Making the (Business) Case for Clinical Ethics

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Setting the scene: local context

- Trust located in the North West of England, 5 district general hospitals, spread over a 50 mile radius
- In the past, the Trust has received high profile scrutiny of the maternity care provided
- Relatively new medical school, good working relations with Trust colleagues
- Curriculum lead for ethics, law and professionalism for >8 years at local medical school, not clinically trained
- No CESS available within the local region for hospital and/or community based practitioners
- Ethical matters discussed within individual clinical units, occasionally at hospital clinical presentations e.g. Grand Rounds, Schwartz Rounds.

Setting the scene: national context

Lancaster University

- Clinical ethics support
  - Reported decrease in clinical ethics committees registered with UK CEN (Austin, 2018)
  - Not legal requirement for NHS hospitals to have CESS available (Magelssen et al., 2016)
  - Grassroots, voluntary system, goodwill of enthusiasts (UKCEN, 2014)
- NHS
  - Insufficient staff to cope with patient demand (BMA, 2018; Kinman & Teoh, 2018)
  - Challenges around staff recruitment and/or retention in certain healthcare specialties (BMA, 2017; Chaudhuri et al., 2013)
- Wellbeing
  - Provision of reflective spaces to address staff emotional burden (Gannon, 2014; Kerasidou & Horn, 2016; Cornwell & Fitzsimons, 2017) e.g. Schwartz Rounds (Goodrich, 2018)
  - GMC currently undertaking a UK wide review of the wellbeing of medical students and staff

“Have you got time for a chat?”: the phone call

- Colleagues known to each other through medical school clinical ethics teaching and assessment
  - Have not received such in depth ethical training (Demir & Büken, 2016)
  - Feel the weight of expectations upon them to be able to support junior colleagues
  - Often uncertain how to approach and resolve their own and others ethical dilemmas (Royal College of Physicians, 2005)
  - Clinicians often lack ethical sensitivity, failing to identify that a difficult issue or case has an ethical as well as a clinical component (McLean, 2009)
  - Lack of ethical and legal training available once doctors qualify (Guillemin et al., 2009)
  - Clinical Ethics Forums, gaps and possibilities (Johnston et al., 2012; Machin et al., 2018)

A meeting of minds: an evening meeting

- Perceptions surrounding CESS
  - Grassroots phenomenon (Slowther et al., 2012) and a perceived need for ethics support
  - Healthcare Professionals facing greater ethical complexity as a result of complex clinical environment, societal attitudes, medical advances, financial constraints (Agich, 2005; Williamson et al., 2007; Larcher et al., 2010)
  - CESS have tended to be discussed around high profile or difficult cases e.g. Charlie Gard, Asha King (see Austin, 2018) and the 'ethics of the ordinary' (Corley & Minick, 2002)
  - Medical specialisms, depts, types of decisions or groups of patients e.g. paediatrics, intenstive care (Larcher et al., 1997; Gold et al., 2011; Schneiderman et al., 2003), and acute-care hospitals and community based practitioners (Racine & Hayes, 2006)
- Alternative explanation for the reported low referral cases to UK CESS (Slowther et al, 2012; Bates et al., 2017)? Continued isolation and loneliness staff experience (Oliver, 2018)?
  - Everyday care? Last resort? (Hamric & Wocial, 2016)

‘I’ve been trying to avoid this…”: the business case template

- ‘Evidence’ required
  - Common-sense? Resources available? Scale?
  - Efficiency of the ethics consultation through cost savings generated, effectiveness of the ethics consultation service through satisfaction is scarce
  - Direct causal relationship between the positive outcomes i.e. patient satisfaction, employee morale and presence of a CESS is hazy
- The real problem
  - Articles advising to stay clear from studies referring to the financial considerations e.g. not meaningful, overlook the intangible benefits created by a CESS, loss of trust from staff and patients
- A compromise?
  - A proposal that addressed the key themes from business case and enabled us to use available evidence, including making the argument to reduce emphasis on financial considerations

‘We could time it for a CQC visit’: the proposal

- Timing
  - Influence how the proposal is received, sway the decision makers
  - Visit from the Care Quality Commission
  - CQC recognised important role of CESS in other hospital visits
- CESS: A way of responding to failings in healthcare systems?
  - Reputational branding
  - Responding to staff and patients needs
  - Positive impact on staff recruitment and retention
  - Improve organisational culture
- Realistic optimism
  - Business plan and problem-solution mindset
  - Avoiding scandals, eradicating conflicts and disagreements
  - Mindful of our own and others’ expectations of CESS

Concluding thoughts

- Significance of research when making the case for CESS
  - More qualitative and quantitative empirical research is needed
  - UK experience and cultural context of healthcare
  - Funding and time given over to conduct research
- Shift our perceptions of CESS
  - A form of staff investment e.g. facing everyday ethical uncertainty, CPD, emotional and well being
  - Reframe the problem, alter our evaluations
  - Timescales and deadlines and justifying the continuous nature and permanent presence of the solution – CESS!
- State of CESS in the UK
  - Public commitment to the ethical issues that arise and are experienced by our healthcare staff and patients (UKCEN, 2014)