

CEJA Report 3 – I-97 Ethics Consultation

INTRODUCTION

Institutional ethics committees have become commonplace in the past decade. Recent surveys estimate that between 66 and 70 percent of hospitals have at least one such committee.¹ Informal estimates are much higher. The design and function of these committees vary considerably. In addition to ethics committees, some institutions offer ethics consultation services. The exact percentage of institutions that offer ethics consultation is unclear at this time, but it is a growing practice. The 1992 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) manual requires that health care organizations “have in place a mechanism for the consideration of ethical issues arising in the care of patients, and to provide education to caregivers and patients on ethical issues in health care.”² Some institutions even have multiple, specialized committees. For example, the Department of Health and Human Services (HHS) interpretation of the Child Abuse Amendments of 1984 (often referred to as the “Baby Doe” Regulations) suggest the establishment of an Infant Care Review Committee (ICRC) to, among other things, “offer counsel and review in cases involving disabled infants with life threatening conditions.”³ Other institutions have developed specific services to deal with end-of-life issues or organ-transplant issues.

While there has been much talk about consultation services, there has not been much guidance on the design or responsibility of such services. Unlike ethics education and policy making, ethics consultation is fairly controversial. One author stressed the potential problems of consultation including the possibilities that: recommendations may be unsound, ethics “experts” may receive undue deference, procedures may be unfair, consultations may not be timely, and problems may be outside the scope of committee expertise.⁴ On the other hand, ethics consultation has been hailed by many people as an alternative to what is seen as a bloated and inefficient legal system.⁵

In 1994, the Council issued an opinion based on a 1984 report which provides general guidance for ethics committees.⁶ Given the recent proliferation of ethics committees, the new changes in the delivery of health care, and the need for alternatives to judicial forums, the Council has revisited this issue, focusing specifically on ethics consultation. In the past year there has been a movement within academic bioethics organizations to establish criteria and mechanisms for ethics consultations.⁷ The Council strongly encourages such efforts. The following discussion identifies general guidelines for ethics consultation services.

TYPES OF CONSULTATIONS

Ethics consultations may be requested for a number of different reasons. For example, an ethics consultation may be called to clarify ethical issues without reference to a particular case, to facilitate discussion of an ethics dilemma in a particular case, or to resolve an ethical dispute. In the first role, the consultation service acts to educate the parties involved. In many respects this is simply an offshoot of the educational function of an ethics committee. Individuals who request such a consult may feel uneasy about certain practices or certain types of cases. For example, a respiratory therapist may question whether the hospital's DNR policy is effective, or a resident may wonder how to respect the autonomy of patients with decision making impairments. One of the most important responsibilities of ethics consultants is to provide a “reflective space” within the institution where health care providers feel comfortable discussing ethical issues.⁸ The advantage of “hallway consults” is that they facilitate discussions of ethical issues with the same informal regularity as other medical issues—emphasizing the role of ethics in day-to-day interactions. As a result, informational consults should be available to all institutional personnel. In addition, with the shift in the locus of health care services from the hospital to external settings, the institution may want to offer informational consults to community health care practitioners in the area. The American Hospital

Association, in its guidelines for bioethics committees, suggest that hospital ethics committees offer such support to the community.⁹

Secondly, in addition to informational consults, a consult may be called to facilitate discussion of an ethical dilemma in a particular case. Different interests may be balanced against each other in such a way that the parties are unable to identify an acceptable course of action. An ethics consultation is sought in order to enable the parties to work through the ethical issues. For example, a surrogate and treatment team may be uncertain whether treatment may be ethically withheld from a patient. The emphasis in these cases should be on facilitating discussion and making clear the range of possible ethical courses of action.¹⁰ Specifically, the consultation service should “help ensure that various points of view are recognized and appreciated, and [that] whatever proposals emerge [are] respectful of the liberties of the groups represented.”¹¹

A third type of consultation is a true ethical dispute, where both sides have taken ethical positions that are in conflict with one another. It is in the dispute resolution role that ethics consultation is most vulnerable to charges of bias and abuse. Where there is a dispute, the consultation role is one of negotiation and resolution.¹² In this situation the parties have clearly defined positions that are in conflict. For example, a treatment team may feel that resuscitation is futile for a particular patient but the family insists upon continued efforts. In part, the ethics committee may be asked to enter the discussion in order to evaluate the ethical basis of the position of one side or the other. It is extremely important for consultants in these circumstances to be careful to give credence to many different types of beliefs. In addition, it may be necessary to clarify whether an ethical dispute actually exists. In some cases the conflict may be due to a misunderstanding or lack of communication between the parties.

These three types of consultations are not so clear-cut in the clinical setting as they are on paper. Each may shade into the other. For example, a physician initially may request a clarification of general issues which then leads to a discussion of an ethical dilemma in a particular case. Moreover, discussion of a dilemma may break-down into a dispute between the parties. The distinctions are nevertheless useful in clarifying the consultants’ role. For example, a consultation service may provide information to hospital staff on a relatively informal basis. Since there is no specific case under consideration, other parties need not be brought into the discussion, and a formal write-up is probably not necessary. Services may find it useful to keep track of these informational requests, which may then be used to focus educational efforts or prompt development of institutional policy. In contrast, when the consult focuses on a dilemma or dispute in a particular case, patients and families should be brought into the discussion.¹³ Furthermore, when recourse to the consultation service is sought as an alternative to a judicial forum, hospital counsel may need to be consulted about potential legal repercussions.¹⁴ Formal write-ups are more important in these types of cases.¹⁵

STRUCTURE OF CONSULTATION SERVICES

There is little consensus on the ideal model for an ethics consultation service. A recent article identified three mechanisms that are presently used—committee, consultation service, or individual consultant.¹⁶ However, it stressed that there is considerable variation between the different models among institutions. For example, committee consultation may involve the chairperson assembling an ad hoc team, a pre-identified sub-group, or a whole committee review.¹⁷ Alternatively, a consultation service may consist of members of the ethics committee, or may be a completely separate service.¹⁸ Finally, individual consultants vary considerably in their formal educational training and experience. Skills involved in consultation may be drawn from such diverse fields as philosophy, religion, medicine, or law.¹⁹

Despite the differences in structure, some things remain consistent across institutions. First, education and training are extremely important. The individuals involved in a consultation service should include one or more people with extensive training and/or experience in clinical ethics. One

possibility is to engage a person whose professional identity is linked to ethics and whose job description includes an ethics-related role. Recently, various institutions have begun offering formal graduate teaching in clinical biomedical ethics with the goal of training individuals for such roles. Alternatively, the consultation service may include people who have made a serious and substantial commitment of time and energy over several years to gain sufficient knowledge, experience, skills and understanding of the complexity and subtlety of clinical ethics.

Consultation services must have clear structural standards which are consistently followed. In part, all of the issues below depend on a number of factors including institutional structure (where the consultation service is in the administrative hierarchy), composition (who is on the service), and accountability (to whom does the service report). For example, the service's role must be described explicitly and disseminated to institutional staff. This description should include decisions about what types of cases the service will address, through what mechanism cases will be brought to the service, who will be able to bring the cases (access), and the impact of the service's recommendations. Presently, most consultations are optional and provide advisory, rather than binding, recommendations. The American Hospital Association strongly urges the use of advisory recommendations.²⁰ Some services may provide only information and education because they are unable to handle the more complex issues of dispute resolution. In general all institutional staff should have access to the service, but some services may limit patient or family access or access by outside health care professionals according to time and resource constraints.

In addition to questions of access, there are other structural concerns that should be clearly addressed from the outset. One important issue is whether the patient's informed consent is necessary for the consult to occur. Informed consent clearly does not apply in the case of an informational consult requested by staff. Institutional staff should not be restricted from requesting help and information on difficult cases. Likewise, patient and families should not have to obtain staff consent for a consult. It is less clear whether it should be required for other types of consults. In general, the Council believes that consent may be presumed for ethics consultation in the same way it is presumed for a social services consult. When the ethics committee or consult becomes formally involved in a particular case, patients and/or families should always be informed. Furthermore, they may be given the opportunity to "opt-out" of the consult either formally through the institutional structure, or informally by not participating in the discussions. Recommendations in cases where patient and family input are absent should be carefully tempered.

Payment for consults is another important issue. It seems unfair to argue that informed consent should be presumed but require the patient to pay for the services of the consult. Furthermore, patients who lack funding or insurance coverage should not be restricted from gaining access to ethics consultation. In general, consultation services should be provided and financed by the institution. In this sense ethics consultation services are similar to social services. The primary obligation of ethics consultation services, like pastoral services, should be to service staff and patient needs, not promote institutional interests.

CONCLUSION

- 1) Ethics consultations may be called to clarify ethical issues without reference to a particular case, facilitate discussion of an ethical dilemma in a particular case, or resolve an ethical dispute. The consultation mechanism may be through an ethics committee, a subset of the committee, individual consultants or consultation teams. Only recently have ethics consultation services come under scrutiny by professionals in a number of fields.²¹ Despite lack of data regarding the preferability of the different mechanisms, the Council believes that the concept of ethics consultation is a useful one. Moreover, because consultation services are presently ongoing,

guidance in this area is necessary. With this in mind the Council makes the following recommendations:

- 2) All hospitals and other health care institutions should provide access to ethics consultation services.
- 3) Institutions offering ethics consultation services must appreciate the complexity of the task, recognizing the potential for harm as well as benefit, and act responsibly. This includes true institutional support for the service.
- 4) Ethics consultation services require a serious investment of time and effort by the individuals involved. Members should include either individuals with extensive formal training and experience in clinical ethics or individuals who have made a substantial commitment of time and energy over several years to gain sufficient knowledge, skills, and understanding of the complexity of clinical ethics. A wide variety of background training is preferable, including such fields as philosophy, religion, medicine, and law.
- 5) Explicit structural standards should be developed and consistently followed. These should include developing a clear description of the consultation service's role and determining which types of cases will be addressed, how the cases will be referred to the service, whether the service will provide recommendations or simply function as a forum for discussion, and whether recommendations are binding or advisory (e.g. the Council's opinion entitled, "Medical Futility in End of Life Care").
- 6) Explicit procedural standards should be developed and consistently followed. These should include establishing who must be involved in the consultation process and how notification, informed consent, confidentiality and case write-ups will be handled.
- 7) In general, patient and staff informed consent may be presumed for ethics consultation. However, patients and families should be given the opportunity not to participate in discussions either formally, through the institutional process, or informally.
- 8) In those cases where the patient or family has chosen not to participate in the consultation process, the final recommendations of the consultant(s) should be tempered.
- 9) In general, ethics consultation services, like social services, should be financed by the institution.
- 10) Finally, a consultation service should be careful not to take on more than it can handle, *i.e.* the complexity of the role should correspond to the level of sophistication of the service and the resources it has available. As a result, some services may offer only information and education, others a forum for discussion but not advice, others might serve a mediation role, and some might handle even administrative or organizational ethics issues.²²

REFERENCES

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2. JCAHO, Comprehensive Accreditation Manual for Hospitals, (Oakbrook Terrace, IL: 1992) 104.
3. Department of Health and Human Services: Model Guidelines for Health Care Providers to Establish Infant Care Review Committees. 50 Fed. Reg. 14893, 14894 (1985).
4. Bernard Lo, *Resolving Ethical Dilemmas*, at 147 (1995).
5. See, e.g., Bernard Lo, "Behind Closed Doors: Promises and Pitfalls of Ethics Committees," *New England Journal of Medicine* 317(1):46-50, 1987.
6. Opinion 9.11 "Ethics Committees in Health Care Institutions."
7. See, e.g., Ellen Fox and James Tulsky, "Evaluation Research and the Future of Ethics Consultation," *The Journal of Clinical Ethics* 7(2):146-149, 1996.
8. Margaret Urban Walker, "Keeping Moral Space Open." *Hastings Center Report*, 23(2): 33-40, 1993.
9. Bowen Hosford, "Guidelines: Hospital Committees on Biomedical Ethics," *Bioethics Committees: The Health Care Provider's Guide*, Appendix A (Aspen 1986).
10. Margaret Urban Walker, "Keeping Moral Space Open." *Hastings Center Report*, 23(2): 33-40, 1993.
11. Jonathan Moreno, "Ethics By Committee: The Moral Authority of Consensus," *The Journal of Medicine and Philosophy*, 13: 411-432, 426, 1988.
12. See, e.g., Janet Burstein, "Checks and Balances Against Hasty Consensus in Ethics Consultation: Moral Deliberation Shifts and the Zone of Equipose." Masters Thesis, Michigan State University Interdisciplinary Program in Health and Humanities, 1997.
13. It is possible to have a dilemma or dispute between two health care professionals without respect to particular patient (for example, a dispute about past history of actions in certain types of cases). In these situations the patients and families do not need to be brought into the discussion. Only where there is a question of what to do in a pending case is it necessary to include all parties.
14. Ethics Consultants need not be legal experts, nor should they give legal advice. However, they need to be aware of the legal rights of the parties involved and know when to seek legal counsel.
15. Bernard Lo suggests that all recommendations and the rationale supporting them be entered into the patient's medical record. Bernard Lo, *Resolving Ethical Dilemmas*, at 151 (1995).
16. John C. Fletcher and Mark Siegler, "What are the Goals of Ethics Consultation? A Consensus Statement," *The Journal of Clinical Ethics*. 7(2): 122-126, 123, 1996.
17. Id.
18. Id.
19. Margaret Urban Walker, "Keeping Moral Space Open." *Hastings Center Report*, 23(2): 33-40, 39, 1993. It may be difficult to find one individual with training or expertise in all necessary areas.
20. Bowen Hosford, "Guidelines: Hospital Committees on Biomedical Ethics," *Bioethics Committees: The Health Care Provider's Guide*, Appendix A (Aspen 1986).
21. Ellen Fox and Robert Arnold, "Evaluating Outcomes in Ethics Consultation Research," *The Journal of Clinical Ethics*. 7(2):127-138, 1996; James Tulsky and Carol Stocking, "Obstacles and Opportunities in the Design of Ethics Consultation Evaluation," *The Journal of Clinical Ethics*. 7(2):139-145, 1996.
22. Compare Bruce Cornsino, "Bioethics Committees and JCAHO Patients' Rights Standards: A Questions of Balance," *The Journal of Clinical Ethics* 7(2):177-181 (1996) with John Fletcher, "Responding to JCAHO Standards: Everybody's Business," *The Journal of Clinical Ethics* 7(2):182-3 (1996).