

Clinical Ethics Consultation

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Contemporary medical practices place patients, families and healthcare providers in situations with complex moral questions and difficult decisions. In this context, ethics consultation, “a service provided by an individual or a group to help patients, families, surrogates, health care providers or other involved parties address uncertainty or conflict regarding value-laden issues that emerge in health care,” has flourished.¹ Courts have endorsed ethics consultation since 1976. The effort stemmed from the controversial case of Karen Ann Quinlan.² Her parents, against the hospital’s wishes, wanted to let her die by removing the respirator keeping her alive. This conflict of views on the state of human life resulted in a conundrum that forced the courts into a “Solomon-like” position. To avoid the future appearance of such complex cases in the court, the justices suggested developing ethics committees in hospitals.

In 1993, a Presidential Commission³ issued a report endorsing the use of ethics committees and consultation for resolving difficult cases. Also by 1993, all accredited hospitals had to have a way to address ethical issues arising in the care of patients and provide ongoing ethics education for health care providers and patients.⁴ Today, the needs of addressing ethical issues in complex medical issues are met mostly by ethics committees, small groups and individual consultants.^{5,6}

There have been some studies of the actual structure and operations of ethics committees but much less is known about practice by ethics consultants. Work has been done regarding the nature, goals, procedures and competencies required for an ethics consultant, but few studies have collected data to characterize the individuals who are actually performing these ethics consultations and how they proceed. Collecting data on the demographics, education and training, practice settings, and consultation styles of clinical ethicists can direct recommendations to improve the quality of ethics consultation and better serve patients, families and health care providers.

1. Literature Review

The American Society for Bioethics and Humanities has adopted the *Core Competencies for Health Care Ethics Consultation* as a standard for ethics consultation.^{1,7} Without taking a position as to whether or not individual consultants, teams or committees should perform ethics consultations, the report defines: 1) the nature and goals of ethics consultation; 2) the types of skills, knowledge and character traits important for conducting ethics consultations; and 3) the special obligations of consultants

and institutions. It is expected that consultants, especially those working independently, possess all the core competencies including, for example, the ability to discern and gather relevant data, assess social and interpersonal dynamics of the case, distinguish the ethical dimension of the case from other dimensions and identify various assumptions that involved parties might bring to the case. As for the type of approach to a case consultation, the *Core Competencies* recommend the *ethics facilitation approach* that involves: 1) ensuring that all involved parties have their voices heard; 2) assisting involved individuals in clarifying their own values; and 3) facilitating the building of morally acceptable shared commitments or understandings within the context.^{1,8} Some authors have criticized the *Core Competencies*⁹ and others propose entirely different models.^{10,11} While arguments as to the best way to conduct ethics consultations continue, there are no good data on what models are actually being used in the field. Only two empirical studies have looked at backgrounds of individual ethics consultants.^{12,13,14} Additional empirical studies have specifically focused on hospital ethics committees^{15,16,17} and competence of ethics committee members¹⁸.

As indicated, most studies of ethics consultations have looked at ethics committees. While data has described the background and training of ethics committee members, few studies have looked at characteristics of those who actually do clinical consultations, especially those who perform clinical consultations independently for an institution. Questions arise as to how individual consultants differ from ethics committee members; how the process of arriving at a recommendation operates and differs in both models; what guidelines are used; the role of the ethicist within the organization; payment arrangements; and types of cases seen in consultations.

2. Methods

A Web-based survey was distributed via email to 101 members of the Association for Professional and Practical Ethics identified as having a primary focus in medical or health care ethics. The survey had questions related to education, professional consulting and to institutional settings, caseload, types of cases, documentation practices, and liability insurance. The overall response rate was 27.1%, which is within the normal response rate range of Internet-based surveys.¹⁹

3. Results

Seventy-three percent of respondents were male and 88.5% were non-Hispanic White. Half of all respondents were between the ages of 40 and 59; 31.1% were over 60. Eighty percent had a Ph.D. and 50% had a Ph.D. in philosophy.

Overall, 42.3% named philosophy as their professional discipline and 23.1% named health care or bioethics. Almost 77% described their current professional setting as an educational institution and 15.4% named a hospital. Almost 54% had participated in some clinical ethics training activity, most likely a workshop or conference; 23.1% received clinical ethics training as part of their graduate degree; and 19.2% have participated in a certificate program. Half participate on Institutional Review Boards and 46.2% on Hospital Ethics Committees. Over half (53.8%) conduct individual clinical case consultations.

Respondents who perform case consultations did not differ from the sample on the demographic variables. Comparisons with respect to education, professional discipline and work setting showed no significant differences whether a respondent performed case consultations or not. That one held a Ph.D., had a Ph.D. in philosophy, had philosophy as a profession or worked in an educational setting had no bearing on consultation activities.

There were significant differences in case consultations activity based on clinical ethics training. First, having any clinical training showed a significance ($\chi^2=19.102$, $p<.001$). Virtually all respondents doing individual consultation had training while those with no training did not. Also, the type of clinical ethics training showed differences. Those whose training came from a degree program ($\chi^2=6.686$, $p=.01$) and those who used an ethics workshop ($\chi^2=11.798$, $p=.001$) were significantly more likely to be engaged in individual case consultations. However, those who used Internet training programs showed no significant difference ($\chi^2=2.907$, $p=.088$).

Fifty percent of respondents who do clinical ethics case consultations are paid. Of these (7), four are on retainer, one on an hourly rate, and two have other arrangements. The average number of years experience conducting ethics case consultations was 9.2 years. The range was between 2 and 22 years, with 9 respondents having over 10 years of experience. Individual caseloads were extremely varied, ranging from as few as two individual case consultations per year to over 50 per year.

Respondents reported that withdrawal of ventilation/ extubation, health care provider-patient communication, palliative care/pain management/hospice care, do-not-

resuscitate orders, and family disputes are the issues that have occurred most frequently in consultations over the past 12 months. Issues that are cited as occurring least frequently include confidentiality/ privacy, neonatology, clinician competency and genetic testing/counseling.

Of the consultants, 43% never follow a written protocol, while 35.7% always do. Of those who follow a written protocol, half were developed alone and/or with local hospital ethics committees or colleagues. All conducting individual clinical case consultations were familiar with the *Core Competencies* and 35.7% find them very useful while 21.4% find them somewhat useful.

In terms of outcomes of clinical case consultations, 35.7% reported they offer their own recommendation as one option from which the decision-makers might choose. A like percentage does not make a recommendation but try to bring parties to consensus. The remaining 28.6% issue a non-binding recommendation but try to convince the parties to make a choice. Participants were asked to describe the outcomes of their clinical consultations. A variety of themes emerged: providing and clarifying facts to all involved parties; giving spiritual guidance, such as helping people "let go" and/or feel comfortable with decisions to end futile care; and developing institutional policy after difficult cases to avoid similar problems.

Clinical ethics consultants collaborate with a range of specialists. They are most likely to collaborate with patient representatives, chaplain and social worker. They are least likely to collaborate with a genetic counselor, psychiatrist or risk manager. Almost a third (30.8%) stated they always collaborate with other "philosophers" regarding cases.

Written records were kept by 78% of respondents with 30.8% writing notes in the patient record and 30.8% in other permanent records. No clinical ethics consultants reported having "jurisdiction" over issues such that hospital staff are obligated to consult them.

By a wide margin (78.6%), consultants believe that it is likely or very likely that a clinical ethicist will be named in a lawsuit within the next five years. Two thirds (64.3%) felt that liability insurance should be available for ethics consultants. Those who felt this way were willing to pay anywhere from \$100 to \$1000 annually.

4. Conclusion

The goal was to determine the practice of clinical ethics consultants. Although low response limits generalization about individual ethics consulting or comparisons among subgroups, some observations can be made. This study also shows that it is feasible to conduct Internet-based surveys with professionals working in health care ethics.

Clinical ethics consultations are being performed as part of service on a hospital ethics committee, as duties as staff ethicists and in an independent capacity. It is unclear from comparisons with previous studies if there is a trend towards using individual consultants rather than committees in complex clinical cases. Individual ethics consultations can be a response to the complex nature of resolving ethical issues in the increasingly diverse organizational environments of health care. More research is needed on the specifics of these arrangements to determine how and why these consultations differ. The shift from a team to an individual ethics consultant may also be one reason for the seemingly high concern regarding legal liability.

It appears that most (85.7%), but not all, individuals conducting clinical case consultations have participated in some kind of clinical ethics training activity. This training takes the form of workshops, courses and/or formal degrees – a marked difference from “on the job” training described by Fletcher.¹² Most importantly, the fact is that ethics consultants are significantly more likely to be trained in a formal training process, either degree program or workshops. Educational programs are being used for this critical area of health care. A larger sample size would allow for comparisons to see how training, either early in one’s career or as continuing education, affects the consultation model followed.

Most literature on consulting frameworks is normative, that is, it suggests the way clinical ethics consultations ought to be performed. The answers in this survey suggest that many consultants’ practices do not fit neatly into categories suggested by the literature. More qualitative surveys might be useful to uncover some of these details.

Health care ethics is still a relatively new field, and clinical ethics consultation is only one activity in the broader profession. Information about education and training, discipline orientation, practice setting and consulting approaches of those identifying as clinical ethics consultants is critical to developing a coherent picture of the field and making recommendations for improving the practice of clinical ethics consulting.

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