

Variance in Bioethics Services: Challenges and Opportunities in Canada with a Focus on In-house vs. Outsourced Health Care Ethics Consultations

ÉTUDE DE CAS / CASE STUDY

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Résumé

Les services de bioéthique varient à la fois entre et à l'intérieur des différentes juridictions. Cette étude de cas décrit cette diversité au Canada, notant les défis et les opportunités que cette variance offre.

Mots clés

bioéthique, Canada, clinique, consultations, organisationnel, recherche, services, variance

Summary

Bioethics services vary within and across many jurisdictions. This case study describes such inconsistencies in Canada, and notes challenges and opportunities related to this variance.

Keywords

bioethics, Canada, clinical, consultations, organizational, research, services, variance

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None to declare

Introduction: Variance in Canadian Bioethics Services

Bioethics has been in place in its current general form for a few decades, at least in the Western world [1]. It largely developed as a reaction to atrocities committed by health care providers, researchers and policy makers in the 20th century, such as by Nazi doctors in World War II and by American public health officials in Tuskegee [1]. Its most prominent conceptual innovation may be its emphasis on autonomy or personal choice, e.g., in comparison to ancient and medieval health care ethics [2], as illustrated in the contemporary notion of informed consent [3]. Yet, in practice it has gone much beyond such conceptual innovation, establishing services that support ethical decision making in relation to health care; such services are commonly viewed as *bioethics services*.

Bioethics services address health care provision, research, policy making, and more. Although there are guidelines, legislation and some research related to bioethics services [4, 5], there does not seem to be consistency within and across jurisdictions regarding which bioethics services are provided in which circumstances. In Canada, bioethics services are currently inconsistent within and across jurisdictions. For example, although Research Ethics Boards (REBs) are required in Canada, there is no consistency in their decision making processes or outcomes [6]; indeed, this inconsistency has been addressed as a barrier to multi-site research [7]. Multi-site studies are known to often have slow starts due to the multiplicity of REBs involved, which can have varying submission requirements or

even reach different conclusions. Delays encountered may result in smaller than planned sample sizes and other challenges. In turn, these may compromise the scientific soundness of the research and hence its ethical acceptability.

Another example of variance refers to clinical and organizational bioethics consultation services. In-house bioethics consultation services are available in many if not most hospitals in Ontario, but less uniformly so in British Columbia. For instance, some hospitals in the Greater Vancouver Area offer such services, whereas hospitals on Vancouver Island do not (this is based on personal knowledge, informed by my practice in both provinces, including at Vancouver Island Health Authority). Although such inconsistency may be due to funding variance, it may also be due to lack of clear agreement that in-house bioethics consultations are more valuable than alternatives, such as outsourcing of bioethics consultation services, as indeed occurs on Vancouver Island and in some community health care centres in Ontario.

Even among bioethicists there is no agreement on best practices: a recent study of bioethicists affiliated with the University of Toronto Joint Centre for Bioethics – which presumably would confer some coherence, if not consistency among its affiliates – found that they agreed primarily on some procedural matters (including the domains of practice, individual reporting relationships, service availability within business hours, and the education and training of bioethicists), but apparently not on more substantive matters such as models of bioethics service delivery [8].

Such inconsistencies or variance may pose challenges for the provision of best practices in bioethics services, as best practices require some standardization, e.g., in the form of guidelines. At the same time, over-standardization may create risks, possibly due to a lack or insufficient consideration of the divergent contexts in which bioethics services operate. Some variance can offer opportunities for improvement, as it may enable learning from positive (advantageous outlier) variance for all services [9]. Similarly, learning from negative (detrimental outlier) variance may help prevent one's own errors. An example of system learning from both positive and negative variance can be found in research ethics, where access to REBs' previous decisions and decision making processes has been shown to facilitate improvement across REBs in Canada and elsewhere [10]. Also, exploring REBs' innovative – hence variant – approaches, such as in relation to community-based participatory research, can positively impact research ethics more generally [11], for instance by promoting the inclusion of research participant representatives in the planning of all human research.

The following case study demonstrates challenges and opportunities of in-house versus outsourced bioethics consultation services. This case study suggests that comparing in-house to outsourced services using rigorous research methods could be very informative for the development of best practices.

Case: In-house vs. Outsourced Ethics Consultations for Mental Health Care

A mental health care team is tasked with providing outreach to homeless patients who have concurrent disorders (serious mental illness with addictions), which poses some risk if done by a sole staff member due to the often crime-ridden environments in which these patients reside. Yet, routinely sending staff to outreach in couples is inefficient and may result in the team not providing outreach to as many patients as they could otherwise.

An in-house bioethicist is asked to review the situation and suggests that staff safety is paramount, partly based on the collective agreement of the health care organization, while recognizing that the team has to achieve its mission for numbers of patients as well as for quality of care. This bioethicist engages the team's leaders in a discussion about identifying and reducing inefficiencies elsewhere in

order to uphold safety of staff by allowing them to conduct outreach in pairs while providing care to the allotted number of patients the team is funded for.

An outsourced bioethicist reviews the same situation and suggests that patient care is paramount, while recognizing that staff safety is important. The bioethicist argues that there is no care without some risk to staff, such as a nurse or physician being pricked by a needle in the operating room in spite of taking all safety precautions. This bioethicist engages the team's leaders in a discussion about changing the culture of care of the staff to be less risk averse, while optimizing safety as much as possible when sole staff outreach to patients. The bioethicist suggests strategies to manage risks, such as the use of smartphones that are programmed to connect their GPS location directly to the local police department if their panic button is pressed.

Questions

1. Recognizing that the choice between the in-house bioethicist's suggestions and the outsourced bioethicist's suggestions may be a fool's choice because more options may be available:
 - What do you think of their respective suggestions? Can a combination of their suggestions be considered? What additional options could be considered?
 - What ethical issues do such situations raise, for example, in terms of distributive justice concerns, such as the allocation of health care resources?
 - What kind of capacity building (training and more) of the team's leadership and the staff would be useful to help the team make ethical decisions about such situations?
 - Which models of bioethics consultation services could facilitate such capacity building and decision making?
2. How much variance would be helpful in relation to bioethics services? Would that differ for different types of bioethics services, such as clinical, organizational, research and other bioethics services?
3. What resources could be made available to support learning from variance of bioethics services? How could these resources be made as accessible as possible to all the relevant stakeholders (perhaps including the general public)?
4. What research should be conducted on variance of bioethics services? What should be its primary foci?
5. What education should be provided on variance of bioethics services? To whom should it be provided to? Who should provide it?

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Suggested readings

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