Organization ethics in health care: What can we learn from QI and safety science?

Matthew Wynia, MD, MPH
Director, Patient and Physician Engagement
Improving Health Outcomes
American Medical Association
Disclosure and Disclaimer

Matthew Wynia, MD, MPH, FACP

Developed the Climate Assessment Tools program for the AMA, a non-profit endeavor to produce tools to measure the quality climate in health care organizations.

Views and opinions expressed are mine alone and should not be construed as statements of the American Medical Association.
Goals for Today

I. Historic Links Between QI and Medical Ethics
   – The Evolution of QI in Medicine

II. Traditional Ethical Concerns about QI Methods
   – Equity
   – Efficiency
   – Reliability/Fairness

III. New Ways of Thinking about Improving Ethics
   – Using QI and Safety Methods and Mindsets
   – Example: The NQF-Endorsed C-CAT Measures
   – Example: The VA’s Preventive Ethics Program
Part I

Historical Links Between QI and Ethics
Are Physicians Part of the Problem?

“Physicians sometimes are viewed as obstacles to quality improvement programs.”

Goode et al., 2001
The Historical Evolution of “QI”

- **FROM:** A personal commitment to humility, self-improvement, continuous learning, getting better from day to day…
- **TO:** A collective (professional) responsibility, based in science
- **TO:** An industrial model of cyclic system design, examination, action and redesign.
  - focus on systems instead of individuals
  - population-based data collection, statistical analysis
  - benchmarking and guideline development
Hippocrates of Cos (c460-370 BCE)
Hippocratic School

• Combined physicians’ scientific and ethical promises
  – These promises are personal, as exemplified in the Hippocratic Oath
• Injunction to refrain from intentional harm the central ethical duty
• Humility a core virtue
“Life is short, the art long, opportunity fleeting, experiment treacherous, judgment difficult.”

Hippocrates

Aphorisms
John Gregory (1724-1773)

- Perceived moral laxity in the English medical profession
- Urged renewed “diffidence” (humility) in practice
- Still personal: “Ethics of character”
- Influenced 1823 New York System of Ethics and 1832 Baltimore System of Medical Ethics
I may reckon among the moral duties incumbent on a physician, that candor, which makes him open to conviction, and ready to acknowledge and rectify his mistakes. An obstinate adherence to an unsuccessful method of treating a disease, must be owing to a high degree of self-conceit, and a belief of the infallibility of a system… It sometimes happens too, that this obstinacy proceeds from a defect in the heart. *Such physicians see that they are wrong; but are too proud to acknowledge their error, especially if it be pointed out to them by one of the profession.* To this species of pride, a pride compatible with true dignity and elevation of mind, have the lives of thousands been sacrificed.

Gregory, 1772, *Lectures on Duties and Qualifications of a Physician*
QI as a “Professional” Responsibility

Thomas Percival (1740-1804)
Thomas Percival (1740-1804)

- Manchester Infirmary rules: 1792, 1794, 1803
- Recognized the increasingly complex medical environment of hospitals
  - Invented clinical rounds, presenting cases in reverse hierarchical order → Teamwork
- Coined terms “medical ethics” and “professional ethics”
- Profession’s “tacit compact” with society
“By the adoption of the register… physicians and surgeons would obtain a clearer insight into the comparative success of their hospital and private practice; and would be incited to a diligent investigation of the causes of such difference.”

-Medical Ethics, 1803

N.B. Register data to be available only to physicians
Code of Medical Ethics of the AMA, 1847

• Derived directly from Percival’s work
• An explicit professional *social compact*
  – Obligations to patients, colleagues and community
  – Reciprocity
  • social/economic rewards for those in the profession in exchange for putting patients’ interests first, guaranteed competence of practitioners, and guarding public health
• The birth of “professionalism”
  – First national code of ethics for any profession
Professionalism defined

- Profess: (v) To speak out in public, openly declare
- Profession: (n) A group speaking out, together, about their shared standards and values
- Professional: (n) An individual member of the group; (adj) acting in conformance with the shared standards and values of the group
- Professionalism: (n) a belief system (an “-ism”), holding that professional groups are uniquely well-suited to organize and deliver certain social goods.
  - Establish our own standards for quality
  - Ensure adherence to them…
Inherent Tensions
Professional Standards/Personal Virtues

• AMA Committees set increasingly stringent quality standards for medical education, medical sciences, practical medicine, surgery, obstetrics, medical literature, etc.

• But also…

…”there is no tribunal, other than his [the physician’s] own conscience, to adjudge penalties for carelessness or neglect”

AMA Code, 1847
“... the Code is more what you’d call ‘guidelines’ than actual rules.”

Captain Barbossa

*Pirates of the Carribean*
Ernest Codman (1869-1940)
Codman’s “End Result Idea”

• “Every hospital should follow every patient it treats long enough to determine whether the treatment has been successful, and then to inquire ‘if not, why not’ with a view to preventing similar failures in the future”

• “A new paradigm for medicine:” outcomes research, based in organizations, leading to EBM

• Left Massachusetts General Hospital in dispute over use of outcomes data to determine promotions
Art & Science in Medicine

“With the incoming of scientific precision there is the outgoing of so-called art. Diagnosis by intuition, by careless ‘rule of thumb’… is as little trustworthy as the shifting sand of the Sahara”

Dr. John Musser
AMA President 1904

The Essential Art of Medicine
Scientific Medicine Brings Awesome Successes

**Graph:**
- **Y-axis:** Mortality Rate per 100,000 per Year
- **X-axis:** Year
- Data points for Diphtheria, Pertussis, Measles, Poliomyelitis

**Graph:**
- **Y-axis:** Life Expectancy (years)
- **X-axis:** Year
- Data for United States Life Expectancy from age 0, 20, 40, 60

*References:*

**Website:** www.healthsonline.com
Whither Art in Medicine?

- Individualized treatment based on personal experience, patient preferences and clinical judgment

Vs.

- Population-based guidelines: “Art kills.”
  » David Sackett, 1997
Public Concerns About QI based on EBM/Guidelines

- Questioning of authority, including medical/scientific paternalism
- The bioethics revolution
  - Shared decision-making/informed consent
- Growth of medical consumerism
  - Cultural competence, patient-centered care and customer satisfaction
- Conflation of QI and cost-containment
  - Cynicism about ‘real’ goals of QI
“Next, an example of the very same procedure when done correctly.”
Part II

Traditional Ethical Concerns about QI Methods
Quality Measurement and Equity: What do physicians say?

- If my pay depended on A1c values, I have 10-15 patients whom I would have to fire. The poor, unmotivated, obese and noncompliant would all have to find new physicians.”
  - Physician in a 2005 survey on P4P (Casalino et al 2007)

- “39% of physicians in this study were willing to discharge hypothetical patients who were nonadherent or questioned the physician’s decision-making.”
  - Farber et al. JGIM 2007
Inequities of bonuses for hitting target performance level

Those in this area have little hope of gaining the bonus.

Those in this area have a strong incentive to improve.

Those in this area will get the bonus with no additional work.
Could performance measurement harm quality?

- *Boyd et al*: 79 yo woman with DM, COPD, HTN, osteoporosis and osteoarthritis
  - Follow relevant guidelines: 12 meds, $406/month, complex lifestyle modifications, possible interactions… ?? top quality

- *Fee and Weber*: Of patients not receiving antibiotics within 4 hours for pneumonia, 58.5% not diagnosed before leaving the ED
  - Could prompt overuse of antibiotics
Part III

New Ways of Thinking about Improving Ethics
What if we thought about better communication as a target for QI?

• Dyad focused
  – Motivational interviewing
  – Teach-back
  – Clear language
  – Cultural competency
  – Etc.

• Systems focused
  – Appreciative inquiry
  – Community engagement
  – Team-based care
  – Build teach-back into forms and processes
  – Provide resources to respond when pts fail a teach back
  – Provide educational materials, videos, interpreter services

Adapted from: Wynia MK. Making it easier to do the right thing: A modern communication QI agenda. Patient Educ Couns. 2012; 88(3):364-6
Is ethics like safety?

• Ethics
  – Ethical behavior requires individual moral virtues
    • Unethical actions therefore reflect moral failures

• Safety
  – Safe practice requires personal competence and attentiveness
    • Errors therefore reflect incompetence

• But views of medical errors are changing
“Swiss Cheese Model” of medical error
PROBLEM STATEMENT

TE catheter misplaced (could have caused aspiration)

Catheter placed with no assistance

Feeding tube new/unfamiliar

Device instructions are ambiguous

X-ray not taken to verify placement

NP did not recognize misplacement

NP did not use protocol for X-ray

Informal Norm

TE catheter looks like NG tube

No reinforcement to use policy day to day

Lack of Human Factors involvement in procurement process

Informal norm to not provide reason for X-ray on request

Results occasionally not timely

Informal norm occasionally to not get X-ray

This and the next 3 slides borrowed from John Gosbee, M
Small IV bags with KCl

- **Potassium Chloride Injection**
  - 10 mEq
  - 20 mEq
Insulin “pen” for diabetes self care
"on/off" label was added
What if ethics is like safety?

What if ethical behavior reflects latent – and changeable – organizational and systems factors?
Example 1
The Veterans Administration Integrated Ethics Program

Slides courtesy of Ellen Fox, MD
Ethics Quality Iceberg

Decisions & Actions

Systems & Processes

Environment & Culture

Ethics Consultation

Preventive Ethics

Ethical Leadership
A comprehensive, systematic, integrated approach to managing ethics in health care

Three core functions:

**Ethics Consultation**
- Responding to ethics questions in health care (CASES)

**Preventive Ethics**
- Addressing ethics quality gaps on a systems level (ISSUES)

**Ethical Leadership**
- Fostering an ethical environment and culture (Compass Points)
The Concept of Preventive Ethics

• Applies the principles and practices of quality improvement to ensure that organizational systems and processes promote strong ethical practices

• PE is oriented to understanding why the “right” practice is not occurring and then applying systems level solutions to measurably improve ethical practice
Preventive Ethics
The ISSUES Approach

- Identify an issue
- Study the issue
- Select a strategy
- Undertake a plan
- Evaluate and adjust
- Sustain and spread
# Privacy and Confidentiality Storyboard

<table>
<thead>
<tr>
<th>Ethics Issue</th>
<th>Ethical Standard Source</th>
<th>Best Ethics Practice “Should”</th>
<th>Current Ethics Practice</th>
<th>Refined Improvement Goal</th>
<th>Strategies</th>
<th>Results</th>
</tr>
</thead>
</table>
| Identified through SOARS visit and rounds that auditory privacy was an issue during patient care rounds and that personally identifiable information was discussed in hallways | VHA Handbook 1605.1 – Privacy and Release of Information - Facilities must have in place administrative, physical and technical safeguards that will protect patient privacy and electronic health information | Patients personally identifiable information should not be discussed in public areas | Through observations it was determined that personally protected information is discussed in hallways and in patient rooms with others present on all patients. CEP (100%) | Decrease % of times that protected information is discussed with patients in a non private setting from 100% to 0% by 4th qtr FY 2010. | •Teaching rounds done in conference room prior to rounding at bedside.  
•In a shared room, others are asked to step out for discussion with patient  
•Round completion will be done at bedside with patient versus the hallway | Protected information is discussed in a non-private setting 0% of the time |
# Informed Consent Storyboard

<table>
<thead>
<tr>
<th>Ethics Issue</th>
<th>Ethical Standard Source</th>
<th>Best Ethics Practice “Should”</th>
<th>Current Ethics Practice</th>
<th>Refined Improvement Goal</th>
<th>Strategies</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported by Nurse Manager that patients having a GI procedure initiates informed consent discussions with patients after they have received sedating medicines in preparation for the procedure.</td>
<td>Policy 1004.01 Informed Consent for Clinical Treatments and Procedures</td>
<td>Patients should receive fully informed consent prior to preparing for a procedure. Consent.</td>
<td>Observed clinic and 0% obtained consent prior to completing preparations for the procedure and receiving sedating medications.</td>
<td>Increase the % of patients who obtain consent prior to entering the procedure room from 0% to 99%.</td>
<td>Revise patient flow process in the GI suite • Physician and staff education</td>
<td>Increased the % of patients who obtain consent prior to entering the procedure room from 0% to 100%.</td>
</tr>
</tbody>
</table>
INTRODUCING

C·CAT
Communication Climate Assessment Toolkit

• Essential Risk Management and Quality Improvement for High-Performing Health Care Organizations
Patient-Centered Communication
Conceptual Framework

Organizational Climate

Effective Communication

Health Literacy
Language
Culture

Organizational Micro-Climates
Leadership, Resources, Commitment and Priorities
Workforce Diversity and Training
Community Engagement
Quality Improvement Infrastructure
“Whoa—way too much information.”
C•CAT Provides Comprehensive Communication Assessment Among Different Populations

**Patient**
Did doctors ask you to repeat their instructions?

**Executive**
How many of your clinicians have received specific training on ways to check whether patients understand instructions?

**Health Literacy**

**Staff**
Have you ever received specific training on ways to check whether patients understand instructions?

**Policy**
Is it hospital/clinic policy for staff members to ask patients to repeat instructions?
## Results

**Multivariate correlations of a 5-point change in performance on each domain and patient-reported quality and trust**

<table>
<thead>
<tr>
<th>Communication Domain</th>
<th>I receive high quality medical care</th>
<th>My medical records are kept private</th>
<th>If a mistake were made in my health care, the system would try to hide it from me</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>Org. Commitment</td>
<td>1.34 (1.22-1.54)</td>
<td>1.22 (1.05-1.40)</td>
<td>0.73 (0.66-0.86)</td>
</tr>
<tr>
<td>Data Collection</td>
<td>0.95 (0.90-0.95)</td>
<td>1.00 (0.95-1.05)</td>
<td>1.0 (1.00-1.05)</td>
</tr>
<tr>
<td>Develop Workforce</td>
<td>1.47 (1.28-1.69)</td>
<td>1.28 (1.10-1.47)</td>
<td>0.73 (0.62-0.86)</td>
</tr>
<tr>
<td>Engage Community</td>
<td>1.54 (1.28-1.76)</td>
<td>1.28 (1.10-1.54)</td>
<td>0.73 (0.59-0.86)</td>
</tr>
<tr>
<td>Engage Individuals</td>
<td>1.40 (1.22-1.61)</td>
<td>1.22 (1.05-1.40)</td>
<td>0.73 (0.62-0.86)</td>
</tr>
<tr>
<td>Health Literacy</td>
<td>1.40 (1.22-1.61)</td>
<td>1.28 (1.10-1.47)</td>
<td>0.73 (0.62-0.86)</td>
</tr>
<tr>
<td>Language Svcs</td>
<td>0.90 (0.82-0.95)</td>
<td>1.05 (0.95-1.16)</td>
<td>1.0 (0.90-1.16)</td>
</tr>
<tr>
<td>Cross-Culture</td>
<td>1.28 (1.16-1.40)</td>
<td>1.16 (1.05-1.28)</td>
<td>0.82 (0.73-0.90)</td>
</tr>
<tr>
<td>Perf. monitoring</td>
<td>1.40 (1.22-1.54)</td>
<td>1.22 (1.05-1.40)</td>
<td>0.73 (0.66-0.86)</td>
</tr>
</tbody>
</table>

Quality and trust items from Rose A. et al. *Journal of General Internal Medicine*, 2004

Summary

• Organizations can undertake a valid 360° assessment of their communication climate, with discrete results in 9 important domains.
  
  – Results strongly correlated with patient perceptions of quality of care, trust and reported level of understanding.

• Assessment results may be useful for:
  
  – Tracking organizational performance
  – Benchmarking
  – To inform tailored quality improvement interventions
Thank You

What questions do you have?

matthew.wynia@ama-assn.org