Principles and procedures of medical ethics case consultation

Ethical conflicts are common in hospital medicine. This article reviews core medical ethics principles, describes models for conducting hospital-based ethics case consultations, and highlights the contributions of hospital ethics committees to high quality patient care.

Despite the increasing availability of medical ethics consultation, physicians have not fully embraced this resource in the practice of hospital medicine. In one survey, 18% of physicians reported no experience with ethics consultation (Duval et al, 2004), and many physicians aware of the existence of a hospital ethics committee (HEC) exhibit reservations about requesting an ethics consultation (Gacki-Smith and Gordon, 2005).

To address both a persistent knowledge gap about clinical medical ethics and clinician reluctance to engage HECs in the course of patient care, the authors provide a clinician-oriented overview of medical ethics consultation. This article reviews core principles relevant to the practice of clinical medical ethics, describes models for conducting hospital-based ethics consultations and highlights the contributions of HECs to quality patient care with special attention to the contributions of the HEC in the intensive care unit (ICU). In this article, the terms 'ethics consultation service' and 'HEC' are used interchangeably. However, some ethics consultation services consist of a sole consultant, and in some settings, only a subset of HEC members conduct case consultations.

Addressing ethical tension: why call an ethics consult?

Physicians are challenged frequently by ethical dilemmas; 95% of internists have reported 'a dilemma they found most difficult to resolve' and 89% recalled a specific recent ethical dilemma (Duval et al, 2001). HECs were created to address difficult ethical situations, but clinician doubts about HEC's qualifications may impede the utilization of these services (Duval et al, 2001). Indeed, there is no conclusive evidence that ethics committee members are better at moral reasoning than even the general population (Dobrin, 2003). What, then, is the utility of ethics case consultation?

Conflict resolution is a major objective of ethics consultation. Duval et al (2004) found that the most common factor triggering ethics consultation was seeking help in resolving a conflict. Breen et al (2001) noted that during decisions considering the limitation of life-sustaining treatment in the ICU, 78% of cases exhibited some degree of conflict. In an analysis of end-of-life clinical decision making in the ICU, medical house staff described a wide range of conflicts between medical staff, patients and families (Rosenbaum et al, 2004). HEC's emphasis on clarifying medical facts and uncertainties that contribute to ethical conflicts has been shown to facilitate conflict resolution (Schneiderman et al, 2000; Forde et al, 2005).

Communication concerns constitute the main complaint of families in the ICU with half of the families of ICU patients reporting inadequate communication with their physicians (Azoulay et al, 2000; Thompson et al, 2004). Lack of communication can lead to conflict between the care team and the patient and family (Curtis et al, 2005; Mularski et al, 2005). Improved communication facilitated by HEC consultation can increase patient and family satisfaction (Lilly et al, 2000).

These reports suggest that HECs improve care by promoting improved communication and reducing conflict between physicians, patients and families. Von Gunten et al (2000) advocate a seven-step approach to improved communication, noting that conflict resolution requires skill in communication (*Table 1*). Yet conflict resolution involves expertise beyond communication skills. Providers engaged in conflict resolution must balance the values and autonomy of the patient or surrogate with medical knowledge, societal law and hospital policy to build an acceptable consensus.

Hospital ethics committee core competencies

To delineate the core competencies required for ethics consultation, a task force was convened by two bioethics organizations, the Society for Health and Human Values and the Society for Bioethics Consultation. They identified nine areas of knowledge that HEC members should possess including: ethical principles such as respect for

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Table 1. Seven-step approach to communication

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Prepare for the discussion
Establish what the patient (and family) knows
Determine how information is to be handled
Deliver the information
Respond to emotions
Establish goals for care and treatment priorities
Establish a plan

Adapted from Von Gunten et al (2000)

autonomy, hospital policies regarding ethical issues such as informed consent and surrogate decision making, and professional society codes of ethics (Aulisio et al, 2000) (*Table 2*).

Methods of education for HEC members include journal clubs, ethics fellowships, ethics courses or ongoing service on an HEC. There is no accreditation process that evaluates these skills in members of HEC and the task force discouraged a formal certification process for HEC members, arguing that certification would be exclusionary (Aulisio et al, 2000). Indications that HEC members possess these skills lie in the effectiveness of the consultation service at facilitating communication and conflict resolution, i.e. demonstrable success in accomplishing its core mission. However, this effectiveness may be a function of the consultation process in aggregate rather than the individual skills of HEC members.

Ethics facilitation: serving patient and provider

An impediment to broader utilization of ethics consultation is the concern of health-care providers that ethics consultation will lead to a loss of autonomy by the primary team (Davies and Hudson, 1999). This concern about losing control is rooted in the trend towards patient-centred care and the loss of autonomy of the clinician (Dunn, 2003). As a result, some providers have advocated an enhanced autonomy model where patients and providers work mutually towards a shared decision via open dialogue, in the process maintaining both patient and provider autonomy (Quill and Brody, 1996). However, in some clinical situations the primary team may misunderstand information presented to them by the patient or be unaware of patient values vital to understanding the decision-making process, impairing patient autonomy. A major function of ethics consultation is to identify miscommunication and promote dialogue in an attempt to facilitate this enhanced autonomy model, thus empowering both patient and provider.

Instead of imposing decisions in order to resolve conflict, ethics consultation serves to guide the patient and primary team through thoughtful decision making. Aulisio et al (2004) have labelled this approach the 'ethics facilitation' model, as opposed to the 'authoritarian' model. Through this approach, the HEC assists in deciding who makes the decisions, rather than making the decisions themselves (Aulisio et al, 2004). They do not drive the discussion but instead negotiate a dialogue by which a conflict may be resolved. Thus the question of moral superiority does not come into question. Ethics consultants 'set the table' by identifying and organizing the issues central to the ethical conflict.

Ethics consultation and clinician education

HEC members can play an important role in clinician education. Clinicians may not be aware of recent relevant social and institutional laws regarding patient care. One benefit of consultation is the education of providers and staff about hospital policy and social law (Forde and Vandvik, 2005; Vaszar et al, 2005). For example, Schneiderman et al (2000) noted that their HEC clarified for clinicians the definition of futility, the basis for substituted judgment and the lack of evidence for tube feeding in the context of comfort care.

Structure of hospital ethics consultation: who am I calling?

There is no single model for addressing ethical conflicts. The three most widely used consultation models are: the small consultation team, the committee, and a sole consultant. In 2000, 68% of HECs in the United States of America were small teams, 23% were committees and 9% were individual consultants (Fox et al, 2002).

No formal recommendation exists for the optimal number of members for an HEC, although one group endorses eight to 16 members (Vaszar et al, 2005) and another 12 to 15 (Spike and Greenlaw, 2000). Professional diversity among members ensures a broader knowledge base compared with single profession (e.g. physician) representation (Meijberg and Meulen, 2001). One potential disadvantage of a large HEC is the excessive time it may take to evaluate and deliberate a case. Also,

Table 2. Core knowledge for ethics consultation
Moral reasoning and ethical theory
Bioethical issues and concepts that typically emerge in ethics consultation (e.g. autonomy, informed consent)
Health-care systems (managed care, governmental systems)
Clinical context (anatomy, diagnosis, treatment, prognosis, provider roles)
Health-care institution structure, service and resources
Health-care institution's policies relevant to ethics consultation (e.g. informed consent, confidentiality, withholding life-sustaining treatment)
Beliefs and perspectives of patient and staff population
Relevant codes of ethics, professional conduct and guidelines of accrediting organizations (e.g. British Medical Association, American Medical Association, and the Joint Commission on Accreditation of Healthcare Organizations)
Health law (end-of-life care, surrogate decision making)

Adapted from Aulisio et al (2000)

its size may be threatening to patients and families in sensitive situations.

Some hospitals use a sole consultant-based approach to ethics consultation. This structure can be more flexible and intimate than a committee. A solitary consultant may be able to develop a closer rapport with a patient or family and may conduct the consultation faster than a committee-based model. In one study, 71% of physicians preferred consultant-based models over committees (Swenson and Miller, 1992). This preference may arise partly because physicians prefer discussing cases with their colleagues and are wary of sharing power with the ancillary providers that may be present in a committee (Phillips, 1996). In the sole consultant-based model, time is gained, but the breadth of the committee is lost. If the consultant lacks some of the skills of ethics consultation, the process will suffer as there is no other provider to supplement the deficit.

One alternative is to use a lead consultant or small team, first to assess the consult and then to report to the full committee (Vaszar et al, 2005). This method maintains the intimacy and efficiency of the consultant model and the breadth of the committee model. Moreover, in choosing a committee over a sole consultant, the idea of moral discourse as a community enterprise rather than the realm of a consultant expert is reinforced (Swenson and Miller, 1992). No study has been conducted to assess outcomes as a function of mode of ethics consultation. Given the complexity of the consultation process, the authors recommend a team approach using a rotating lead consultant who has a major leadership role in directing the entire consultation.

Process of consultation: how does it work?

The CASES approach advocated by the United States Department of Veterans Affairs Veterans Health Administration, the largest health-care system in the United States, is a simple framework that provides a reminder of essential elements of the consultation process:

C = Clarify the consultation request
A = Assemble the relevant information
S = Synthesize the information
E = Explain the synthesis
S = Support the consultation process (Veterans Health Administration National Center for Ethics in Health Care, 2006).

An extensive discussion of CASES is available at: http://www1.va.gov/integratedethics/download/Ethics_consultation_primer.pdf.

Some hospitals allow only physicians to make consult requests, but the recommendation of the American Society for Bioethics and Humanities is to allow any care provider or patient to call an ethics consult. Services are on call and available at all hours in some hospital systems. Frequently, access is more limited to weekdays and daytime. After receiving the consult, the HEC will have access to all patient information as part of the care team.

The crucial initial aspect of the consultation process is to clarify the ethical issues and conflicts at stake, i.e. does the requester want help resolving an ethical dilemma pertaining to an active patient case? Once this has been affirmed and the objective of the consultation formulated, the lead consultant should review the medical record and seek to speak with the consulting team, patient, family and ancillary staff to obtain pertinent information. This investigation focuses on the consultation question, but may also disclose conflicts or issues that had previously been unidentified, amending the initial consultation objective. In one system, the information gathered is organized along four axes: medical history, prognosis and treatment goals; patient values, preferences and goals of care; quality of life and social support; and economic, legal and administrative aspects of the case (Vaszar et al, 2005).

After assembling the information, it must be synthesized by the HEC. This involves reviewing and applying relevant ethical knowledge to the case and determining the ethically appropriate decision maker, whether it be the patient or, in those situations where a patient lacks decision-making capacity, a surrogate (Veterans Health Administration National Center for Ethics in Health Care, 2006). Typically, a meeting is then convened between the patient or surrogate, HEC, and a representative from the consulting team. The goal of the meeting is to achieve a consensus between all parties by promoting and facilitating dialogue (LaPuma et al, 1992). The reason for the consultation should be articulated by the person or team who submitted the request. In the course of the consultation, the goals and preferences of the patient and family should be elicited and clarified. Discordant viewpoints are acknowledged and the discussion should take a non-judgmental tone. All are given the opportunity to comment and participate.

After the meeting, the HEC typically delineates and documents the reason for the consultation, the relevant information from the discussion, and the HEC's recommendations (Vaszar et al, 2005). These recommendations are formed after thoughtful discussion and informed by societal law and institutional policy, with practicality emphasized. After review, the recommendations are then entered in the medical record and the consulting team is notified, both verbally and in writing. The HEC remains available after the initial consult for support.

Time-harried clinicians fear that the ethics consultation process will impede patient care (Fox et al, 2002). Yet in one committee-based model, consult requests are typically addressed within 24 hours and initial recommendations are made within another 24 hours (Vaszar et al, 2005). In another, consultant-based model, all patients were seen within a day of the request, and all requesting physicians felt the consultation was delivered quickly (LaPuma et al, 1992). HECs may speed clinical decisions by clearing misunderstandings, improving dialogue and

providing timely information. *Table 3* lists situations where ethics consultation may be particularly useful.

What is the evidence for the benefit of ethics consultations?

Various studies have documented patient and provider satisfaction with the ethics consultation process. In one, the majority of providers felt that ethics consultation was educational and that they would use the service again (Duval et al, 2004). LaPuma et al examined ethics consultation in both academic and community hospitals and noted physician satisfaction rates ranging from 70–90%; most were predisposed to calling another consult (LaPuma et al, 1988, 1992). Schneiderman et al observed similar satisfaction rates for physicians; the majority of patients also expressed satisfaction and a willingness to undergo ethical consultation again (Schneiderman et al, 2000). Despite the difficulty in establishing metrics for the analysis of HEC, some investigators have studied the effect of HEC on care endpoints. These studies have largely examined the effect of HEC on the reduction of non-beneficial care, defined as care inappropriate to a patient's poor prognosis.

Dowdy et al (1998) prospectively studied 99 sequential patients in an ICU setting. One third of study subjects received usual care, one third were under the auspices of a newly created ethics consultation programme, and one third underwent proactive ethical consults designed to identify and address ethical issues in end-of-life care in patients with a poor prognosis. This study documented a decrease in the length of stay in the ICU in the proactive consult group. There were twice as many patients in the proactive group for whom a do not resuscitate (DNR) order was written and there was a significantly higher rate in withdrawal of care. The intervention in the proactive group consisted of two clinicians trained in clinical ethics whose role was strictly to facilitate communication by distributing information. The study demonstrated that this particular form of communication can effectively improve care.

Schneiderman et al confirmed these results in two randomized trials examining the effect of ethics consultation upon outcomes in the care of ICU patients (Schneiderman et al, 2000, 2003). Ethics consultation reduced the amount of hospital days and life sustaining treatments (food and ventilation) when compared to placebo, although total mortality was not affected. This suggests that patients were receiving appropriate care without adverse consequences. The consults were regarded favourably, and the HEC educated providers about palliative care and futility. The criticism remains that although the HEC provided favourable results, the exact type of intervention that is best is unknown (Lo, 2003). A team approach focusing upon improved communication may be the effective arm of these interventions.

Casarett et al (1999) studied the role of the HEC in mediating disputes related to unilateral DNR orders (unilateral DNR orders are orders to withhold resuscitation despite the objections of a patient or surrogate). They were consulted in 31 cases where there was disagreement between physicians and a patient or surrogate about a DNR order. In their review, 17 of the 28 cases where a conference was held were resolved to the satisfaction of patient, physician, and family and none of the patients made legal claims against the hospital. The authors felt that the HEC effected these results by correcting misunderstandings, clarifying points of conflict and identifying areas of agreement.

These studies convincingly show that ethics consultation can result in measurable benefits. Contrary to the notion that HEC 'slow things down', the reduction in length of stay associated with HEC suggests that intervention can result in an appropriate and timely reduction in the utilization of non-beneficial health-care resources.

Future directions in ethics consultation

Although standards have been developed for the process and education of HEC, none exists for their oversight (Aulisio et al, 2000; Vaszar et al, 2005). Also, although most physicians feel that ethics consultants should have medical ethics training (Duval et al, 2004), there are no mechanisms in place to evaluate the competencies suggested by current guidelines. Consideration should be given to an external reviewing mechanism for the oversight of HEC and evaluation of core competencies in HEC members.

Given the positive outcomes derived from ethics consultation in the ICU, perhaps all ICU patients should receive some form of ethics consultation. The initial evaluation might be abridged, but would seek to identify the cohort of patients who would benefit from more extensive consultation.

The best evidence for the benefit of ethics consultation has arisen in the ICU. Yet there is no evidence that ethics consultation could not achieve similar outcomes outside of this setting. Research should be performed to determine whether the reduction in non-beneficial care effected by ethics consultation can be duplicated outside of the ICU and to identify the patient cohort who would

Table 3. Common indications for an ethics case consultation
Conflict regarding end-of-life care, including withholding or withdrawing of life support and resuscitation (code) status
Conflicts regarding potentially non-beneficial or futile care such as artificial nutrition and hydration and mechanical ventilation
Requests for assistance with interpretation of institutional policy and state or federal law
Assistance with interpretation of advance directives and living wills
Conflict between treating team and patient or surrogate regarding management plans
Complex management decisions that need to be made on behalf of a patient who lacks decisional capacity and who has no surrogate

best benefit from these services. It is also possible that ethics consultation could be used in conflict situations not involving patients, such as conflicts between providers, and in formal clinician education.

The ethics consultation process itself merits examination in order to determine which aspects of the process play important roles in improving outcomes. Consultation methods vary and the most effective method of consultation is not yet known. By identifying which elements of HEC interventions are most effective both clinical procedures and research protocols could be standardized to optimize clinical outcomes and systems analyses.

Conclusions

Ethical conflicts and dilemmas are common in clinical medicine, especially in the ICU. Timely resolution of ethical conflicts and dilemmas is an important aspect of quality health care. In the course of consultation, HECs seek to facilitate communication, clarify conflicts with ethical dimensions, frame ethical debates, and assist with interpretation of policies. Ethics case consultation is associated with increased patient and provider satisfaction and, in the ICU, a reduction in costly non-beneficial care. Future research should explore the feasibility of standardizing the consultation process so that these beneficial effects can be reproduced widely in clinical practice. BJHM

Table 1 *is adapted from Von Gunten et al (2002) and* Table 2 *is adapted from Aulisio et al (2000) by kind permission.*

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KEY POINTS

- Ethical conflicts and dilemmas are common in clinical medicine.
- Hospital ethics committees possess a specific skill set allowing them to address and resolve such conflicts.
- Ethics consultation has been shown to improve clinical outcomes and patient satisfaction.
- Hospital physicians should use ethics consultation as a means of enhancing patient care.
- Further research is necessary to determine whether the use of ethics case consultation should be broadened.