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Evaluating the Outcomes of Ethics Consultation

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First motivated by cases involving high-profile debates (such as *Quinlan*¹ and *Cruzan*²), the practice of ethics consultation has become integrated into daily care, and a "mechanism for addressing ethical issues" is now explicitly required by accrediting bodies.³ Because of this integration, there is a growing need to evaluate ethics consultation and to establish criteria for effectiveness. One of the key characteristics of successful interdisciplinary team approaches in a clinical setting is the establishment of "clear goals with measurable outcomes."⁴ Ethics consultants themselves are aware of this need to evaluate effectiveness. Most strive to achieve the most morally appropriate resolution to value conflict. It is important to know, then, which components or methods of ethics consultation yield positive results.⁵ As bioethicists, we are well aware of the theoretical goods such services might achieve, but should insist on evidence regarding the effectiveness of ethics consultation relative to these goods.⁶ Additionally, ethics consultants should be held accountable for their recommendations, and standards are needed to judge the merit of the work any particular consultant does. This concern is especially important because ethics consultation represents a new and relatively mysterious service for many clinicians, administrators, patients, and patients' families. Lack of familiarity with this service can result in evaluating the service on the basis of inappropriate criteria. Perhaps the most important reason offered in support of the need for evaluating ethics consultation, however, is that sustaining the viability of this service may require a demonstration of its value. In the words of Ellen Fox and Robert Arnold, "In this era of escalating healthcare costs, health planners, policy makers, and administrators are increasingly demanding that providers justify the resources they expend by demonstrating measurable results."⁷

In this article, we argue that while all attempts to evaluate ethics consultation will have their share of problems (for reasons we expound upon herein), some proposals are more problematic than others. We appreciate the need for, and advantages of, quantifiable measures of evaluation, but we must stress that these quantifiable measures represent contingent (or contextual) values. It would be problematic indeed to mistake outcome measures that are characteristic of clinical medicine or the social sciences for the true goals of ethics consultation because they are related to the goals of ethics consultation and are more easily measured. To see this more clearly, consider the relative ease with which one might measure such things as length of stay in the intensive care unit (ICU), number of hours on a ventilator, patients' satisfaction scores, et cetera,

versus such things as the promotion of moral values, clarification and respect of patients' and providers' values, optimizing good decision making, et cetera. Further, we worry that the emerging trends in evaluation of ethics consultation, focusing either on empirical data such as costs, or more subjective data, such as satisfaction scores, run the risk of undermining the project of ethics consultation, or winning favor among certain parties (such as hospital administrators) for the wrong reasons. We register our concerns here.

Existing literature evaluating the effectiveness of ethics consultation can be grouped into three categories: first, there is a literature on the theoretical justification of ethics consultation,⁸ which explores the nature, role, and methods of this service and proposes to evaluate it in terms of justified theoretical goals. This literature primarily focuses on issues of justifiable process, neglecting to provide an evaluation mechanism for the outcomes resulting from this process. Since here we are concerned with evaluation of the outcomes of ethics consultation, we will not offer a critique of this "meta-literature." Second, there is a small literature on the effect of ethics consultation on patients', families', or health workers' satisfaction.⁹ This literature attempts to measure either how helpful ethics consultation was perceived to be, or how satisfied one or more of the parties involved were with the process or recommendations made. While attempts to measure satisfaction have a history in clinical medicine,¹⁰ many of the studies concerning satisfaction for ethics consultation utilize samples too small to draw statistically sound conclusions or have other methodological flaws that prevent general conclusions regarding ethics consultation from being drawn. In our opinion, the most significant problem with this approach, however, is that "satisfaction," by itself, may not be an appropriate criterion for evaluating the success of ethics consultation, as we discuss below. Finally, there is a small but growing literature looking at the effect of ethics consultation on clinical outcomes, evaluating ethics consultation in light of these outcomes. It is this literature we are most concerned with here.

Measurement of effects on clinical outcomes have, unsurprisingly, been a domain dominated by interest in standardized, empirical criteria. As Fox and Arnold observe, "Outcomes research is the accepted method for establishing the utility of health services."¹¹ This observation is significant for two reasons. First, outcome research relies, unsurprisingly, on quantifiable measures that may reflect traditional goals in medicine quite appropriately, but may not fit the goals of ethics consultation. This fact may have contributed, in part, to the selection of criteria employed to evaluate the effectiveness of ethics consultation, creating problems for this evaluation, because, by nature, ethics consultation involves contingent empirical goals. Second, because evaluation measures are likely to be taken by hospital administrators (and others) as a demonstration of the worth of ethics consultation, it is of paramount importance that we take care to frame criteria for evaluation that does not undermine the basic nature of the service.

The need to evaluate ethics consultation is not easy to address due to the nature of the intervention itself, and the contingency of specific measurable goals for ethics consultation. Fundamentally (and historically), ethics consultation is concerned with value conflicts as they arise in the acute patient care setting,¹² but measuring success in the resolution of a value conflict is no inconsequential task. This is true because moral and social values like liberty, autonomy, and beneficence (to name just a few) are not easily calculated, quantified, or exchanged. Indeed, it has been argued that many such values are incommensurable, which might suggest any attempt to quantify and balance at this level is doomed.¹³

Prior attempts to measure the outcomes of ethics consultation have focused on outcomes that are not, and should not, be the central aim of ethics consultation itself. While we acknowledge the value of the outcomes in question (which we examine in detail below), these outcomes are valuable only in certain specified circumstances (that is, the value of these outcomes is contingent), a feature not explicitly recognized in attempts to evaluate ethics consultation. To avoid evaluation criteria that undermine the basic nature of ethics consultation, the contingency of practical outcome values must be recognized and accounted for. Any attempt to evaluate ethics consultation, then, must proceed very carefully.

Furthermore (and most importantly for our discussion below), it must account for the fact that the strength and relevance of the contingent features of the cases themselves will differ from case to case. An attempt to universally define the value of a treatment option (for example, developing a universal concept of "nonbeneficial" as we discuss below), will surely encounter problems if it is defined in any terms other than

purely physiological. To evaluate the success of ethics consultation, then, it is necessary to appeal to a criteria system that allows for the contingent nature of practical goals and their relationship to the more general or fundamental goals of ethics consultation. First, at a practical level, what ethics consultation is meant to do will itself differ from case to case. Typically, the goals of ethics consultation might include:

- To help clarify and articulate patients' preferences,
- To bridge the gap between patients' preferences and reality when there is a discrepancy,
- To ensure respect for individuals' values among not only patients and their families, but providers as well,
- To reduce moral distress among all parties,
- To optimize good decision making.

It is important to note that, in one instance ethics consultation may be meant to help resolve conflict between family and physician, while, in another, it may be meant to help identify what would be in the best interests of a nonresponsive patient. What is important in most instances is that the ethics consultation respond to the problem for which the ethicist was consulted.

Second, the criteria used to measure success for any of the goals described above will themselves will serve as "placeholders," whose content will be filled in by reference to specific features of a particular case. For example, the content of the specific criteria used to measure the success of "ensuring respect for individuals' values" will be contingent on the specific values of the patient and/or other parties involved.

The "dual contingency" just described creates problems for many attempts to measure the success of ethics consultation, as we will discuss below. Nonetheless, if we are to examine the impact of ethics consultation, it is important to know whether the lofty ambitions of this enterprise are met. It is possible, for example, that we find ethics consultation does not contribute to realization of the goals that justify it, or even is counterproductive in the context of these goals. A 1995 Conference on Evaluation of Case Consultation in Clinical Ethics identified, as a major problem, the paucity of empirical literature measuring these effects, a relative paucity that continues to exist.¹⁴ This paucity, however, exists for a reason: ethics consultation is unlike most other interventions in the clinical setting, requiring criteria that are difficult to translate into empirical measures. While we believe that the empirical studies that have attempted to measure the success of ethics consultation do have value, it is very important to recognize that the results of these studies must be mitigated by an appreciation of their contingent nature.

MEASURING THE OUTCOMES OF ETHICS CONSULTATION

As noted above, one reason for evaluating ethics consultation in terms of outcome research is that this is the accepted method of clinical evaluation. As a patient care service meant to influence the formulation of treatment plans in a hospital setting, there is a temptation to evaluate clinical ethics consultation according to criteria used to evaluate more traditional clinical interventions. In this context, as Ann Mills, Patricia Tereskerz, and Walt Davis have observed, "Evaluation of consultation outcomes has generally followed the familiar cost and quality approach."¹⁵ Economic criteria for evaluating ethics consultation, Matthew Bacchetta and Joseph Fins argue, "helps administrators compare the value of one clinical activity to another."¹⁶ As Fox and Tulskey observe concerning the increasing pressure for ethics consultants to demonstrate their worth: "What . . . will it take to convince others that ethics consultation is worthy of support? One approach would be to show that by reducing expenditures for unwanted and wasteful resources, ethics consultation can save money for institutions."¹⁷

This trend is clear in a recent study by Schneiderman and colleagues published in *Journal of the American Medical Association*.¹⁸ The study compared ICU days, hospital days, and use of life-sustaining treatments for patients who did not survive to discharge (as well as mortality for those who did survive to discharge) in two groups: those offered ethics consultation, and those who received "usual care." The stated objective of the study was to determine if ethics consultation in an intensive care setting would reduce the

use of life-sustaining treatments for patients who failed to survive to discharge, and, at the same time, measure whether there was a significant effect on mortality for patients overall. The study also incorporated a measure of physicians' and families' perceptions of the helpfulness of ethics consultation. This is not the first attempt to discuss the impact of ethics consultation in terms of objective, measurable outcomes. Dowdy and colleagues examined the effect of proactive ethics consultation on documented patient care communications and on decisions regarding high-risk intensive care unit patients in terms of frequency of communications, frequency of decisions to forego life-sustaining treatment, and on reduced length of stay for ICU patients on continuous mechanical ventilation for more than 96 hours.¹⁹ The SUPPORT study, while it did not utilize the mechanism of ethics consultation, did look at issues commonly associated with ethics consultation. These included attention to DNR (do-not-resuscitate) orders, patients' and physicians' agreement on preferences to withhold resuscitation, days spent in an ICU receiving mechanical ventilation or comatose before death, frequency and severity of pain, and hospital resource use.²⁰

The study by Schneiderman and colleagues offers an examination of the effects of ethics consultation in quantifiable terms that demonstrate the contribution of such a service to goals that are easily identifiable for clinical medicine more generally. In this, the overall goal of the study project is laudable: as we discussed above, there is an imminent need to measure the effects of ethics consultation so that we are better able to evaluate and improve such services. A problem arises, however, concerning the specific criteria that should be employed within this method of assessment. As Tulsy and Stocking observe, "one challenge limiting investigation in this field has been identifying suitable study designs. Ethics consultation differs significantly from drugs and medical procedures for which a wealth of evaluation techniques exist."²¹

Tulsy and Stocking do not elaborate on the ways in which ethics consultation differs from traditional medical interventions; indeed, to facilitate much needed research in the area, they focus on the similarities that might allow lessons to be drawn from outcome research in these other areas. However, identification of these differences (and, most importantly, their relevance for the acceptability of criteria that could be used to measure the effectiveness of ethics consultation), is crucial to the creation of study designs. Below, we will first examine our concerns with the most recent study to evaluate ethics consultation (that of Schneiderman and colleagues), then turn to the broader problems faced by attempts to measure the effectiveness of ethics consultation that ground these specific concerns.

THE CONTINGENCY OF BENEFIT

In assessing the attempt by Schneiderman and colleagues to measure the effectiveness of ethics consultation, our first concern relates to their assumption that the hospital days and treatments provided to patients who did not survive to discharge were "nonbeneficial." According to the authors, the assumption is that since an outcome of death before discharge represents "a failure to achieve a fundamental goal of medicine," continued intervention (administration of antibiotics, ventilator support, tube feedings, and so forth) leading to such outcomes is "nonbeneficial." If such treatment is in fact nonbeneficial, reducing the extent of the intervention is "good" for a number of reasons; the burdensome aspects of continued nonbeneficial treatment have been extensively documented and discussed in the literature.²² However, this assumption is extremely problematic. It is not always the case that treatments provided to those who fail to survive to discharge are nonbeneficial or unwarranted. As can be seen in the bioethics literature, assessing "benefit" is quite complex, and must include a consideration of the effect of treatment on a patient's quality of life.²³ In this, benefit cannot be assessed simply on the basis of survival to discharge (although this is important). Pain medications for terminal patients are the clearest example of treatment provided to patients who will not survive to discharge, but that are universally seen as benefiting the patient. Schneiderman and colleagues would likely point to the fact that the goal of pain medication in these circumstances is realized, and thus such medications are beneficial, while the goal of ICU days, ventilator support, et cetera is to lead to discharge from the hospital. But is this always the case? Cannot aggressive intervention at times be meant to accomplish goals that do not depend on survival to discharge, but that do allow the patient to experience benefit? We believe it can.

Consider a case in which a patient in her mid-sixties, with a history of chronic COPD, diabetes, cardiomyopathy, and ventricular arrhythmia, is admitted to the ICU, suffering from respiratory failure and T5 & T6 fractures after falling. It is likely that she will need long-term ventilator support. Several years earlier, she had made the decision to have cardiopulmonary resuscitation (CPR) withheld (DNR), and stated that she did not want her life to be prolonged through ventilator support if the time should come that such support would be long-term. She has even taken the steps of making future hospice arrangements. Upon the current admission, however, she has requested that her code status be changed to "full-code," and that ventilator support be continued. She has been intermittently confused but was believed to be decisionally capable when she requested reversal of code status. The physician in charge of the case is uncomfortable with these requests for several reasons. First, he does not believe that the treatment (CPR) will benefit the patient, as the patient is unlikely to improve to the point that she could be discharged from the hospital, and would likely not leave the ICU. Second, he believes that her wishes, as stated prior to the current admission, are more reflective of her deeper values, and that her current change in attitude may simply reflect fear, or, perhaps, confusion. He believes counseling and support are more appropriate than ventilator support. An ethics consultation is called. In the course of investigating the patient's values, it emerges that the reason for her change in attitude is that her daughter is pregnant, and will likely give birth in about four weeks. The patient would like to stay alive to see the birth of her only grandchild, even if that means chronic ventilator support and aggressive medical interventions. The physician remains uncomfortable with this approach, as he believes she will not survive for even that time frame, but better understands the patient's concerns.

The above case lacks the complex features that characterize most ethics consultations, especially in regard to conflicts of deeply held values that lead to intractable disagreement. Indeed, the case above may be nothing more than a simple communication problem. However, it is useful for illustrating the problem at hand because of this very simplicity, which makes the assessment of benefit clear. Most would argue that an appropriate recommendation, if not *the* appropriate recommendation from the ethics consultant in this case, would be to allow the patient to fulfill her wish to see her only grandchild before she dies, even though it is highly unlikely that she will survive to discharge, and even though this recommendation will result in significantly more ICU days and time on the ventilator.

Here, "benefit" to this patient clearly cannot be measured accurately if survival to discharge is a *prerequisite* to the value of ICU and ventilator time in the standard of measurement. In fact, even if she does not survive to actually see her grandchild (in fact failing to attain the "benefit" she desired), a recommendation allowing the patient a *chance* to realize this goal is arguably an appropriate recommendation. In short, the concept of benefit is contingent by nature (to use language we employed earlier, a "placeholder concept" to be filled in by reference to particular cases): whether a treatment "benefits" a patient will depend on what that patient values, as well as that patient's circumstances. At root, because the idea of "benefit" is value-laden, it does not lend itself to the types of standardized criteria for measurement that many clinical intervention outcome studies seek. The criteria employed in the study are a legitimate measure of the success of ethics consultation *only if* ethics consultation is limited to conflicts involving insistence on continued treatment that does not benefit the patient (no values outside mere survival are realizable). However, since the idea of benefit is itself contingent by nature, criteria that does not acknowledge this contingency will not measure the effectiveness of realizing the goals of ethics consultation appropriately. This leads to our second concern: that the criteria employed by Schneiderman and colleagues might lead to the adoption of inappropriate criteria for measuring the effectiveness of ethics consultation.

CAN CRITERIA OF SUCCESS IN ETHICS CONSULTATION BE STANDARDIZED?

To the extent that ethics consultation involves the value-laden task of "assessing benefit to the patient" at a fundamental level (as we believe it should), the ethics intervention will reflect significant differences from outcomes measured in the context of most traditional interventions in the clinical setting. First, the effects measured from most clinical interventions tend to be physiological in terms of what is measured; in this,

common standards apply to each person. This means that the outcomes to be measured are not *conceptually* value-laden in regard to effect, but merely value-laden in regard to when that effect is appropriately sought. One need only compare the role of ethics consultation in the task of assessing "benefit" (as described above) to the task of antibiotic administration to see a clear example of how the inherent outcomes of ethics consultation are more conceptually value-laden than that of traditional interventions in the clinical setting, in terms of effects to be measured. For example, whether the goal of killing off a bacteria through the use of an antibiotic is an appropriate goal is an issue that is subject to values (if we do not value the outcome, it is not an appropriate goal); however, whether or not the antibiotic in question actually kills the bacteria in question is not an issue. It is the latter that is the focus of most evaluation of clinical intervention: how effective is this intervention at achieving an outcome (bracketing the question of when the outcome in question *should be* sought)? Thus, measuring the effect of an antibiotic does not require criteria that accounts for differing patients' values, as the outcome measured is not value-laden at a *conceptual* level. In this, it is amenable to standardized criteria.

Ethics consultation, however, is concerned with the formulation of appropriate outcome goals: in this, it is concerned with value-laden issues as an inherent focus. As articulated in a report published by the American Society for Bioethics and Humanities (ASBH), *Core Competencies for Health Care Ethics Consultation*, "To the extent that consensus exists about the goals of ethics consultation, it is that ethics consultation should facilitate the development of treatment plans that are more consistent with a particular patient's life values and goals."²⁴ In this respect, the general goal of an ethics consultation may be standardized; however, what *specific* outcome is appropriate will, *necessarily*, change from circumstance to circumstance, and from patient to patient. Thus, ethics consultation will be less amenable to standardized criteria for outcome measurement, since the very outcomes to be measured will be value-dependent.

In addition, the measurement of the effects of traditional clinical interventions normally relate to outcome *goals* that are, empirically, less susceptible to patient-by-patient differences, making these goals more amenable to across-the-board criteria for outcome measurement. The reason for this is that the outcome goals that are measured are normally already assumed to be valued: if they are not, the patient (presumably) would not have accepted the intervention. Thus, universal standards of "good" are more easily established within the more narrow context of patients who have already deemed this intervention to be of value. The goal of a heart transplant, for example, is for an outcome of extended life. This goal normally is consistent across the patient population of transplant recipients. However, the existence of an outcome goal that is clear and consistent (across patients) is not normally the case in regard to ethics consultation. In fact, it is lack of clarity on this very issue that gives rise to ethics consultation: the *Core Competencies for Health Care Ethics Consultation* begins by stating, "Health care ethics consultation is a service provided to . . . address uncertainty or conflict regarding value-laden issues that emerge in health care."²⁵ Thus, ethics consultation is normally concerned with issues of *establishing what outcomes are valued*, and thus which interventions offer outcomes that are appropriate for a particular patient. Such a goal is, by nature, not amenable to measurement using across-the-board criteria that fail to account for differing values and goals of *particular patients*. Indeed, it is this feature of ethics consultation that grounds our concern with the attempt to deem, for example, days in an ICU or time on a ventilator to be, universally, "nonbeneficial" for patients who do not survive to discharge.

ETHICS CONSULTATION AND COST REDUCTION: AN UNINTENDED SIDE-EFFECT?

There is a very real danger in representing ethics consultation in a way that glosses over the unique and specialized role of ethics in healthcare and that minimizes the fundamental differences between ethics consultation and traditional clinical interventions. Since the benefits that can be assessed through patients' values are contingent by nature, the criteria that are meant to measure effectiveness in the context of benefit must have a contingent dimension if patients' values are to be taken seriously. Thus, the absence of a contingent dimension in the criteria employed by Schneiderman and colleagues can be taken to imply that the

goods that are measured take priority over patients' values, rather than being weighed in the context of patients' values. If this is the case, the specific criteria employed by Schneiderman and colleagues further imply that ethics consultation is a mechanism to reduce costs, since ultimately the criteria reflect these types of concerns. Each of the criteria employed by the study (length of stay, time in the ICU, and time spent on a ventilator) often are associated with hospital costs.²⁶ Thus, the implied "good" measured by the study in question (given how the criteria employed normally are used) is that of ethics consultation's usefulness as a mechanism that reduces costs through reduction of ICU time, hospital days, use of ventilators, and so forth. It is important to note that we do not wish to claim that this was the position of the authors of the study. Our concern is with the (*likely* unintended) implication that might be drawn from the authors' criteria: that reduction of the use of resources is how ethics consultation contributes value to clinical medicine. Even if ethics consultation *does* have this effect in some cases, our point is that to consider this a goal of ethics consultation is a mistake.

Further, we do not wish to claim that costs are, or should be, at all times irrelevant to ethics consultation. There may well be situations in which justice-related issues of resource allocation, in terms of the value returned for the use of resources, are appropriate dimensions of ethics consultation. In an age of increasing financial crisis within the healthcare system, it is simply not feasible to provide expensive treatments to patients who are unable to benefit, or even to some who might benefit (in all cases).²⁷ Thus, the reduced use of resources in "nonbeneficial" circumstances would be a positive outcome. However, our point is that, while ethics consultation *should* contribute to the value gained in the use of resources, it should do this *not* through reduction in resource use *per se*, but instead through formulating treatment plans that are more oriented toward goals that are deemed to be valuable. This, in turn, must involve a contingent dimension that incorporates a recognition that "benefit" will be assessed differently, given the values of different patients. In this, the treatment plan that is most appropriate may cause a reduced length of stay, a similar length of stay that is deemed to be more beneficial, or even a longer stay in which significant benefit is present. It may often be the case that ethics consultation causes a reduced use of resources, but this reduction is contingent on the case in question, and should not *itself* be the goal of ethics consultation.

The dangers of "unintended consequences" from using quality assessment tools is problematic throughout clinical medicine.²⁸ By attempting to measure the effect of ethics consultation through standardized criteria, the danger is one of creating benchmarks for the evaluation of ethics consultation that undermine its very goals.²⁹ This is true whether the study seeks to use the criteria as a goal, or simply to measure the effect not as a goal, but because of interest in the phenomenon itself. That is, even if one simply wished to measure the effect of ethics consultation on the use of resources without implying that this is a goal, if the effects of ethics consultation on length of stay indicate that it is associated with reduced length of stay, while it does not increase mortality, administrators (and others who are peripherally familiar with ethics consultation) are likely to take this as a benchmark for the contribution of ethics consultation to institutional goals (as other clinical interventions would be evaluated accordingly). This is especially true in an era when hospital services are increasingly required to demonstrate their financial viability or improve efficiency. Once established, however, such a benchmark would clearly provide an incentive for ethics consultation to cause outcomes that contribute to this benchmark. Our point, however, is this: even treatment planning that utilizes similar (or even more) resources than alternative plans, but that aim toward goals that are of more fundamental value, would contribute value to the improved utilization of resources and should be considered successful.

A benchmark of cost reduction might result in bias toward withholding or withdrawing a therapy, because forgoing it would result in a reduced length of stay. This phenomenon was raised as a criticism of a report on a pilot study that was written by Schneiderman and colleagues³⁰ several years prior to their study published in *Journal of the American Medical Association*: "The use of 'reducing unwanted and inappropriate treatments' as an outcome measure and the comments in the discussion that the ethics consultation helped in clarifying the legal basis for forgoing treatment suggest that the ethics consultation may have been one-sided, possibly leaning toward persuasion to forgo therapy rather than independently clarifying the views of

all parties and recommending their enactment. Would not a measure of 'fulfilling the patient/proxy's expectations' have been an outcome measure more accurately reflecting the true objective of the ethics consultation?"³¹ We share the commentators' concern with the potential bias for cost-saving, as well as the general need to incorporate patients' and family members' values into outcome measures, as our previous comments make clear. It is worth noting a potential problem, however, with the suggestion of using "fulfillment of patient/family expectations" as a measure of effectiveness. If the expectations of a family are not appropriate — for example, perhaps they wish for active euthanasia — then the ethics consultant *should not* attempt to fulfill these expectations. It is to this general area of concern that we shall now turn our attention.

MEASURING SATISFACTION WITH ETHICS CONSULTATION

The complexity of the goals of ethics consultation are not only a problem for traditional medical criteria of outcomes measurement, but also for traditional social science criteria. Consider one attempt to evaluate ethics consultation through the satisfaction of patients and family members.³² This study conducted interviews with patients or surrogates for whom an ethics consultation was provided, within a few weeks after hospital discharge. Using a five-point Likert scale, interviewees were asked if the ethics consultation was helpful to the family, and asked whether the consultation had been helpful or detrimental to the patient (a similar tool was also employed by Schneiderman and colleagues). The authors concluded that ethics consultation had been helpful in a majority of cases, and rarely detrimental.

As was the case with attempts to evaluate ethics consultation through objective outcomes criteria, such as length of stay, attempts to evaluate ethics consultation through traditional "social science" satisfaction criteria can be problematic. In this case, the benchmarks established may provide an incentive to make recommendations that maximize the contentment of one (or both) parties with a recommendation by ethics consultants. Given the fundamental goals of ethics consultation, the ethics consultant should be aligned with no particular party.³³ While, in general, it is a good thing to have patients, families, and healthcare workers express positive attitudes toward ethics consultation, the integrity of the service requires that we separate these attitudes from the consultation process.

In some instances, cases that result in the discontent of one (or more) parties may be cases in which ethics consultation was most needed. Imagine, for example, the case of a severely retarded patient, when the physician believes that the patient's (healthy) baseline quality of life does not warrant aggressive intervention (because he is severely retarded), but family members have grown weary of the "burdens" of caring for him. Imagine that, due to the patient's severe retardation, he is unable to participate in decision making (or, for that matter, offer valid assessment of satisfaction with the ethics consultation process). Both the physician and family, then, believe that lifesaving intervention should be foregone, despite the fact that the patient would be expected to make a full recovery and return to what, for him, is a happy baseline quality of life. The ethics consultant's role may well be one of protecting the patient's access to aggressive intervention that would benefit him, despite the family's and the physician's unhappiness with this recommendation. If this were the case, the "correct" recommendation *may* result in low satisfaction scores from both the family *and* the physician.

At root, ethics consultation is not about making friends or becoming popular. Indeed, attempting to bring about an appropriate moral outcome can be difficult, inconvenient, and, in some cases, even burdensome. This may, in some cases, lead to bias in the evaluation of the consultation process: assessments of "helpfulness" might be subject to others' perception of ethics consultation's ability to assist in bringing about the outcomes that *they* desire in circumstances where an individual's values are not the appropriate framework for decision making. Here, we do not wish to claim that satisfaction is *irrelevant* to assessing the effectiveness of ethics consultation. Rather, satisfaction *by itself* should not be the basis of assessing ethics consultation, but should be placed in context with the fundamental goals of the intervention. Ethics consultants should seek to help allay moral distress in these circumstances through assistance in understanding the basis

of appropriate decision making. This itself *may* lead to perceptions of helpfulness *or* appreciation with the ethics consultation process, which is always desirable. However, satisfaction with the outcome of a decision or a process *per se* is not the outcome goal.

CONCLUSION

It is understandable how some phenomena that are commonly associated with ethics consultation become identified and employed as criteria to evaluate such services. In fact, ethics consultation does (based upon our own observations) seem to result in more withdrawal of treatments that are deemed "nonbeneficial" by patients (rather than continuing contested interventions), and does commonly result in the increased satisfaction of patients and families. This, perhaps, due to circumstances that leave patients and families vulnerable and create power differentials between patients and families and physicians; thus, ethics consultants more often find themselves advocating for patients than not. It is no surprise, then, that evaluations of ethics consultations find these services to be both cost-effective and value-added services.³⁴ Because both of these phenomena are positive, there is an understandable desire to systematically demonstrate these effects. However, it is important to recognize that these are *contingent* phenomena that are associated with ethics consultation through circumstance, not phenomena that can be *directly* tied to the foundational goals of ethics consultation itself. That is, these goals are appropriate for many, but not all, cases, and have value if properly framed as contingent. If they are allowed to be used as benchmarks for evaluating the effectiveness of ethics consultation, however, "outlying cases" that do not conform to these common phenomena (as described throughout this article) will either evaluate ethics consultation as ineffective when it has been, possibly, its most effective; or will provide incentives for consultants to (consciously or subconsciously) make recommendations that are in line with the benchmarks, rather than with the goals of ethics consultation itself (the worst scenario of all). This is profoundly important when one considers that ethics consultation nearly always involves difficult "outlier cases" in some respect: it is this feature that normally leads to a request for ethics consultation.

One foundational issue we have pointed to concerns the relation of ethics consultation to clinical outcomes *per se*. Here, it may be instructive to consider some issues raised by attempts to measure the effects of spiritual interventions in the clinical setting. Ethics consultation and pastoral care consultations serve different functions in the clinical setting. This is true not only because ethics consultation is grounded in a secular concern with values, but also because ethics consultation is focused on resolving problems in clinical decision making. Nevertheless, as ethical issues involve subjective, normative dimensions that are in some respects analogous to spiritual matters, some lessons may be drawn from attempts to assess spiritual practices in the acute care setting; the focus of ethics on intangible values shares some characteristics with spiritual matters that are relevant to assessing appropriate evaluation criteria. For example, one study that attempted to measure the clinical effects of prayer³⁵ met with criticisms that questioned whether the function of prayer is such that it can or should be measured through observable clinical results.³⁶ Likewise, the role and importance of many values (particularly moral values) in an individual's life may not be readily apparent, observable, or quantifiable.

Furthermore, in circumstances in which intervention can only offer outcomes that are at odds with a patient's values, the patient may reject the intervention to maintain his or her values. Indeed, the value of independence or dignity, for example, may be most apparent when these are threatened or undermined, at which time a person may risk all (including life) to maintain these values. Like prayer, the worth of ethics consultation is not simply a function of its clinical effects. As Ezekiel and Linda Emanuel have observed, there are good reasons for pursuing greater respect of patients' rights and wishes, *even when there will be little or no cost-savings*.³⁷ Close attention to these important differences leads to significant questions about the suitability of the criteria employed by Schneiderman and colleagues to evaluate ethics consultation.

Attempts to measure the effectiveness of ethics consultation must take into account a variety of complex goals and features, some of which are objective, and some of which are subjective. Studies that focus on one

or the other of these do contribute to our understanding, but must be careful not to create other difficulties. Effective measurement studies must find a way to measure quality of life during and after treatment for those patients who receive an ethics consultation, contrasting this to the quality of life for similar patients who do not. To the extent that justice-related allocations of resources are a part of ethics consultation, a mechanism that uses, for example, quality adjusted life years (QALYs) might be employed. Similar difficulties in measuring the effectiveness of complex clinical services have been identified within the hospice movement, which has sought multivariable measurement devices that include both more objective components (for example, pain, functional status) as well as subjective components (such as satisfaction, anxiety).³⁸ A similar multivariable measurement scheme is surely needed for ethics consultation. Whatever measure is developed, it is important to recognize that the best measure of the success of an ethics consultation is the extent to which it contributes to the creation of treatment plans that are more appropriate for the patient in the contexts described above. While this may at times result in treatment plans that involve reduced length of stay, reduced length of stay should not, itself, be the measure used in evaluating ethics consultation. Nor is the satisfaction of surrogates, family members, or health providers, *per se*, equivalent to the goals described.

NOTES

1. *In the Matter of Karen Quinlan, An Alleged Incompetent*, Supreme Court of New Jersey, 70 N.J. 10; 355 A.2d 647; 1976 N.J.

2. *Cruzan v. Director, Missouri Department of Health, et al.*, 497 U.S. 261; 110 S. Ct. 2841; 111 L. Ed. 2d 224; 1990 U.S. Lexis.

3. Joint Commission on Accreditation of Healthcare Organization (JCAHO) Standards. Patient Rights and Organization Ethics, 2004.

4. K. Grumbach and T. Bodenheimer, "Can Health Care Teams Improve Primary Care Practice?" *Journal of the American Medical Association* 291, no. 10 (2004): 1246-51.

5. E. Fox, "Concepts in evaluation applied to ethics consultation research," *The Journal of Clinical Ethics* 7, no. 2 (1996): 116-21.

6. E. Fox and J. Tulskey, "Evaluation research and the future of ethics consultation," *The Journal of Clinical Ethics* 7, no. 2 (1996): 147-9.

7. E. Fox and R. Arnold, "Evaluating outcomes in ethics consultation research," *The Journal of Clinical Ethics* 7, no. 2 (1996): 127-38.

8. D. Bernard, "Reflections of a reluctant clinical ethicist," *Theoretical Medicine* 1992; R. Macklin, "Consultative roles and responsibilities," *Institutional Ethics Committee and Health Care Decision-Making* 1984; D. Thomasma, "Why philosophers should offer ethics consultation?" *Theoretical Medicine* 1991; J.E. Frader, "Political and interpersonal aspects of ethics consultation," *Theoretical Medicine* 1992; H.S. Perkins et al., "Clinical ethics consultation: reasons for optimism," *The Journal of Clinical Ethics* 3, no. 2 (Summer 1992): 133-7.

9. R.D. Orr et al., "Evaluation of an ethics consultation service: patient and family perspective," *American Journal of Medicine* 101, no. 2 (1996): 135-41; D. Heyland and J. Trammer, "Measuring family satisfaction with care in the intensive care unit: the development of a questionnaire and preliminary results," *Journal of Critical Care* 16, no. 4 (2001): 142-9; B.M. Yen et al., "Impact of pediatric ethics consultations on patients' families, social workers and physicians," *Journal of Perinatology* 19, no. 5 (1999): 373-8; J.A. McClung et al., "Evaluation of a medical ethics consultation service: opinions of patients and health care providers," *American Journal of Medicine* 100, no. 4 (1996): 456-60; H.S. Perkins et al., "Clinical ethics consultation: reasons for optimism," *The Journal of Clinical Ethics* 3, no. 2 (Summer 1992): 133-7.

10. L.L. Steele et al., "Patient and caregiver satisfaction with end-of-life care: does high satisfaction mean high quality of care?" *American Journal of Hospice and Palliative Care* 19, no. 1 (2002): 19-27; J.B. Hopkinson and C.E. Hallett, "Patients' perceptions of hospice day care: a phenomenological study," *International Journal of Nursing Studies* 38, no. 1 (2001): 117-25; D. Parker-Oliver, "Hospice experience and perceptions in nursing homes," *Journal of Palliative Medicine* 5, no. 5 (2002): 713-20; D.J. Casarett et al., "Caregivers' satisfaction with hospice care in the last 24 hours of life," *American Journal of Hospice and Palliative Care* 20, no. 3 (2003):

205-10; I.R. McWhinney, M.J. Bass, and A. Donner, "Evaluation of a palliative care service: problems and pitfalls," *British Medical Journal* 309, no. 6965 (19 November 1994): 1340-2; G. Rinck et al., "Trails in palliative care," *British Medical Journal* 310 (4 March 1995): 598-9; N.M. Levy, "End-of-life care in the intensive care unit: can we do better?" *Critical Care Medicine* 29, supp. 2 (February 2001): N56-61; K.S. Ogle, B. Mavis, and G.K. Wyatt, "Physicians and hospice care: attitudes, knowledge, and referrals," *Journal of Palliative Care* 5, no. 1 (February 2005): 85-92; G.W. Hanks et al., "The imPaCT study: a randomized controlled trial to evaluate a hospital palliative care team," *British Journal of Cancer* 87, no. 7 (23 September 2002): 733-9.

11. E. Fox and R. Arnold, "Evaluating outcomes in ethics consultation research," *The Journal of Clinical Ethics* 7, no. 2 (1996): 127-38.

12. Society for Health and Human Values — Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation, *Core Competencies for Healthcare Ethics Consultation* (Glenview, Ill.: American Society for Bioethics and Humanities, 1998).

13. T. Nagel, *The view from nowhere* (Oxford, U.K.: Oxford University Press 1986); J. Griffin, "Are there incommensurable values?" *Well-Being: Its Meaning, Measurement, and Moral Importance* (Oxford, U.K.: Clarendon Press, 1986).

14. J. Tulsy and E. Fox, "Evaluating ethics consultation: framing the questions," *The Journal of Clinical Ethics* 7, no. 2 (1996): 109-15.

15. A. Mills, P. Tereskerz, and W. Davis, "Is Evaluating Ethics Consultation on the basis of Cost a Good Idea?" *Cambridge Quarterly of Healthcare Ethics* 14 (2005): 57.

16. M. Bacchetta and J. Fins, "The Economics of Clinical Ethics Programs: A Quantitative Justification," *Cambridge Quarterly of Healthcare Ethics* 6 (1997): 452.

17. E. Fox, and J. Tulsy, "Evaluation research and the future of ethics consultation," *The Journal of Clinical Ethics* 7, no. 2 (1996): 147-9.

18. L. Schneiderman et al., "Effect of ethics consultation on nonbeneficial life-sustaining treatments in the intensive care setting," *Journal of the American Medical Association* 290, no. 9 (2003): 1166-72.

19. M.D. Dowdy, C. Robertson, and J.A. Bander, "A study of proactive ethics consultation for critically and terminally ill patients with extended lengths of stay," *Critical Care Medicine* 26 (1998): 252-9.

20. The SUPPORT Principle Investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)," *Journal of the American Medical Association* 274, no. 20 (1995): 1591-8.

21. J. Tulsy and C. Stocking, "Obstacles and opportunities in the design of ethics consultation evaluation," *The Journal of Clinical Ethics* 7, no. 2 (1996): 139-45.

22. D. Clark, "Between Hope and Acceptance: The Medicalisation of Dying," *British Medical Journal* 324 (13 April 2002): 905-7; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death* (Washington, D.C.: U.S. Government Printing Office, 1981); Institute of Medicine, Committee on Care at the End of Life, *Approaching Death: Improving Care at the End of Life* (Washington, DC: National Academy Press, 1997); T. May, *Bioethics in a Liberal Society* (Baltimore, Md.: Johns Hopkins University Press, 2002).

23. R.M. Veatch, "Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients," *Journal of Medicine and Philosophy* 25, no. 6 (December 2000): 701-21; D. W. Brock, "Separate Spheres and Indirect Benefits," *Cost Effectiveness and Resource Allocation* 1, no. 1 (26 February 2003): 4; S. Younger, "Who defines futility?" *Journal of the American Medical Association* 260, no. 14 (14 October 1988): 2094-5; J.L. Nelson, "Families and futility," *Journal of the American Geriatric Society* 42, no. 8 (August 1994): 879-82; J. Lynne, "Serving Patients Who May Die Soon and their Families: the Role of Hospice and Other Services," *Journal of the American Medical Association* 285 (21 February 2001): 925-32.

24. See note 12 above.

25. *Ibid.*

26. M.L. Campbell and J.A. Guzman, "Impact of a Proactive Approach to Improve End-of-Life Care in a Medical ICU," *Chest* 123 (January 2003): 266-71; D.V. Schapira et al., "Intensive Care, Survival, and Expense of Treating Critically Ill Cancer Patients" *Journal of the American Medical Association* 269, no. 6 (February 1993): 783-6; D.C. Angus et al., "Use of Intensive care at the end of life in the United States: an epidemiologic

study," *Critical Care Medicine* 32, no. 3 (March 2004): 638-43; A. Taghreed, D.B. Evans, and C.J.L. Murray, "Economic Estimation of Country-Specific Hospital Costs," *Cost Effectiveness and Resource Allocation* 1, no. 1 (February 2003): 3.

27. A. Wood, "When Increased Therapeutic Benefit Comes at Increased Cost," *New England Journal of Medicine* 346, no. 23 (2002): 1819-21.

28. R. Werner and D. Asch, "The Unintended Consequences of Publicly Reporting Quality Information," *Journal of the American Medical Association* 293, no. 10 (2005), 1239-44.

29. A. Mills, P. Tereskerz, and W. Davis, "Is Evaluating Ethics Consultation on the basis of Cost a Good Idea?" *Cambridge Quarterly of Healthcare Ethics* 14 (Winter 2005): 57-64.

30. L. Scheiderman, T. Gilmer, and H. Teezel, "Impact of Ethics Consultation in the Intensive Care Setting: A Randomized Controlled Trial," *Critical Care Medicine* 28, no. 12 (2000): 3920-4.

31. P.D. Levin and C.L. Sprung, "Are Ethics Consultations Worthwhile?" *Critical Care Medicine* 28, no. 12 (2000): 3942-4.

32. R.D. Orr, et al., "Evaluation of an ethics consultation service: patient and family perspective," *American Journal of Medicine* 101, no. 2 (1996): 135-41.

33. T. May, *Bioethics in a Liberal Society* (Baltimore, Md.: Johns Hopkins University Press, 2002).

34. G. Daly, "Ethics and Economics," *Nursing Economics* 18, no. 4 (July- August 2000): 194-201.

35. H. William et al., "A Randomized, Controlled Trial of the Effects of Remote, Intercessory Prayer on Outcomes in Patients Admitted to the Coronary Care Unit," *Archives of Internal Medicine* 159, no. 19 (1999): 2273-8.

36. J. Bishop, "Prayer, Science and the Moral Life of Medicine," *Archives of Internal Medicine* 163, no. 12 (23 June 2003): 1405-8; R. Sloan and E. Bagiella, "Data Without Prayer," *Archives of Internal Medicine* 160, no. 12 (26 June 2000): 1870; author's reply 1877-8.

37. E. Emanuel and L. Emanuel, "The Economics of Dying — The Illusion of Cost Savings at the End of Life," *New England Journal of Medicine* 330, no. 8 (1994): 540-4.

38. D. Parker-Oliver, "Hospice experience and perceptions in nursing homes," *Journal of Palliative Medicine* 5, no. 5 (2002): 713-20.