
ETHICS AS AN INTEGRAL ELEMENT OF QUALITY OF CARE: THE PRACTICAL APPLICATION OF THE STAFF ETHICS SURVEY

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INTRODUCTION

California Pacific Medical Center has inaugurated a marketing program under the title, “Beyond Medicine.” The publicity states, “We research the most up-to-date treatments ...and practice the most modern, innovative medicine available. But we also believe that medicine alone is only part of the solution. That’s why we look intently at each individual case and treat the whole person and not just the illness.” This may be an appealing tactic of public relations but, at least with respect to the ethics of care, it is misleading. Ethics is not “beyond” medical care; it is an integral element of medical practice and delivery of care. If ethics is, in part at least, “looking intently at the individual case and treating the whole person and not just the illness,” then ethics is not beyond “beyond” medicine, taken as diagnosis and treatment, but essential to it.

QUALITY OF CARE & ETHICS

One of the 20th centuries most distinguished medical philosophers, the Spanish physician Pedro Lain Entralgo, wrote that “the medical act,” namely the transactions of diagnosis and therapy between patient and physician, cannot be completed without “a moral element, namely, attention to the dignity of the patient as a person.” (*La Historia Clinica*, Madrid, 1998, p.490) Also, the first major text of modern medical ethics, written by the theologian Paul Ramsey in 1970, was

entitled *The Patient as Person*. This seminal book demonstrated the ethical judgment was not simply an adjunct to clinical decisions but shaped the very nature of the medical actions. While it is possible to perform a diagnostic procedure, such as a CAT scan or to administer a treatment, such as intubation for respiratory insufficiency, as a purely mechanical act, that act will not be a medical act unless it represents a human transaction, done with the intention of benefit to the patient and in accord with the desires and the dignity of the patient. Thus, we propose that ethics should be seen as intrinsic to medicine. We further propose that assessment of the quality of medical care must reflect competence in ethical judgment and appropriate ethical policy.

The late Avedis Donabedian was the father of quality assurance studies in modern health care. In his last book, *Introduction to Quality Assurance in Health Care*, he lists seven components of quality of care: efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy and equity. These components, taken together, “constitute a definition of quality and when measured in one way or another will signify its magnitude.”¹ The first four of these seven components are familiar to all who are concerned about quality assurance. Efficacy is the ability of health care to bring about improvements in health. Effectiveness is the degree to which the attainable improvements are in fact attained. Efficiency is the ability to lower cost of care without diminishing attainable improvements; Optimality is the balancing of improvements against the costs of such improvements. Considerable effort has been made to specify these components and dimensions and to find quantifiable measures to assess them. Indeed, since it is often easier to identify failures and below quality performance, quality assurance sometimes becomes

¹ Avedis Donabedian, *An Introduction to Quality Assurance in Health Care*. New York: Oxford University Press, 2003, p.4.

mired in the negative task of preventing error rather than promoting, in Donabedian's term, "optimality."

The final three components, acceptability, legitimacy and equity, are less familiar. By acceptability, Donabedian means conformity to the wishes, desires and expectations of patients. Legitimacy means conformity to social preferences as expressed in ethical principles, values, norms, mores, laws, and regulations. Equity means conformity to a principle that determines what is just and fair in distribution of health care among members of the population. These three components, taken together, are the topics of modern medical ethics or bioethics as applied to the delivery of care.

The field of quality assurance and the field of bioethics have developed in parallel over the same time span, the last thirty years. Almost no intellectual or administrative contact has been achieved or even attempted. The last three of Donabedian's components have essentially been ignored by quality assurance activities; the first four have been distant from the concerns of bioethics. Hospitals have established quality assurance departments and instituted many measures of efficacy, effectiveness, efficiency and optimality. Hospitals have also established ethics committees, and in some rare cases, ethics services or departments. These usually operate quite peripherally to the main administrative functions of the hospital and have little, or no, input into policy making.

The Mission of the Program in Medicine and Human Values at California Pacific Medical Center is to promote "the coordination of medical care delivered to a particular patient with the values and the goals of the patient. That is, essentially, our definition of medical ethics. It corresponds, as well, with Donabedian's component of Acceptability. Another of the goals of the Program is "to study the ethical implications of complexity and cost of care as they impact patients, including how to provide health care equitably." This goal corresponds to

Donabedian's Equity. His component, "legitimacy," for example, refers to conformity to social preferences as expressed in ethical principles, values, norms, mores, laws, and regulations. This implies that the institution has the capability of dealing with patients from a diversity of cultures in accord with their values. It raises the question of how well our providers know and appreciate the moral norms and values of persons from other cultures.

In light of these correspondences between ethics and quality, we propose that a closer relationship between quality assurance and ethics would benefit patients, providers and the institution. The mere association of quality and ethics, as a conceptual unity, would send an important message about the institution's understanding of its role. But more importantly, the effort to introduce, in a serious way, the features of Donabedian's last three components, into the way in which care is delivered and evaluated, would have great value.

During 2005 the Program conducted a Staff Ethics Survey to ascertain how well our professional employees, that is, medical and nursing staff, administrators and select support staff, understood contemporary medical ethics. That Survey demonstrated that while the staff held a high view of themselves and the institution as ethical, they showed significant deficits when responding to questions about particular issues in modern medical ethics.

The full report of the Survey appeared in Winter, 2005 and was shared with major administrators. In this paper, we will select certain questions/responses that reveal the deficits shown by the Survey. We do so in summary form; an appendix states the questions and responses, with statistical data, referenced by bracketed numbers in the text. Our purpose in this paper is not to review the entire Survey. It is, rather, simply to demonstrate that there are deficits, that they pertain to important matters in medical ethics and quality assessment and that they can be defined in ways that fit Donabedian's categories of quality. The next step is to go

beyond illustrative examples and make a point by point analysis of the survey's responses with the intention of developing an actionable program of improvement.

ILLUSTRATIVE EXAMPLES

We have selected a few illustrative examples from among the seventy four questions of the Survey. These selected questions represent what we consider important links between ethics and quality. The questions are stated, with survey data, in the Appendix, referenced by a number in brackets. The second number in parenthesis indicates the page of the Staff Ethics Survey Report where the question and responses can be found.

Before going to the questions that illustrate weakness, we must note that the survey showed some strengths. 51% of respondents stated that ethics is viewed as an integral part of health care quality (33.8% were neutral and 15.4% disagreed). A significant majority (71.2%) stated that they had never “felt obligated to act in a way that conflicted with your understanding of ethical health care practices.” 65.3% said they had not “gotten ‘mixed messages’ about expectations for health care practices.” [1(12)]. However, when we turn to particular questions about ethical health care practices, the picture is not so encouraging.

For example, the Survey asked a number of questions under the general heading of “shared decision making.” These questions pertain most clearly to what we usually consider issues of medical ethics, that is, informed consent, decision making capacity, advance directives and surrogate decision making. These matters fit into Donabedian's quality component of Acceptability, i.e. conformity to the wishes, desires and expectations of patients and responsible members of their family.

The survey showed that only 30% of the staff believed that our clinicians are effective in integrating the patient's values and preferences into health care recommendations. Only 40% believed that patients are informed of the probability of a recommended treatment's success. 14% stated that they did not believe that patients were asked, outside their families' hearing, about how they wanted their family to be involved in their care [²(15)].

Questions were asked about End-of-Life care. These questions fall under Donabedian's category of Legitimacy, that is, correspondence to social norms, laws and values. Only 28% of respondents judged that physicians provided effective pain relief; only 16% considered that psychological distress was well managed. When asked whether clinicians decrease their interaction with dying patients when goal of care is comfort only, 16% agreed, 17% disagreed, 10% were unsure and 56% answered "don't know." A significant majority of staff, 64%, disagreed that the facility educates staff about ethical issues in end of life care [³(17)]. A large number of respondents, however, answered "don't know" to these questions.

When asked about privacy and confidentiality, staff affirmed that they felt the facility educates staff about privacy and confidentiality (66.2% agree, 24.2% neutral, 9.6% disagree). However, the efficacy of this education is cast in doubt when two factual questions were posed. Only 20% answered correctly those two factual questions about application of HIPAA rules). 66% agreed that private information about a patient is often discussed within earshot of others not involved in their care [⁴(18-19)].

With regard to Equity, questions about resource allocation revealed major deficits in knowledge. About 44% do not understand this institution's decision-making process about resource allocation and do not think the management communicates the reasoning behind these decisions. However, 44% disagree with the statement, "This facility makes resource allocation decisions consistent with its mission and values" [⁵(23)].

Although Donabedian does not include professionalism explicitly among his components, we must note that our physician staff does not clearly understand one crucial element of professionalism, that is, the important ethical and legal concepts about conflict of interest: 10% of clinicians answered the two knowledge questions incorrectly; 71% answered one out of two correctly; 19% answered both correctly [⁶].

CONCLUSION

Unquestionably, these illustrative examples must be interpreted in light of the statistics of the survey and possible interpretations of the questions. Also, we have not stressed here the strengths revealed by the Survey which are substantial. Still, it is apparent that our staff shows notable deficits in knowledge about medical ethics and in their perception of the ethical standards and behavior at the institution. Indeed, the staff itself seems to be aware of this, for 42% do not think that the institution "provides practical assistance to staff members who want help with health care ethics concerns," (13). Yet, the overall impression gained from the Survey is that California Pacific Medical Center is not a shining example of health care ethics. This certainly does not mean that it or its practitioners are unethical; rather it means that important ethical matters are either ignored or poorly

understood. If ethics is an essential component of quality, quality of care is diminished by these deficits.

We believe that the next step should be a point by point study of the results of the survey. Each point should be scrutinized for its legitimacy and for its translatability into a measure of quality. Means of remedying the deficits at the institutional and individual level should be devised. We believe that the deficits are due not to malice but to ignorance and absence of incentive. Means to improve education and to create policies that will clarify and motivate must be devised. The administration, at every level, should announce its support for such education and policies. Ethics is an essential element of quality of care and it does not come without effort, as philosophers and educators have stated for centuries.

¹ Respondents rated their agreement or frequency of experience with the following statements: “At this facility, ethics is viewed as an integral part of health care quality,” “At this facility, in the last 12 months, how often did you feel obligated to act in a way that conflicted with your understanding of ethical healthcare practices?” and “At this facility, in the last 12 months, how often did you get mixed messages from managers that created ethical uncertainty or concern?”

² Respondents rated the following questions from Almost never-Almost Always: “How effective are your facility’s clinicians at integrating a patient’s values and preferences into health care recommendations?” “At this facility, how often are patients informed of the probability of a recommended treatment’s success?” and “At this facility, how often are patients asked, where their family cannot overhear, about how they want their family involved in treatment decisions?”

³ Respondents rated the following responses according to their agreement and frequency of experience: “How well do your facility’s clinicians treat pain in dying patients?” “How well do your facility’s clinicians manage the psychological distress of dying patients?” “At this facility, how often do clinicians decrease their interaction with dying patients when the goal of care is comfort only?” “How well does your facility educate staff about ethical issues in end-of-life care?”

⁴ “How well does your facility educate staff about privacy and confidentiality?” “This facility has more stringent confidentiality protections for information about HIV, mental health disorders, and sickle cell anemia than other types of health information,” “This facility has procedures that allow patients to request changes in their medical record.” “At this facility, how often is private information about a patient discussed within earshot of others who are not involved in that patient’s care?”

⁵ “How well do you understand your facility’s decision-making process for allocating resources?”

⁶ “Patients should be informed of all reasonable treatment options including those that are not available at your facility,” and “A staff member who eats a meal provided by a drug or medical device company faces a conflict of interest.”