Special Section: Open Forum

Is Evaluating Ethics Consultation on the Basis of Cost a Good Idea?

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Despite the fact that ethics consultations are an accepted practice in most healthcare organizations,[1] many clinical ethicists continue to feel marginalized by their institutions. They are often not paid for their time, their programs often have no budget, and institutional leaders are frequently unaware of their activities.[2] One consequence has been their search for concrete ways to evaluate their work in order to prove the importance of their activities to their institutions through demonstrating their efficiency and effectiveness.[3]

The activities of clinical ethicists include education, policy review, research, and clinical ethics consultation. These activities all have a place in the well-constructed clinical ethics infrastructure of a healthcare organization, but ethics consultation can be regarded as the driving force of these activities. It is from case consultations that clinical ethicists draw much of their educational materials. Cases highlight for clinical ethicists "gaps" or other inadequacies in policies that need addressing, and where research is needed. Furthermore, cases are often the most visible aspect of the work of clinical ethicists because other healthcare organization stakeholders (patients, surrogates, family members, other clinicians, and staff) are generally involved in consultations. So it is not surprising that clinical ethicists have been concerned to generate rigorous evaluations that demonstrate the efficiency and effectiveness of the ethics consultation.

The components of the consultation can be separated into process, structure, and outcomes,[4] and in spite of the central tenant of the "quality movement" that assumes envisioned outcomes will occur if processes and structure are appropriate,[5] clinical ethicists have been encouraged to focus their evaluation efforts on outcomes.[6] Again, this is not surprising. Process and structure evaluations are often of little interest to administrators because they do not prove either efficiency or effectiveness of outcomes.

Evaluation of consultation outcomes has generally followed the familiar cost and quality approach. Clinical ethicists have sought to prove either the efficiency of the ethics consultation through the cost savings that it generates[7] or the effectiveness of the ethics consultation service through satisfaction studies.[8] More recently, a multisite study has been released that combines both a cost and quality approach to evaluating the outcomes derived from ethics consultations.[9] This study demonstrates that the intervention of a clinical ethics consultation with patients facing end-of-life decisions saves resources while producing quality outcomes. The results of the study have been widely reported[10] and the temptation to use it to justify their activities may be irresistible to

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clinical ethicists. Although it may be that evaluation efforts concerning the clinical ethics consultation should continue to focus on quality outcomes (to ensure that they continue to be realized) we caution against using this study or any other cost approach to evaluate the ethics consultation.

We have two reasons for making this recommendation. First, proving efficiency does not merely mean proving that savings are realized through the use of an activity. It also means proving that savings outweigh the costs of the activity[11] and from this perspective the data is incomplete. Our second reason for making this recommendation is more important. If clinical ethicists use this or similar data to justify their activities they are asking for future evaluations to be based on similar criteria. Although satisfaction studies can and possibly should continue to be used as a means of evaluating the effectiveness of consultation, evaluation criteria based on the cost savings achieved through it have profound implications for the integrity of all the activities of clinical ethicists. These implications will ensure that healthcare organization stakeholders eventually view the activities of clinical ethicists with the most profound cynicism. This will inevitably weaken stakeholders' trust in *all* the services offered by the healthcare organization.

In this essay we discuss in more detail our reasons for cautioning clinical ethicists against using this study or others like it as a means of evaluating outcomes associated with consultation activities. This recommendation does not relieve clinical ethicists from the burden of evaluating it. Rather, it suggests that a different approach should be used, and so we conclude with the suggestion that clinical ethicists view case consultation as a mechanism that produces intangible benefits for the organization. We note that there are difficulties associated with this approach. Adopting it means taking a broader perspective on how the case consultation affects the healthcare organization's mission and goals, and it means generating a more difficult research agenda than a straightforward agenda concerned with cost and quality.

Using Cost Savings to Evaluate the Ethics Consultation

Once a significant number is generated it becomes a relatively easy task for clinical ethicists to estimate the cost savings generated in their own institutions when ethics consultation is used to help patients, families, and others address end-of-life issues. For instance, in the study referred to above, 1.44 fewer days in the ICU were associated with the intervention of the ethics consultation in these situations. It is a simple matter then for the clinical ethicist interested in proving the efficiency of the consultation to call a knowledgeable administrator and get an estimate or average of the daily costs incurred in the institution's ICU. For instance, if the average day in the ICU costs $10,000 then 1.44 days is $14,440. The clinical ethicist can then multiply that figure by the number of end-of-life consultations that occurred throughout the year to get an idea of the amount of resources saved through the intervention of the ethics consultation associated with the ICU. It is a rough estimate to be sure, because the patient population is heterogeneous—but, nevertheless, it could serve as a reasonable proxy for costs saved. However, it is only one side of the picture.

An evaluation of any activity based on revenue earned or savings generated must also include the costs of that activity. Manufacturers or service providers are generally not interested in providing a good or service that costs more than

the revenue it generates or that costs more than it saves, and we have been unable to find one evaluation of ethics consultation that takes into account a significant cost associated with it. This is the opportunity cost of the time spent by ethics consultants on their activities.[12]

In this context, opportunity costs are those costs that are incurred by deciding to pursue one activity rather than another.[13] For instance, if a physician spends 40 hours a year on ethics consultation activities and her salary is $200,000, then one cost to the institution in allowing the physician to spend that time on ethics consultation activities is $3,848. But there is an additional cost: the amount of revenue lost to the institution when the physician is involved in ethics consultation activities. For instance, in the above example, if the physician generates $20,000 per week in revenue, then the true cost to the institution is $23,848, not $3,848. There may be other opportunity costs to consider. For instance, if the physician is required to participate in educational activities as a condition of her involvement in consultations, then the time spent on those activities should also be considered an opportunity cost.

The opportunity costs associated with consultation activities will vary from one institution to another. They will depend on the type and composition of the service offering consultations and it very well may be that the savings generated from pursuing ethics consultation activities in specific institutions are greater than their associated costs. Nevertheless, an evaluation based solely on cost savings is incomplete and, in our opinion, should not be used to justify consultation activities unless the costs, including opportunity costs, of the consultation are considered as well.

But there is another, more serious, problem associated with justifying clinical ethics service on the basis of cost savings. Using that as the justification of an activity invites future evaluative criteria based on the same data (cost savings). This will seriously compromise the integrity of clinical ethics activities.

Compromising the Integrity of Ethics Consultation?

Evaluations are intended to generate data that can be used for performance measures. Performance measures are benchmarks against which achievements can be measured. For instance, if the data imply that cost savings of $50,000 are achieved in one year by performing consultations, this figure becomes a benchmark for future performance, creating the expectation that similar, preferably greater, savings will continue to be realized.

One goal of ethics consultation is to facilitate difficult decisionmaking within a voluntary and supportive context by clarifying ethically troublesome questions.[14] But if the consultation is to be evaluated on the basis of cost saved, then attaining cost savings also becomes a goal of the consultation, and this goal may influence (or dominate) the original goals of the consultation. For instance, it is entirely conceivable that initiation of a consultation may change from voluntary to *being required* in situations where savings can be realized. Or it may be that the process of consultation will change. For instance, there may be a shift from "facilitating" a decision to "urging" or "recommending" or possibly "imposing" a decision. It is entirely plausible that ethics consultants, under the guise of "facilitating" end-of-life decisions, could be used to encourage decisions that could result in costs savings or could perhaps systematically fail

to explain or explore alternatives that could be more costly. In these scenarios, it is difficult to see how the goals of consultation, as they are currently understood, can be realized. Furthermore, the introduction of an evaluation based on resource or cost savings may influence the other activities of clinical ethicists.

The other activities of clinical ethics include education, policy review, and research. Clinical ethicists point with justifiable pride to the inroads they have made in educating their colleagues on the ethical issues involved in healthcare delivery.[15] It is not fanciful conjecture to suppose that successful educational activities can lead to a decrease in the number of consultations requested. If it is true that there is a direct relationship between education and the number of consultations requested, one must ask whether or not it is in the best interest of clinical ethicists to continue their education activities so enthusiastically. Evaluations based on cost savings obtained from consultation activities introduce a disincentive to produce and disseminate knowledge that may render the service unnecessary. Policy activities and the research associated with them may also change for the same reasons. Evaluation on this basis introduces a disincentive to pursue or develop any policy or other tool that could potentially make the service less relevant or less visible.

So far our discussion has ignored issues of "quality" or "effectiveness." Consumers of a good or service evaluate the quality of it based on their expectations for it, and quality is achieved when those expectations have been met or surpassed.[16] To date, the quality or effectiveness of consultations has been measured through satisfaction studies. Participants in the consultation have generally been asked if they have found the consultation helpful in some way. But if the goals of the consultation change, then stakeholder expectations of it will change as well. For instance, if attending physicians were required to call consultations for some kinds of cases, their expectations of it would change and they might not find it as helpful as they found it in the past. If patients and their families or surrogates whose decisions may result in cost savings were required to participate in a consultation, we can safely assume that their perceptions and expectations of it would change. In the scenarios we have painted above, if one of the goals of a consultation is to realize cost savings, it very well may be that stakeholders, including patients, surrogates, and family members, would begin to view consultation with suspicion and distrust. If the "quality" or effectiveness of an outcome has any relationship to trust, as it should in healthcare-related activities, then quality will be eroded, as stakeholders understand that cost savings may be one of the reasons for initiating a consultation.

A Different View of Ethics Consultation

Clinical ethicists have viewed the ethics consultation as a process that is similar to other healthcare-related processes, and so some have sought to evaluate it in similar terms, notably by its effect on costs and quality. In our opinion, this is a mistake. This approach will inevitably compromise the goals and processes of the consultation service as well as other ethics activities. Further, any perception that the service is not to be trusted will inevitably reflect on the institution itself—a perception that no healthcare organization can afford. This does not mean that consultation or, for that matter, any of the other activities of clinical ethicists should not be evaluated. It does, however, require looking at them differently.

Persons interested in valuing organization activities or organization assets know that some activities, while producing value for the organization and its stakeholders, cannot be evaluated, or measured, in the same way as other activities or assets. These assets are often called "intangible assets" or "intangible benefits."[17]

An intangible asset is a claim to a future benefit that does not have a physical or financial embodiment. Intangible assets explain the difference between the book value of an organization (which generally measures tangible assets) and the market value of an organization. For instance, in 1980 the stock market was trading at a price-to-book value of about 1 to 1. Now it is trading at a ratio of 5 to 1 and the difference is attributable to the value of intangible assets.[18]

Intangible assets are generated by one of three things: innovation, unique organizational design, or human resources.[19] One unique intangible asset of human resources is their knowledge—or their "intellectual capital" as it has come to be called in accounting circles.[20] In what follows we focus on this dimension of intangible assets. Consultation is a use of the intellectual capital of human resources, in that persons involved have a specialized knowledge, which is used to attain the goals of consultation. This intellectual capital can be used again and again, unlike a physical asset that has a definite life span.

This view of consultation as an intangible asset of the organization means formulating a more difficult research agenda to evaluate it than the more common cost and quality approach. In spite of widespread agreement on the importance of intangible assets, particularly knowledge capital, it remains difficult and controversial in managing, measuring, and valuing it for the individual organization.[21] It is difficult to "capture" the benefits of intangible assets, especially in terms of human resources—who, after all, may leave the organization and thus disrupt projected revenue (or cost savings) streams associated with them. Nevertheless, some organizations are getting around these problems by linking intangible assets to other variables, for instance the effect of training (an intangible asset) on employee retention, or linking investment in human resources (recruitment activities) to the growth of the market that is served by the organization.[22] Although this approach may not give an accurate valuation of the intangible asset, it does give important information in terms of the benefit of the asset, and benefits can be used to evaluate the value of the asset relative to its cost.

If we think of the consultation from this perspective then we have to look at its effect on the goals of the institution. For instance, most healthcare organizations are concerned about the markets that they serve, especially if they have competitors. To understand their market, to ensure that their quality efforts are being met, most healthcare organizations ask patients to fill out a "satisfaction" survey. This information can be used to anticipate market demand for particular services, it can be used to ascertain what is most important to patients, it can be used for in-house training, and so forth. Consultation activities might also have a positive effect on the healthcare organization's market. It would be a relatively simply matter to include in these surveys a simple question: "Are you more comfortable knowing your hospital has an ethics consultation service? If so, why?" This would give clinical ethicists an idea of their impact on their organization's overall goals. This information, if it is positive, can be used to justify and improve consul-

tation activities as well as other clinical ethics services. It is also information that could be of enormous importance to managers.

Given the nation's nursing shortage, another goal of most healthcare organizations is the recruitment and retention of nurses. Recent studies have asked why, in spite of increasing wages, nurses are refusing to return to the profession.[23] One possible answer is that nurses often experience "moral distress," or the distress that arises when they know the right thing to do but are prevented from doing it by organizational constraints, a condition that may lead to "burnout."[24] The availability of a clinical ethics consultation can provide alternative pathways for nurses experiencing moral distress in particular situations. Does the availability of this service have any effect on retention rates among nurses? Again, it would be a relatively simple matter to survey a population of nurses and ask. This would not only give management information on a crucial issue, possibly affecting recruitment activities, it may also provide information on how to improve the consultation service. Another possible route would be to compare turnover rates between two clinical units—one associated with a clinical ethicist, the other not.

There are other areas for exploration. For instance, does access to such a service provide a level of comfort among department heads that routinely deal with potentially complex ethical issues? If it does provide a level of comfort, does it have any effect on decisionmaking or productivity? Again, studies of this sort would be relatively simple to design and it would be a relatively simple matter to collect the data.

Conclusion

We find the argument that the cost savings generated through ethics consultation activities are too small to interject incentives that may change the behavior of clinical ethicists unpersuasive.[25] Incentives do change behavior—no matter how small they are. The managed care revolution taught us that. And in this context even the *appearance* of distorting incentives may have a profound effect on the perceptions of the organization's stakeholders.

Activities in any well-run organization should be evaluated on some basis—no matter how small these activities may be relative to others. We are advocating that clinical ethicists dispense with the cost savings approach to evaluating the consultation, and so avoid possible conflict and controversy that may destroy its integrity. We suggest that clinical ethicists change their perspective and see the consultation not as a healthcare process like any other but as an activity that produces benefits for the institution other than cost savings. This approach preserves the future integrity of the ethics consultation as well as the integrity of the other activities of clinical ethicists.

We are aware that this approach is not as straightforward as the familiar cost and quality approach. Yet, balanced against the probable erosion of ethics activities, including the ethics consultation as a trustworthy vehicle for patients and their families and staff, we believe alternative approaches are worth the time and trouble to explore.

Notes

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2. Fletcher JC, Lombardo PA, Marshall MF, Miller FG, eds. *Introduction to Clinical Ethics*, 2nd ed. Frederick, Md.: University Publishing Group; 1995:262–3.
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4. Donabedian A. Basic approaches to assessment: Structure, process, and outcomes. In: *The Definition of Quality and Approaches to Its Assessment*. Ann Arbor, Mich.: Health Administration Press; 1980:79–128.
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8. In 1996, James Tulsky and Ellen Fox comprehensively critiqued the evaluations that had been completed concerning the ethics consultation. Although they found that all the studies had methodological flaws, they also found helpful information in that outcomes (or effectiveness) studies did demonstrate that the majority of physicians requesting consultations did appreciate them. See note 3, Tulsky, 1996. Also see Yen B, Schneirderman LJ. Impact of pediatric ethics consultations on patients, families, physicians, and social workers. *American Journal of Perinatology* 1999;19:373–8.
9. Schneiderman LJ, Gilmer T, Teetzel HD, Dugan DD, Blustein J, Cranford R, et al. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: A randomized controlled trial. *JAMA* 2003;290:1166–72.
10. Study finds ethics consultations reduce futile end-of-life treatments. *Health & Medicine Week* Sep. 22, 2003:154; Study finds ethics consultations reduce futile end-of-life treatments. *Managed Care Weekly* Sep. 22, 2003:4; UC San Diego team finds that ethics consultations reduce futile end-of-life treatments. *AScribe Health News Service* Sep. 2, 2003. Available at http://web2.infotrac.galegroup.com/itw/infomark. Accessed Dec. 2, 2003.
11. Fox E. Concepts in evaluation applied to ethics consultation research. *Journal of Clinical Ethics* 1996;7(2):116–21.
12. Fox briefly mentions "opportunity costs" in her discussion on "Evaluating Efficiency." However, her focus is on nonsalaried physicians. See note 11, Fox 1996:119.
13. Baumol WJ, Blinder AS. *Economics: Principles and Policy*, 4th ed. New York: The Dryden Press; 2004:102–5.
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16. See note 5, Deming WE 1981–1982.
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22. See note 18, Bernhut 2001.
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24. Corley MC. Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics* 2002;9(6):636–51.
25. See note 7, Heilicser et al. 2000.