;untangle&quot; themselves when they are conflicted ethically about a patient they are caring for</td>
<td>3.58</td>
<td>3.79</td>
<td>3.63</td>
</tr>
<tr>
<td>88</td>
<td>Have staff members come to ethics committee meetings to present different ethical dilemmas they have encountered in practice</td>
<td>3.56</td>
<td>3.32</td>
<td>3.50</td>
</tr>
<tr>
<td>38</td>
<td>Survey staff regularly on what the ethics committee can do to support the work in the critical care units</td>
<td>3.44</td>
<td>3.26</td>
<td>3.40</td>
</tr>
<tr>
<td>73</td>
<td>Provide a pamphlet for patients and families on the principles and values underlying the work of the ethics committee</td>
<td>3.24</td>
<td>2.95</td>
<td>3.17</td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td><strong>3.76</strong></td>
<td><strong>3.7</strong></td>
<td><strong>3.75</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td><strong>0.31</strong></td>
<td><strong>0.40</strong></td>
<td><strong>0.32</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>Get opinions from staff directly involved in care of the patient</td>
<td>4.20</td>
<td>4.00</td>
<td>4.16</td>
</tr>
<tr>
<td>49</td>
<td>Talk with physicians and staff about the decision making behind the conclusions reached in an ethics consult</td>
<td>4.16</td>
<td>4.00</td>
<td>4.12</td>
</tr>
<tr>
<td>4</td>
<td>Ensure that whatever steps are taken in patient care are consistent with ethical practice, Ohio law and OhioHealth policy</td>
<td>4.02</td>
<td>4.00</td>
<td>4.01</td>
</tr>
<tr>
<td>10</td>
<td>Provide opportunities for employees to be able to talk to someone about their feelings when dealing with critically ill patients</td>
<td>3.85</td>
<td>3.68</td>
<td>3.81</td>
</tr>
<tr>
<td>71</td>
<td>Facilitate provision of appropriate support when staff are showing signs of burnout</td>
<td>3.84</td>
<td>3.42</td>
<td>3.74</td>
</tr>
<tr>
<td>25</td>
<td>Create a safe haven where staff can discuss distressing ethical concerns</td>
<td>3.82</td>
<td>4.16</td>
<td>3.89</td>
</tr>
<tr>
<td>57</td>
<td>Hear from all sides of the ethical dilemma in a private setting before discussing with the entire committee</td>
<td>3.76</td>
<td>3.47</td>
<td>3.69</td>
</tr>
<tr>
<td>9</td>
<td>Mediate between staff members who are in disagreement on how to approach an ethical dilemma</td>
<td>3.74</td>
<td>3.79</td>
<td>3.75</td>
</tr>
</tbody>
</table>

Continued
Table 37 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Provide support for staff who wish to be relieved from a case for ethical reasons</td>
<td>3.72</td>
<td>3.74</td>
<td>3.73</td>
</tr>
<tr>
<td>47</td>
<td>When an ethical dilemma has not been handled in an ideal way, have non-committee</td>
<td>3.71</td>
<td>3.16</td>
<td>3.59</td>
</tr>
<tr>
<td></td>
<td>staff participate in committee review of the dilemma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>Acknowledge individuals who demonstrate high quality ethical decision making</td>
<td>3.50</td>
<td>3.53</td>
<td>3.51</td>
</tr>
<tr>
<td></td>
<td>so they can serve as a role models for peers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Provide peer to peer support groups for staff dealing with difficult ethical</td>
<td>3.43</td>
<td>3.47</td>
<td>3.44</td>
</tr>
<tr>
<td></td>
<td>issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Help staff connect with pastoral care if staff’s personal religious beliefs</td>
<td>3.30</td>
<td>3.42</td>
<td>3.33</td>
</tr>
<tr>
<td></td>
<td>are being challenged</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Provide chart notes (exclusively available to physicians) to help with</td>
<td>3.25</td>
<td>3.16</td>
<td>3.23</td>
</tr>
<tr>
<td></td>
<td>documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Meet with staff one on one to understand what might be learned from a particular</td>
<td>3.13</td>
<td>3.28</td>
<td>3.16</td>
</tr>
<tr>
<td></td>
<td>case</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td><strong>3.7</strong></td>
<td><strong>3.62</strong></td>
<td><strong>3.68</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td><strong>0.31</strong></td>
<td><strong>0.31</strong></td>
<td><strong>0.31</strong></td>
</tr>
</tbody>
</table>
Table 38

Performance Ratings by Statement and Cluster for Non EAC Staff, EAC Members and All Participants

Note: The scale used in the Performance rating was: 1 = Very poorly, 2 = Poorly, 3 = Adequately, 4 = Well, and 5 = Extremely well

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Provide information to all staff on how to contact the committee to discuss an issue or ask a question without generating a full consult</td>
<td>2.83</td>
<td>4.00</td>
<td>3.11</td>
</tr>
<tr>
<td>81</td>
<td>Educate residents on how to approach families and explain code status in layman's terms</td>
<td>2.78</td>
<td>3.20</td>
<td>2.88</td>
</tr>
<tr>
<td>19</td>
<td>Provide clear information on HOW to get the ethics committee involved</td>
<td>2.74</td>
<td>3.67</td>
<td>2.97</td>
</tr>
<tr>
<td>83</td>
<td>Provide staff education on advance directives such as living will, healthcare power of attorney</td>
<td>2.72</td>
<td>3.27</td>
<td>2.85</td>
</tr>
<tr>
<td>39</td>
<td>Inform critical care staff of what to expect from an ethics consult and how the consults affect care</td>
<td>2.65</td>
<td>3.33</td>
<td>2.82</td>
</tr>
<tr>
<td>91</td>
<td>Offer education on spiritual and religious concerns that may impact patient and family decision making</td>
<td>2.62</td>
<td>3.07</td>
<td>2.73</td>
</tr>
<tr>
<td>20</td>
<td>Provide education on the types of cases that are appropriate for an ethics consult versus questions that should go to legal or human resources</td>
<td>2.61</td>
<td>3.00</td>
<td>2.70</td>
</tr>
<tr>
<td>32</td>
<td>Educate staff on OhioHealth’s approach to futile treatment</td>
<td>2.57</td>
<td>3.40</td>
<td>2.77</td>
</tr>
<tr>
<td>18</td>
<td>Provide practical tools staff can use with family members to provide answers and guidance with common ethical dilemmas</td>
<td>2.52</td>
<td>2.73</td>
<td>2.57</td>
</tr>
<tr>
<td>34</td>
<td>Educate staff about State of Ohio laws related to care of terminally ill patients</td>
<td>2.52</td>
<td>3.40</td>
<td>2.74</td>
</tr>
<tr>
<td>8</td>
<td>Provide education and training to staff on when they are permitted to be relieved from a case for ethical reasons</td>
<td>2.48</td>
<td>3.00</td>
<td>2.61</td>
</tr>
<tr>
<td>78</td>
<td>Provide education about basic ethical principles</td>
<td>2.48</td>
<td>3.07</td>
<td>2.62</td>
</tr>
<tr>
<td>53</td>
<td>Provide online learning describing specific situations, common problems and their resolution</td>
<td>2.46</td>
<td>2.40</td>
<td>2.44</td>
</tr>
<tr>
<td>93</td>
<td>Provide staff education on how to deal with unrealistic, angry or difficult patients and families</td>
<td>2.42</td>
<td>3.00</td>
<td>2.57</td>
</tr>
</tbody>
</table>

Continued
Table 38 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #1: Staff development</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Provide periodic in-service training by reviewing cases or situations and discussing how these might be approached</td>
<td>2.35</td>
<td>3.00</td>
<td>2.51</td>
</tr>
<tr>
<td>76</td>
<td>Educate staff on what treatments physicians may refuse to provide</td>
<td>2.33</td>
<td>2.60</td>
<td>2.39</td>
</tr>
<tr>
<td>90</td>
<td>Provide training in crucial conversations and communication skills</td>
<td>2.33</td>
<td>2.60</td>
<td>2.39</td>
</tr>
<tr>
<td>11</td>
<td>Provide information sheets at the start of the ICU experience with examples of commonly encountered ethical dilemmas that may arise</td>
<td>2.26</td>
<td>2.00</td>
<td>2.20</td>
</tr>
<tr>
<td>21</td>
<td>Create flow charts showing the decision trees for common ethical dilemmas</td>
<td>2.24</td>
<td>2.13</td>
<td>2.21</td>
</tr>
<tr>
<td>1</td>
<td>Use simulations and role playing exercises to teach staff about potential ethical situations that could arise in the clinical setting</td>
<td>2.24</td>
<td>2.33</td>
<td>2.26</td>
</tr>
<tr>
<td>68</td>
<td>Provide regular staff education on ethical standards and issues related to critical care</td>
<td>2.22</td>
<td>2.73</td>
<td>2.36</td>
</tr>
<tr>
<td>58</td>
<td>Offer inservices to staff to study and discuss interesting ethical cases from beginning to end</td>
<td>2.17</td>
<td>2.6</td>
<td>2.28</td>
</tr>
<tr>
<td>50</td>
<td>Provide articles to staff presenting research, case studies or expert opinion on ethical issues and dilemmas</td>
<td>2.15</td>
<td>2.93</td>
<td>2.34</td>
</tr>
<tr>
<td>67</td>
<td>Have a regular article in newsletter or hospital's print publication providing information on the committee's functions and how to access committee services</td>
<td>2.13</td>
<td>2.13</td>
<td>2.13</td>
</tr>
<tr>
<td>72</td>
<td>Provide lectures to staff on current events and hot topics in bioethics</td>
<td>2.11</td>
<td>2.6</td>
<td>2.23</td>
</tr>
<tr>
<td>12</td>
<td>Provide a newsletter to staff on current events and hot topics in bioethics</td>
<td>2.02</td>
<td>2.07</td>
<td>2.03</td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td><strong>2.42</strong></td>
<td><strong>2.86</strong></td>
<td><strong>2.53</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td><strong>0.22</strong></td>
<td><strong>0.50</strong></td>
<td><strong>0.28</strong></td>
</tr>
</tbody>
</table>

Continued
Table 38 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #2: Guidance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Give guidance to staff on how to deal with family members who wish to continue</td>
<td>2.74</td>
<td>3.47</td>
<td>2.92</td>
</tr>
<tr>
<td></td>
<td>with treatment that is deemed futile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Provide clear guidelines on when it is appropriate to get the ethics committee</td>
<td>2.67</td>
<td>3.4</td>
<td>2.85</td>
</tr>
<tr>
<td></td>
<td>involved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>When a situation arises where an ethics committee consult may be indicated,</td>
<td>2.65</td>
<td>3.0</td>
<td>2.74</td>
</tr>
<tr>
<td></td>
<td>provide information on how prior cases have been resolved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Assist in developing a policy on when family members can be at the bedside</td>
<td>2.61</td>
<td>2.4</td>
<td>2.56</td>
</tr>
<tr>
<td></td>
<td>during a code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>Provide clear, easy to access definitions of code status (e.g., DNR-CC)</td>
<td>2.52</td>
<td>2.93</td>
<td>2.62</td>
</tr>
<tr>
<td>46</td>
<td>Offer a summary of the ethics committee meeting to explain the process and</td>
<td>2.48</td>
<td>2.73</td>
<td>2.54</td>
</tr>
<tr>
<td></td>
<td>reasoning behind its decisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>87</td>
<td>Provide staff with a card listing the chain of medical decision makers in</td>
<td>2.46</td>
<td>2.6</td>
<td>2.49</td>
</tr>
<tr>
<td></td>
<td>families</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>89</td>
<td>Assist in developing a policy on dealing with disruptive families</td>
<td>2.41</td>
<td>2.47</td>
<td>2.43</td>
</tr>
<tr>
<td>75</td>
<td>Encourage brown bag discussion of day to day ethical concerns</td>
<td>2.37</td>
<td>2.53</td>
<td>2.41</td>
</tr>
<tr>
<td>35</td>
<td>Create a screening tool to be used at admission to identify situations that</td>
<td>2.24</td>
<td>1.93</td>
<td>2.16</td>
</tr>
<tr>
<td></td>
<td>may become ethically difficult</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td><strong>2.52</strong></td>
<td><strong>2.75</strong></td>
<td><strong>2.57</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td><strong>0.15</strong></td>
<td><strong>0.44</strong></td>
<td><strong>0.21</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #3: Liaison with patients &amp; families</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Provide thorough, concise recommendations when consulted</td>
<td>3.22</td>
<td>3.73</td>
<td>3.34</td>
</tr>
<tr>
<td>62</td>
<td>When requested, meet with families that seem to be at odds with the medical staff</td>
<td>3.20</td>
<td>4.07</td>
<td>3.41</td>
</tr>
<tr>
<td>28</td>
<td>Help family members understand their legal and ethical rights</td>
<td>3.13</td>
<td>3.47</td>
<td>3.21</td>
</tr>
<tr>
<td>#</td>
<td>Cluster/Statement</td>
<td>Non EAC</td>
<td>EAC</td>
<td>All</td>
</tr>
<tr>
<td>----</td>
<td>----------------------------------------------------------------------------------</td>
<td>---------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>55</td>
<td>Help explain in layman's terms the rationale physicians have for withdrawal of care</td>
<td>2.93</td>
<td>3.60</td>
<td>3.10</td>
</tr>
<tr>
<td>52</td>
<td>Help families realize staff are there to help them and the patient not to judge them or &quot;kill off&quot; their family member</td>
<td>2.93</td>
<td>3.40</td>
<td>3.05</td>
</tr>
<tr>
<td>60</td>
<td>Meet with families of patients whose treatments are considered futile to assist them in understanding why treatments are considered futile</td>
<td>2.91</td>
<td>3.33</td>
<td>3.02</td>
</tr>
<tr>
<td>70</td>
<td>Meet with families who are in crisis about decision making for the care of their loved ones</td>
<td>2.91</td>
<td>3.80</td>
<td>3.13</td>
</tr>
<tr>
<td>31</td>
<td>Be available to meet with family members of gravely ill patients so they have the opportunity to discuss end-of-life decisions before a crisis arrives</td>
<td>2.89</td>
<td>3.53</td>
<td>3.05</td>
</tr>
<tr>
<td>7</td>
<td>Decide who should be the decision maker when family is estranged and friends are sincerely involved with the patient</td>
<td>2.87</td>
<td>3.73</td>
<td>3.08</td>
</tr>
<tr>
<td>24</td>
<td>Become involved in cases where families are struggling with the issue of whether or not to place a feeding tube</td>
<td>2.72</td>
<td>2.73</td>
<td>2.72</td>
</tr>
<tr>
<td>2</td>
<td>Identify when difficult clinical situations or difficult families require debriefing for staff and make a referral to get this going</td>
<td>2.65</td>
<td>2.87</td>
<td>2.70</td>
</tr>
<tr>
<td>16</td>
<td>Work with pastoral care, nursing, and/or social work to establish daily rounds in the waiting rooms to talk with families about issues like life support or code status</td>
<td>2.65</td>
<td>2.53</td>
<td>2.62</td>
</tr>
<tr>
<td>48</td>
<td>Help identify the primary contact for the patient</td>
<td>2.63</td>
<td>3.87</td>
<td>2.93</td>
</tr>
<tr>
<td>17</td>
<td>Automatically become involved anytime family members make a decision that appears to be inconsistent with patient's Living Will</td>
<td>2.59</td>
<td>2.20</td>
<td>2.49</td>
</tr>
<tr>
<td>66</td>
<td>Communicate with patients and families about the availability of the clinical ethics committee</td>
<td>2.41</td>
<td>3.27</td>
<td>2.62</td>
</tr>
</tbody>
</table>

*Cluster average*  
2.84 3.34 2.97

*Standard deviation*  
0.23 0.52 0.27

Continued
Table 38 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster 4: Visibility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Communicate with front line staff about the situation and the status of the ethics consult</td>
<td>2.80</td>
<td>3.47</td>
<td>2.97</td>
</tr>
<tr>
<td>6</td>
<td>Be physically present to help bedside personnel better assess emerging ethical issues related to patient care</td>
<td>2.48</td>
<td>3.20</td>
<td>2.66</td>
</tr>
<tr>
<td>85</td>
<td>Round regularly on the critical care unit to discuss ethical issues related to patient care</td>
<td>2.39</td>
<td>2.40</td>
<td>2.39</td>
</tr>
<tr>
<td>37</td>
<td>Round daily on the critical care unit to discuss ethical issues related to patient care</td>
<td>2.33</td>
<td>2.00</td>
<td>2.25</td>
</tr>
<tr>
<td>40</td>
<td>Be visible and present in clinical activities, including on &quot;off shifts&quot;</td>
<td>2.30</td>
<td>2.47</td>
<td>2.34</td>
</tr>
<tr>
<td>74</td>
<td>Have the ethics committee communicate with front line staff through the medical record</td>
<td>2.24</td>
<td>2.33</td>
<td>2.26</td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td>2.42</td>
<td>2.64</td>
<td>2.48</td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td>0.19</td>
<td>0.51</td>
<td>0.26</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster 5: Liaison with system</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Ensure that whatever decisions are made are grounded in the best interests of the patient</td>
<td>3.37</td>
<td>4.27</td>
<td>3.59</td>
</tr>
<tr>
<td>95</td>
<td>Have a medical social worker in ER 24 hours a day</td>
<td>3.09</td>
<td>2.33</td>
<td>2.90</td>
</tr>
<tr>
<td>84</td>
<td>Respond and meet promptly and make decisions quickly</td>
<td>2.93</td>
<td>3.6</td>
<td>3.10</td>
</tr>
<tr>
<td>92</td>
<td>Be a liaison with the legal department when there are problems with guardianship</td>
<td>2.91</td>
<td>3.73</td>
<td>3.12</td>
</tr>
<tr>
<td>44</td>
<td>Be available to assist staff communicate with families when it feels like neither side is understanding the other</td>
<td>2.80</td>
<td>3.87</td>
<td>3.07</td>
</tr>
<tr>
<td>61</td>
<td>Be physically present to review the case with the social worker and nursing staff when patients appear to have been either abused or neglected by their caregivers</td>
<td>2.74</td>
<td>2.73</td>
<td>2.74</td>
</tr>
<tr>
<td>23</td>
<td>Work with palliative care to assist with pain management, goals of care and end-of-life decisions</td>
<td>2.7</td>
<td>2.73</td>
<td>2.70</td>
</tr>
</tbody>
</table>
### Table 38 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #5: Liaison with system</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Involve clinical nutrition in ethics consults when there are issues related to nutrition and hydration</td>
<td>2.58</td>
<td>2.73</td>
<td>2.62</td>
</tr>
<tr>
<td>79</td>
<td>Be easily available 24/7 to clarify ethical standards and for difficult decisions, such as withdrawing care</td>
<td>2.54</td>
<td>3.67</td>
<td>2.82</td>
</tr>
<tr>
<td>36</td>
<td>Inform customer service that the ethics committee has been called in to consult on care of a particular patient</td>
<td>2.47</td>
<td>2.47</td>
<td>2.47</td>
</tr>
<tr>
<td>33</td>
<td>Maintain an informational website for families to help them prepare for discussions with critical care staff</td>
<td>2.24</td>
<td>1.67</td>
<td>2.10</td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td>2.71</td>
<td>2.99</td>
<td>2.78</td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td>0.33</td>
<td>0.78</td>
<td>0.40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #6: Outreach &amp; accessibility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Have a process in place to assist staff when care decisions need to be made and there is no decision maker</td>
<td>2.76</td>
<td>3.67</td>
<td>2.98</td>
</tr>
<tr>
<td>69</td>
<td>Identify and acknowledge best practice, high-quality, ethical decision making</td>
<td>2.76</td>
<td>3.47</td>
<td>2.93</td>
</tr>
<tr>
<td>63</td>
<td>Help staff distinguish between a bioethical dilemma and a disagreement about physician’s care plan</td>
<td>2.76</td>
<td>3.33</td>
<td>2.90</td>
</tr>
<tr>
<td>30</td>
<td>Make it clear that any critical care staff member can request an ethics consult</td>
<td>2.67</td>
<td>3.60</td>
<td>2.90</td>
</tr>
<tr>
<td>80</td>
<td>Provide resources to help staff &quot;untangle&quot; themselves when they are conflicted ethically about a patient they are caring for</td>
<td>2.57</td>
<td>3.20</td>
<td>2.72</td>
</tr>
<tr>
<td>64</td>
<td>Make services of the ethics committee well known and contact information for the ethics committee widely available</td>
<td>2.54</td>
<td>3.60</td>
<td>2.80</td>
</tr>
<tr>
<td>88</td>
<td>Have staff members come to ethics committee meetings to present different ethical dilemmas they have encountered in practice</td>
<td>2.48</td>
<td>2.53</td>
<td>2.49</td>
</tr>
<tr>
<td>38</td>
<td>Survey staff regularly on what the ethics committee can do to support the work in the critical care units</td>
<td>2.41</td>
<td>2.33</td>
<td>2.39</td>
</tr>
</tbody>
</table>

Continued
Table 38 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #6: Outreach &amp; accessibility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Come to staff meetings periodically to increase associate awareness of ethics</td>
<td>2.39</td>
<td>2.80</td>
<td>2.49</td>
</tr>
<tr>
<td></td>
<td>committee resources and provide opportunities to dialogue about ethics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Conduct unit-based meetings to discuss ways in which the committee could be best</td>
<td>2.33</td>
<td>2.53</td>
<td>2.38</td>
</tr>
<tr>
<td></td>
<td>utilized</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td><strong>2.54</strong></td>
<td><strong>3.00</strong></td>
<td><strong>2.65</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td>0.18</td>
<td>0.57</td>
<td>0.27</td>
</tr>
<tr>
<td></td>
<td><strong>Cluster #7: Ethical &amp; moral support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Ensure that whatever steps are taken in patient care are consistent with ethical</td>
<td>3.41</td>
<td>4.13</td>
<td>3.59</td>
</tr>
<tr>
<td></td>
<td>practice, Ohio law and OhioHealth policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Talk with physicians and staff about the decision making behind the conclusions</td>
<td>2.96</td>
<td>3.67</td>
<td>3.13</td>
</tr>
<tr>
<td></td>
<td>reached in an ethics consult</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Get opinions from staff directly involved in care of the patient</td>
<td>2.91</td>
<td>3.67</td>
<td>3.10</td>
</tr>
<tr>
<td>10</td>
<td>Provide opportunities for employees to be able to talk to someone about their</td>
<td>2.89</td>
<td>3.13</td>
<td>2.95</td>
</tr>
<tr>
<td></td>
<td>feelings when dealing with critically ill patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Mediate between staff members who are in disagreement on how to approach an</td>
<td>2.76</td>
<td>3.27</td>
<td>2.89</td>
</tr>
<tr>
<td></td>
<td>ethical dilemma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Help staff connect with pastoral care if staff’s personal religious beliefs are</td>
<td>2.76</td>
<td>3.33</td>
<td>2.90</td>
</tr>
<tr>
<td></td>
<td>being challenged</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Hear from all sides of the ethical dilemma in a private setting before</td>
<td>2.67</td>
<td>3.47</td>
<td>2.87</td>
</tr>
<tr>
<td></td>
<td>discussing with the entire committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Create a safe haven where staff can discuss distressing ethical concerns</td>
<td>2.63</td>
<td>3.13</td>
<td>2.75</td>
</tr>
<tr>
<td>13</td>
<td>Provide support for staff who wish to be relieved from a case for ethical</td>
<td>2.54</td>
<td>2.67</td>
<td>2.57</td>
</tr>
<tr>
<td></td>
<td>reasons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Provide chart notes (exclusively available to physicians) to help with</td>
<td>2.47</td>
<td>2.47</td>
<td>2.47</td>
</tr>
<tr>
<td></td>
<td>documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued
Table 38 continued

<table>
<thead>
<tr>
<th>#</th>
<th>Cluster/Statement</th>
<th>Non EAC</th>
<th>EAC</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Cluster #7: Ethical &amp; moral support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>When an ethical dilemma has not been handled in an ideal way,</td>
<td>2.44</td>
<td>2.27</td>
<td>2.40</td>
</tr>
<tr>
<td></td>
<td>have non-committee staff participate in committee review of the dilemma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Provide peer to peer support groups for staff dealing with difficult ethical issues</td>
<td>2.39</td>
<td>3.07</td>
<td>2.56</td>
</tr>
<tr>
<td>71</td>
<td>Facilitate provision of appropriate support when staff are showing signs of burnout</td>
<td>2.37</td>
<td>2.87</td>
<td>2.49</td>
</tr>
<tr>
<td>51</td>
<td>Meet with staff one on one to understand what might be learned from a particular case</td>
<td>2.37</td>
<td>3.07</td>
<td>2.54</td>
</tr>
<tr>
<td>77</td>
<td>Acknowledge individuals who demonstrate high quality ethical decision making so they can serve as a role models for peers</td>
<td>2.35</td>
<td>2.40</td>
<td>2.36</td>
</tr>
<tr>
<td></td>
<td><strong>Cluster average</strong></td>
<td><strong>2.66</strong></td>
<td><strong>3.11</strong></td>
<td><strong>2.77</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Standard deviation</strong></td>
<td><strong>0.29</strong></td>
<td><strong>0.50</strong></td>
<td><strong>0.33</strong></td>
</tr>
</tbody>
</table>