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Values and ethics in healthcare improvement

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“But why is that better?” project (@Phil4HCQ)

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"But why is that better?" project.

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“But why is that better?” project

- Investigating what applied philosophy and ethics can bring to quality improvement
- Working with healthcare partners to:
    - address debates about quality
    - understand how ethical challenges of improvement work can be better managed
- Seeking to open up improvement ethics agenda

Summary

- Values and ethics pervade healthcare improvement
- Normative complexity presents important challenges
- We can usefully (lessons) make
  - normativity of healthcare improvement more explicit
  - complexity of normativity more intelligible and navigable
- Recommended directions include
  - recognise partiality of measurement, improvement claims
  - keep open debates about what matters and why

Outline

- Some key terms
- Illustrations of normative complexity
  - What ‘goods’ should improvers pursue?
    (considering ‘quality’, ‘efficiency’, ‘person-centredness’)
  - What ‘goods’ are at stake in improvement approaches?
    (thinking about measurement)
- Why and how conversations can be useful
- Invite discussion about ‘improvement ethics’

Values and ethics

Values

- The kinds of things that are taken to matter;
- People's judgements about what matters;

Ethics

- A range of activities that consider what is good and right, what actions are justified (or not) and why
- Includes thinking about values and tensions between them

Surely healthcare improvement is good?

- A motivation to improve is good
- Improvement efforts have brought about good
- Improvement colleagues take care to work in good ways

BUT

- There is disagreement about what is good/better in healthcare
- Improvement outcomes are not all unequivocally good
- The costs of improvement can outweigh the benefits
- Benefits and burdens are not equally shared

Implicit normativity

"the presence of
unstated or taken-for-granted assumptions
about what is good or bad, right or wrong,
required or not required"

(Carter, 2018)

Explanatory and normative complexity

Explanatory complexity – of how things work

- Important for thinking about causality, effectiveness
- Open systems, non-linearity, dynamic interactions, feedback loops, emergence, adaptation, unpredictability….

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Explanatory complexity – of how things work

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Normative complexity – of what is good or better

- Important for thinking about what counts as improvement and whether, why and how we should try to bring it about
- Plurality of sometimes conflicting values; contested priorities; contested interpretations of value concepts; uncertainty …

Normative complexity in health care improvement: some illustrations

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Quality in healthcare is…

the degree to which
a healthcare system or service
possesses desired characteristics or
achieves desired objectives

Quality is multi-dimensional

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

(Institute of Medicine, 2001)

(for example)

Other dimensions can be identified

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

(Institute of Medicine, 2001)

- Sustainable
- Resilient
- Accessible
- Caring
- Supports staff wellbeing
- …

Different lists suit different contexts and purposes

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

(Institute of Medicine, 2001)

- These lists are pragmatic
- There is not a fixed natural ‘truth’ about quality
- Ask “Does the list serve good purposes well here?”

Dimensions have contested interpretations

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

(Institute of Medicine, 2001)

- What do we mean by ‘safe’, ‘effective’, ‘patient-centred’ etc.?
- People can (reasonably) disagree

Dimensions of quality are not independent

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

(Institute of Medicine, 2001)

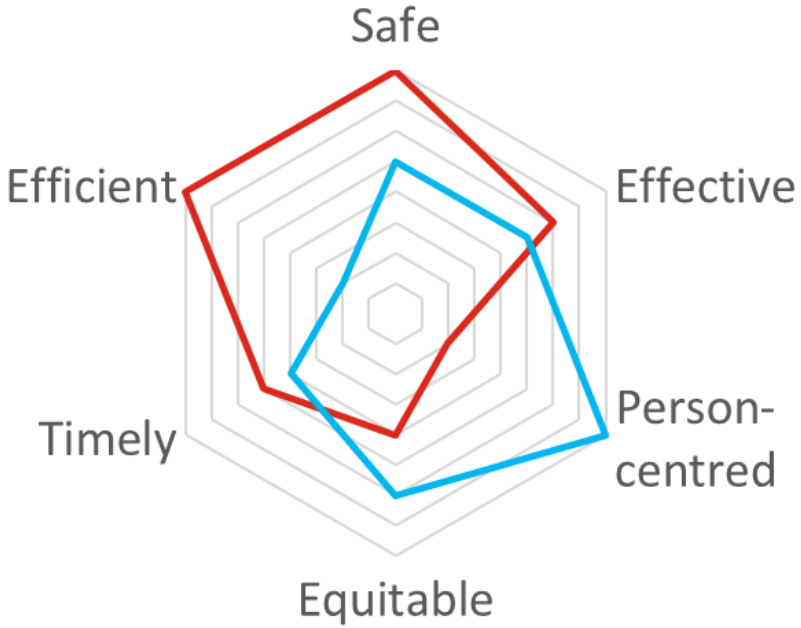
Securing good healthcare is not this simple!

Dimensions have contested priority

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

(Institute of Medicine, 2001)

Which health service is better?



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Situations and perspectives influence interpretations and priorities

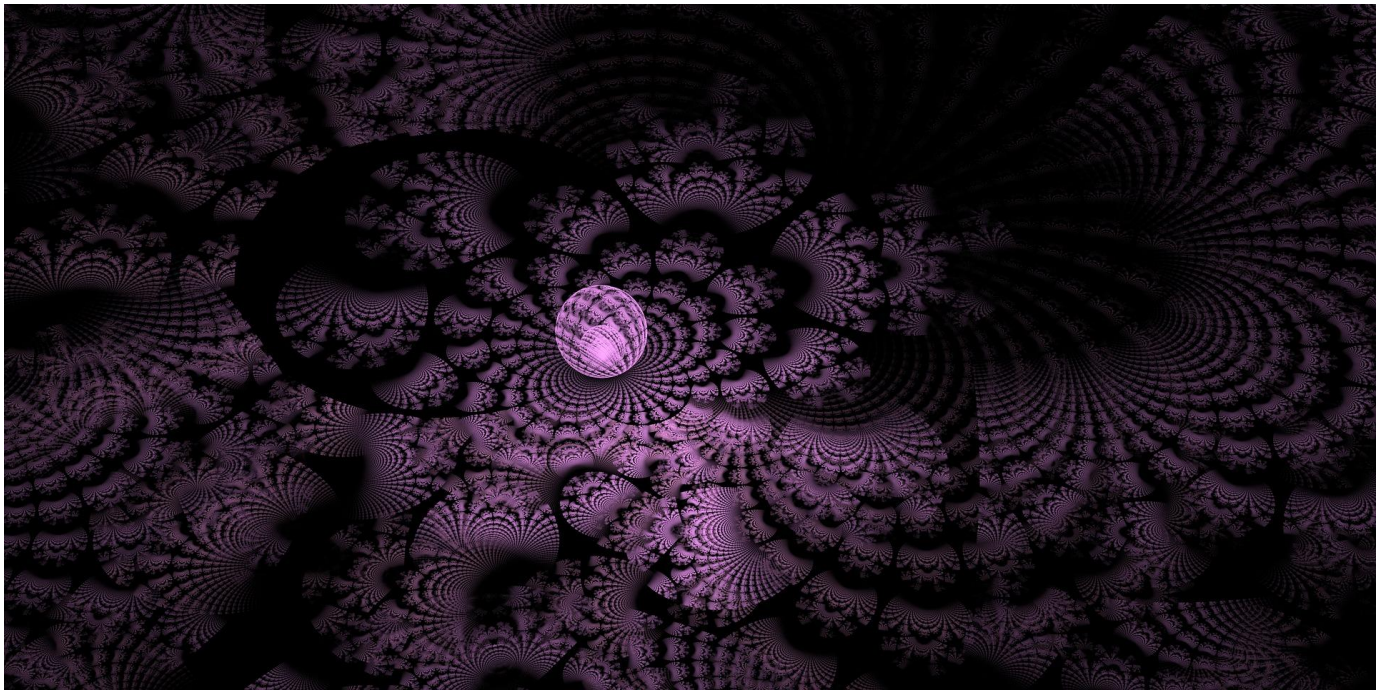
- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

(Institute of Medicine, 2001)

Judgements shaped by:

- People's positions, roles, relationships, responsibilities (also contested)
- Context of policies and features of healthcare system and society

Complexity extends as we focus in



Efficiency

- A value: it matters that we use resources to good effect
- A relationship between inputs and outputs, viewed with a concern to:
  - maximise outputs from given inputs *or*
  - minimise inputs used for given outputs *or*
  - optimise relationship between inputs and outputs
- Selecting inputs and outputs involves value judgements

How might we assess and improve the efficiency of home visits by nurses? (1)

- Nurse work hours (input)
- Number of visits (output)

➢ *Arrange visits to minimise nurses' travel time*

How might we assess and improve the efficiency of home visits by nurses? (2)

- What is done/achieved in visits?
- How well timed are visits?
- Is there relational continuity?
- How often do nurses use top skills?
- Impact on emotional wellbeing?
- Impact on staff retention?

➢ *Several ways to improve efficiency in some respects*

Efforts to assess and improve efficiency have ethical implications

- Which resources and ends are considered (and which neglected)?
- Whose resources and ends are these?
- How is the service shaped by the assessment and modelling of efficiency?
- Who benefits and who loses out?

It's important to acknowledge that:

- In practice, efficiency is tied to other values
- Operationalising efficiency involves normative choices
- Claims of efficiency gains reflect these choices – and are unlikely to be unequivocal improvements
- 'Doing efficiency' is always also 'doing ethics'

Person-centredness

- Widely accepted to be important and good
- But how should we characterise and measure it?
- Various definitions have been offered and adopted
- Should definition and measurement be standardised?
- Which definition and measure are best?
- *BWITB team argue variety and vagueness have value*

Characterising person-centredness

- It's NOT treating patients as just a body, disease, bundle of biological phenomena…
- Core idea is ~ "treating the patient as a person"
- This tells us quite a lot…
- … but is not readily operationalised or measured
- Multidimensional definitions have been developed

Accounts of person-centredness e.g. (1)

- Taking a biopsychosocial perspective
- Seeing the patient as a person
- Sharing power and responsibility
- Working to maintain the therapeutic relationship or alliance
- Acknowledging the doctor-as-person

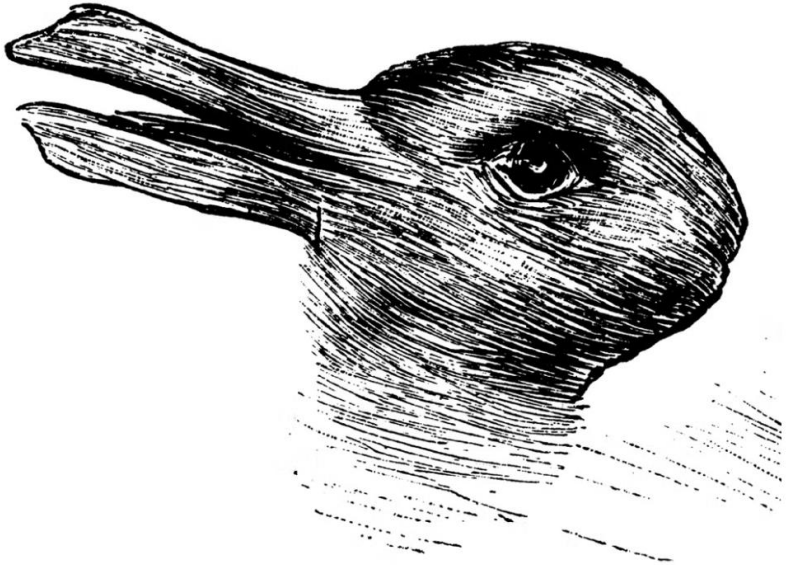
Mead & Bower, 2000

Accounts of person centredness e.g. (2)

- Addressing the person's specific and holistic properties
- Addressing the person's difficulties in everyday life
- The person as expert: participation and empowerment
- Respecting the person 'behind' the impairment or disease

Leplege et al, 2007

Person-centred care: another ambiguity



- Process and achievement
  - a set of practices performed with particular intentions
  - a set of phenomena achieved for patients

Advantages and limitations of 'more' definition

- Definitional frameworks give public substance to the concept and help practical operationalisation
- Highly specified measures can facilitate comparison

BUT

- More precision is not necessarily 'better'
- Different definitions/measures may suit different contexts
- To secure the full value of the concept, we need to retain scope to consider more openly the somewhat vague idea

"Is this *really* 'treating the patient as a person'?"

Vagueness can be valuable

- ‘Person centredness’ is like ‘art’ and ‘democracy’
  - We use terms without settled definition
  - We come to understand them better by considering disagreement about their meaning
- The intelligibility and merits of practically oriented definitions and measures of person centredness are grounded in the vaguer but richer concept

‘treating patients as persons’

Measurement:

- gives us knowledge about healthcare that can
  - help justify claims about how good/bad healthcare is
  - support comparisons across time and settings
- underpins quality improvement strategies

BUT

- may miss important aspects of good/bad healthcare
- doesn't always result in improvement
- has costs and may have 'side effects'

How do we consider which healthcare is better?

Measure performance on dimensions of quality

- Pragmatic advantage
- May obscure and distort some important values

Make evaluative judgement of 'good' in healthcare

- Advantage of breadth and responsiveness
- Less practical

How should we balance these?

Some suggested directions

- Recognise that measurements of quality and claims of improvement are always partial
- Remain open to debate and development of ideas about what's good

  (Keep / create spaces for conversation)

Conversations

- Bring together different voices
- Reflect and sustain respect and mutuality
- Can bring and keep multiple perspectives together
- Recognise possibility of engagement across difference
- Can contribute and respond to emergence of ideas
- Can help create conditions for empathy and imagination
- Allow people to hold or change their perspectives

Conversations for healthcare improvement

Healthcare organisations and improvement teams need to:

- take practical action *and*
- recognise normative complexity, keep debates about what matters and what is good 'open' *and*
- sustain relationships with multiple constituencies

They can usefully:

- Ensure space and time for routine conversations (> conversational tasks)
- Add more "orchestrated" conversations to surface and consider important value concerns

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Thank you for listening!
Thank you to the conference organisers for opening up space to consideration of values and ethics in this conference!

Would you like to talk more about the values and ethics of improvement?

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- Paper on efficiency (with Sonya Crowe and Martin Uttley) currently under review.