Conflicts of Metrics

Mary V Rorty
September 10 2011

I: Introduction

I was invited here to talk about some ethical implications of conflicts of interest and conflicts of commitment on the individual and organizational levels, with reference, when possible, to the topic of this conference, the "ethics of metrics." Most of my experience with ethics consultation and ethics committees has been with less admirable organizations than Kaiser, and I am counting on your experience with the requirements of your system to supplement my examples with examples of your own. Please help me find analogies with my examples, and tell me how they work out in your system. Particular thanks here to Theresa Drought, who contributed some examples of the use of metrics in Kaiser that might well constitute occasions for conflicts of interest on the part of practitioners.

II: Conflicts of Interest

There's a lot of literature on conflicts of interest, and most of it talks about individuals on hospital boards who have financial interests in ancillary services who might be tempted to influence contracts for their own financial advantage. All of that literature points out that, most narrowly considered, Conflict of Interest has to be intentional, has to be a positive act (rather than just commissions, failing to act); and usually only focuses on actual financial benefit. That seems pretty narrow.

I want to talk about CoI in rather different contexts, and in a more general way. It includes interests of individuals like career advancement, prestige, friendship, family obligations. And I want to talk about CoI not just for individuals, but for the organizations themselves. That's where the most intractable, the most common, the most unavoidable CoIs arise.

In much of the literature on CoI it is noted that it is hard to identify, much less prove. The definition (as in the 1993 code of ethics of the American College of Healthcare Executives, cited by Boyle, p. 146) may include the phrase "make a decision to intentionally affect the organization in an adverse manner." Harm is often characterized in purely financial terms--but there are other ways to harm organizations than financially--especially a health care organization, where public trust and internal morale may be equally important. And with those implicit vaguenesses, it is possible that the appearance of an intentional ethical breach may be as damaging as an actual one.

An organization has many interests--not all of which work in the same direction. I think of these as unavoidable structural tensions that every organization must navigate, balance:

--Patient self-determination vs evidence based medicine

that means that patients and their families can not only be refusing medically advisable treatments, but (more commonly these days) asking for treatments that are not being recommended

--Quality improvement vs cost containment

or--mission vs margin (and as Zeke Emanuel has noted, "no margin,

no mission!") And—the two are different!!

And this balancing is done by what the IOM report characterizes as a complex adaptive system (cf. Plesik's appendix in *Crossing the Quality Chasm*), in an unstable and rapidly changing legal and regulatory context.

These interests--these values in tension--are all valid and appropriate interests for the organization. To opt, in any given decision, to prioritize one valid interest over another equally valid interest, may appear to be an unethical conflict of interest--whether it is, in the strictest, legalistic sense, one at all. Instead, it's more of a balancing act on a shifting floor.

I'm interested in ethics committees (as are we all), and the ethics committee or ethics process is itself a strategy, an institutionalized mechanism, for dealing with, minimizing or mitigating, conflicts of interest--a "two heads are better than one", third party intervention, that adds another perspective to conflictual situations.

CASE: *A person on the ethics service is one of the stakeholders in a case that comes to the committee.*

How often does that happen?

(In my experience--very frequently. Committee members can be, and often are, our **best source** of cases: an ethically astute practitioner with good radar can spot problematic situations arising; can often cut them off at the root--and in case of need, invokes our expertise for help in satisfactory resolution.)

Is this a case of a "conflict of interest"?

(Actually, since one of our commitments is to ethical practice in our professional role, it can be seen as a part of our commitment, or a supplement to it, or the same commitment in a different context--so there need not be anything 'invidious' or conflictual about it.)

Suppose in one of the many cases of this sort, you wonder if there **is** a conflict--an individual practitioner's personal ethical commitments are influencing the perception of the case (=eg, racial/cultural biases, conscientious objection to some cases...) what is the proper course for that stakeholder?

--recusal from the case?

--disclosure and participation?

(In my experience, most committees have procedural rules to handle such cases adequately. In my home committee, as many as possible of the people involved are invited to present different perspectives on controversial decisions in a specific case, then those immediately involved are dismissed while the case is discussed by the committee or the consult service in their absence. In my opinion, recusal from the discussion of the case altogether makes things a lot harder by depriving the committee of useful and relevant perspective .)

III: Conflicts of Commitment

There is another piece of vocabulary that might be useful for us when we talk about an analogue to 'conflicts of interest' for organizations: conflict of commitment, or the problem of two hats. The majority of people serving on ethics committees themselves have dual roles. As transplant surgeons and social workers and chaplains and nurses we have role obligations in our clinical role, and through our professional training.

As members of the ethics committee, we each have a separate role to play in our organization. We take off the hat that comes with our professional, primary role--and put on another hat. We commit to reasoning together on the basis of our common humanity to determine the best possible resolution for conflicts that arise in practice, seek a balance between the competing and possibly exclusive structural tensions that constitute the social context in which our HCOs operate.

These dual roles are not conflicts of interest so much as *conflicts of commitment*. They are everywhere; and since they can 't be avoided they need to be acknowledged and balanced. And it's the same for the individual and for the organization. Individuals have obligations to the patient(s); to our colleagues/ fellow employees; to the mission and the policies of the organization we serve--and as human beings, citizens and moral agents, to the society in which we live. The organization has obligations to the patients; to its internal constituents; to its external partners and collaborators--and to the expectations the society has of it, because of the role it plays in that society.

My first case was one where the conflict was hypothesized as being between, eg., a physician's role as attending for a particular patient, and h/her role on the ethics committee. To some extent, that's a fairly straightforward and commonplace balancing act that we all go through, and have mastered so well that we don't even notice. (How many of us are lucky enough to have only ONE role in our institutions?)

So let's complicate it a little. Theresa suggested to me a case where physician income depends upon patient satisfaction surveys. This is a much better "ethics of metrics" case--and it's arguably a "conflict of interest" case rather than just a "conflict of commitment" case.

> CASE: *Physicians receive bonuses for having good patient satisfaction scores, if they don't see a patient, the patient is not given the survey that generates the score. One MD recognizes that she has changed her practice, if a patient seems very angry or hostile, she refers the patient to urgent care, provides referral to a specialist, or finds some way to manage the patient without seeing her. In this way she protects her scores and her income.*

Would this come to your committee as a "case"? Who (what office or department or agent) would it go to? QA? Peer review? Is there a more appropriate place for it to go than to the ethics service? If it DID somehow come to your service/committee, what would you recommend? If (and insofar as) it is an ethical issue--is it an issue for this individual? It might well come to the committee because the person is upset because s/he feels put in an untenable situation. This is not a "conflict of interest" that she intentionally invites. She might feel she's being forced by her institution into bad

behavior. She may have doubts about the value of such surveys. She may feel that this mechanism is a structural or systemic impediment to excellent ethical medical practice. It may be an organizationally imposed source of moral distress for the physician concerned.

(I was glad to hear Dr. Shaner mention 'moral distress' earlier today, and learned that your co-director, Paula Goodman-Crews, is working on a specific project on moral distress with nurses in her institution. I applaud the attention, and would like to see that useful term of analysis extended out of the realm of nursing (where it was introduced in about 1982) to every individual in an HCO—and, if I had my way, to the organizations themselves, as a useful way of pointing out the ethical implications of externally imposed requirements, including various metrics, on the excellent function of those organizations.)

Metrics are arguably value-neutral, in themselves. The ethical valence derives from how they are used. Patient satisfaction surveys can be used to pinpoint areas in which the service of a facility can be improved. That could be useful. They can also be tied into incentives--punishment or reward for individuals. That may be more ethically problematic.

I was recently involved a patient satisfaction survey for a neurology department. They were probably mandated to do it once a year. They got me as a third person with no departmental ties and virtually no information about how things work, and it was multiply anonymous: there was no identification of the patients, unless they wanted to sign it, and it was not tied to any data that could be pinpointed to individuals for purposes of punishing or rewarding them. But it could, and did, include ways of identifying how patient services could be improved. It elicited comments like "the staffing is variable" or "they should have more physicians on service for clinic hours" as well as clear indications that waiting time was an issue for everyone concerned.

Unfortunately, in our competitive market-driven health care environment, the temptation to less-than-ethical strategies are undoubtedly tempting. One can hope that the incentives of the sort described in this case were entered into by mutual agreement, with full disclosure—and I suspect they are less a problem in Kaiser than in many other settings…

III: Mandated reporting

We just did an ethics-of-metrics where organizational requirements expose their members to conflict of interest risks. Not all cases that present problems are avoidable. For instance, consider mandated reporting.

I have imagined that an HCO could set up patient satisfaction surveys in ways which allowed it to gather and use the information in performance improvement without necessarily penalizing (or rewarding) individual practitioners. But these mandatory reporting cases are examples where the institution itself is involved in a larger context which determines some of its actions, and represents potential conflicts.

I'm interested in organization ethics (whatever that is). One of the things that involves is an interest in systems, and their implications. It became obvious in the previous cases that there can be ethical issues that are not questions of individual behavior--but that arise because of the larger organizational context in which the individual agent is involved.

"Local committees review all bloodstream infections to determine if they are line related…some committee members have questioned whether this perceived conflict of interest causes the administrative participants to unduly influence the determination of CLABSI."

So: is this a case that might be discussed in your committee? If not, where would it go. If it did come to you, how are your relations with the department or function to which you should refer it? I assume that the statistics collected have some effect on the national ratings of our institutions. Could they be useful for process improvement in the hospital? Are there any downsides to the protocols such that it might be of a disadvantage to implement them?

My Kaiser MSW daughter brought me the case of mandated turning for patients to prevent bedsores. There are some patients whose skin will break down no matter how often they are turned. There are patients who refuse to be turned. There are patients who aren't competent to refuse, but who scream with pain when they are turned.

What is the problem for the individual nurse who has such a patient? Is this a conflict of interest, as I have defined it, or a conflict of commitment? She has obligations to the best care for her patient—and for the requirements of the organization. What are the implications for her? For her institution? Should she torture her patient? Should she claim that she did? Should she decide she'd rather sell crocheted headbands at the local farmers market, and quit? What kind of provision for exception does the reporting form contain?

IV: Some general issues

We're in the midst of an increasing attention to 'evidence-based medicine', and some of the provisions for our current wave of health care reform involve in various ways quantification, statistics and other metrics. So the ethics of metrics will continue to be an issue for us all. That presents a great deal to think about for the ethics programs in our hcos.

a--What counts as an outcome?

The way we measure defines what counts as an outcome. "Patient satisfaction" seems an odd measure. Our patients are typically ill, terrified, not at their best, and resentful of the fact—and it is hard to assure ourselves that their dissatisfaction has any predicable correlation with the quality of care they are receiving. It is excellent care that we are committed to providing—not necessarily 'what will make the patient 'satisfied.' "Throughput" is better suited to automobile production than to the practice of medicine (and I refer you to an early Rorty article, "Total Quality Management and the Vanishing Patient"(with Ann Mills), *Business Ethics Quarterly* 12/(4) 481-504, 2002.)

b—How are the metrics used?

That statistics measure averages, and not individuals, is something that we're used to dealing with in our clinical practices. One of the things that our organizations have to deal with is scrutinizing the impact of our metrics on the quality of patient care. I've been suggesting that in themselves metrics can be value-neutral. It matters a great deal what

they are used for--the accommodation to the art and the advance of the science of medicine? The improvement of the business of patient care? Or used for punishment/reward?

The truth of the matter is that our organization is in competition with all other providers of healthcare in our fragmented, market-driven, competitive healthcare system, and we can't pretend that's not the case. It is this competitive environment that creates much of what I consider "organizational moral distress" for our HCOs. We are tasked with--we task ourselves with--finding an ethical balance in our clinical / organizational practice. It's never been more necessary than it is today. Our organizations need our help with how to deal with the conflicts and competing goals that structure our health care system.

V: Implications of this for the committees we sit on

Throughout my time with you here today I've been walking on two feet: talking about possible conflicts of interest (or commitment) for individuals--and of the analogous ethical issues that arise in the organizations in which those individuals live and work. My root assumption is that

--all clinical ethics issues have organizational implications, and

--all organizational decisions and policies have clinical implications.

I think that is an important thing for ethics committees to think about. Looking for, thinking about, strategizing about, the upstream, structural, organizational requirements or impediments that underly the individual cases that come to our committees is one of the greatest values we as committee members can add to the organizations in which we serve.

There are many topics for ethical discussion in HCOs. What ABOUT the ethical issues that are arising--and are going to arise--with metrics, with conflicts of interest and with conflicts of commitment, in our practice and in our organizations? Are they our business? Do we want them to be? If not ours, whose?

There are many departments, units, functions and individuals that are tasked to deal with normative, value-laden issues in the HCO: legal services, risk management, patent reps, pastoral care, quality assurance, professional standards, compliance—and ethics!!--and we have representatives from some of them on our committees. If there are this many other departments or functions that also deal with normative issues, what is our role, the role of the ethics service, the ethics committee? Communication and collaboration? Merely case consultation, or wider? One element, or a coordinator and facilitator of a wider project? Initiate? Draft projects? Contribute to them, or do them? Responsive or proactive? Corrective or preventative? Who will be designated—and SUPPORTED—to do the increasingly important work for our wider organization? If not us, it will be someone else. But value what YOU do that no one else in the organization can do so well, and make that a value that you add.

VI: Some metrics for ethics

Metrics can be our friend. Count the hours! Count the people consulted. Calculate the support needed for your activities--and ask for it. Count the conflicts of commitment that your service for ethics creates--and instead of dropping out of the

committee, advocate for more support for it. Count the ways in which institutional, or regional, or federal, metrics impede excellent patient care or create conflicts of interest, and strategize how they can be minimized. Acting as a collective voice, we can advocate for responsible policies as individuals, as a group to our organizations--and Kaiser as an organization has a very powerful voice to policy makers. The summed ethics committees are together more important than just one more voice of an individual.

Evaluation of your committee's work is very important for evidencing the value your work adds to your institution. Evaluation is going to generate more metrics! Scrutinize your evaluation procedures for their ability to contribute to, rather than presenting obstacles to, your efficient and effective work.

There are several ways of integrating wider ethical issues within HCOs. Some institutions give ethical responsibility to their ethics committee. Some have subcommittees (eg subcommittees for consult service, which then meets more frequently than the typical once-a-month, and for organization issues, which has a different constituency) which also meet with the committee of the whole. Some have a parallel committee for organization ethics, an alternate administrative committee, which may or may not liaise with the ethics committee. The VA model has three layers of ethical responsibility.

The option which SoCal Kaiser seems to be adopting is having a designated "professional ethicist" in each institution—and a really remarkable emphasis on coordination and collaboration among those individuals. But some person or service or department or functional unit will be designated--and supported--to do the necessary work. As committees, we can only fill our proper, much less our possible, role in our institutions with the agreement, encouragement and support of our administration. All my suggestions about what we might do are things that our organization as a whole needs to pay attention to. The accomplishment of those tasks depends on how the organization as a whole chooses to distribute them. With the structure I have seen here today, it seems to me that you folks are in an ideal position to run pilot projects to determine how best to do ethics in our institutions—to see what works, what doesn't work—and to think about why.

Conclusion

I am a great fan of Kaiser as a model for responsible health care in America, and I have high hopes for its role as a potential model for, and indeed, as a possible site for pilot projects about, how to do health care ethics really well. As members of your institution's ethics services, you have a great deal to be proud of. You, better than any comparable organization in America today, have the potential to provide a replicable model– or several replicable models—that are both uniform enough to be comparable, and flexible enough to be applicable, to deal with the ethical issues confronting health care in the 21st century. I wish you well of it!

Kaiser CAN!