

Julie W. Childers, Richard Demme, Jane Greenlaw, Deborah A. King, and Timothy Quill, "A Qualitative Report of Dual Palliative Care/Ethics Consultations: Intersecting Dilemmas and Paradigmatic Cases," *The Journal of Clinical Ethics* 19, no. 3 (Fall 2008): 204-13.

A Qualitative Report of Dual Palliative Care/Ethics Consultations: Intersecting Dilemmas and Paradigmatic Cases

*Julie W. Childers, Richard Demme, Jane Greenlaw,
Deborah A. King, and Timothy Quill*

Julie W. Childers, MD, is a Resident in the Department of Internal Medicine at the University of Rochester, Strong Memorial Hospital in Rochester, New York, childersjw2@upmc.edu.

Richard Demme, MD, is an Associate Professor of Medicine and Medical Humanities at the University of Rochester, Strong Memorial Hospital.

Jane Greenlaw, JD, is the Director of the Program in Clinical Ethics at the University of Rochester, Strong Memorial Hospital.

Deborah A. King, PhD, is a Professor of Psychiatry in the Department of Psychiatry at the University of Rochester, Strong Memorial Hospital.

Timothy Quill, MD, is a Professor of Medicine, Psychiatry, and Medical Humanities; Center for Ethics, Humanities, and Palliative Care at the University of Rochester, Strong Memorial Hospital. ©2008 by *The Journal of Clinical Ethics*. All rights reserved.

INTRODUCTION

Palliative care consultation services in acute hospitals have been rapidly emerging over the last 10 years. Recent surveys estimate that 25 percent of all hospitals have palliative care consultation services, with substantially higher percentages in academic medical centers and Veterans Affairs hospitals.¹ In comparison, all hospitals are required by the Joint Commission on Accreditation of Healthcare Organizations to provide some kind of ethics consultations, and 60 to 70 percent of American hospitals now have ethics committees.² The functions of the two services are often seen as separate, with palliative care (PC) addressing the domains of symptom management and clarifying goals of care in severely ill patients, whereas ethics consultants assist with conflict resolution and medicolegal questions. However, because much of the conflict revolves around end-of-life issues, there may be significant overlap between the cases referred to these independent services.

Palliative care is provided in a variety of settings: hospitals, hospices, nursing homes, out-patient offices, and patients' homes. PC assistance is most often sought for management of difficult-to-treat pain and other symptoms,³ but a significant minority also help with goal-setting and with difficult medical decision making, provide support to patients and family members, and link patients with services as they become more severely ill and are moving toward the end of life.⁴

In contrast, the American Medical Association defines the functions of an ethics consultation as education, facilitation of discussion, and conflict resolution among patient, family, and staff.⁵ Previous efforts to characterize ethics consultations have identified a number of common issues. One case series found that questions of withholding or withdrawing treatment and communication issues predominated.⁶ Other reviews have identified questions about patients' autonomy and conflict resolution,⁷ and issues of medical futility, communication, and family conflict.⁸

Ethics and palliative care overlap: both are called upon to do interpersonal work among patients, families, and clinicians treating them, and to assist with difficult decision making. Increases in consultation rates in both fields have paralleled the growing number and complexity of medical choices available to severely ill patients, as well as enhanced regard for patients' autonomous decision making. They both help identify decision makers, set goals of care, and make medical decisions when patients are unable to do so.

This review of cases that received both palliative care and ethics consultations identifies a subset of particularly challenging cases for both families and clinicians. We use qualitative analytic techniques to identify clinical issues that led to the dual consultations, and then describe five paradigmatic cases to explore the roles that palliative care and ethics consultation services assumed and how they attempted to resolve these difficult questions.

METHODS

Setting and Consultation Services

The University of Rochester Medical Center (URMC) is a 750-bed academic tertiary-care hospital in upstate New York. An ethics consultation service has been in existence since 1991, providing an average of three consults per month during the study period. Ethics consultations can be requested by patients, their families, or anyone on the hospital staff. Ethics consultations are conducted by one of three consultants (one nurse/lawyer and two physicians) and are discussed at a consultation meeting held weekly. The URMC palliative care consult service was established in November of 2001, providing an average of 26 in-patient consultations per month over the study period. Consultations must be requested by the patient's primary attending physician. Patients are initially evaluated by a nurse practitioner or a resident, and subsequently by an attending physician. All palliative care consultations are discussed at a weekly multidisciplinary team meeting.

Design

Initial consultation notes from all cases at URMC that had both palliative care and ethics consultations requested within 30 days during the same admission were included. The cases took place during a three and one-half year period from January 2002 to July 2005. Altogether, 47 cases fit these criteria.

Data Collection

A structured, comprehensive PC intake form is routinely completed during the initial patient assessment on all patients seen in PC consultation (this form available from the authors upon request). This includes a wide range of demographic information about patients, as well as data about their medical problems and medications, ratings of pain and other symptoms, advance care planning, performance status, capacity for decision making, family dynamics, and eventual PC assessment and recommendations. The initial form is completed by a nurse practitioner, resident, fellow, or medical student, and the final assessment and recommendations are completed by the attending physician. A much briefer follow-up form summarizing patients' outcomes is then completed weekly by the palliative care nurse practitioner until a patient is discharged, dies, or the team signs off the case. The ethics consultation provides an unstructured, narrative note completed by the consulting faculty member, often after consultation with other members of the ethics team. When follow-up ethics notes were available in the central ethics office, they too were included in the review.

Data Analysis

Initial ethics and palliative care consultation notes on each patient were reviewed simultaneously by each author, who independently categorized the main questions that led to each consultation. The group then discussed the categories and developed a list of the main issues and treatments in question by consensus.

After the analysis was completed, five cases were chosen by group consensus as paradigmatic examples of dual consultation cases. For each of these cases, an author (JC) who was not personally involved in any of the consultations reviewed the medical charts in depth and interviewed consulting clinicians for first-person accounts of the interpersonal dynamics and the roles of the consulting services. Each member of the group then reviewed the cases until consensus was reached on the main issues involved in each.

Research Ethics

The data analysis from the palliative care and ethics intake processes was approved and exempted by the University of Rochester Institutional Review Board. All cases described here have been disguised to protect patient confidentiality, while preserving fundamental characteristics of interest to the study.

Table 1. Ethics and Palliative Care Populations Compared to the Dual Consultation Group, January 2002 - July 2005

Characteristic	Ethics	Palliative Care	Combined
Gender (%)			
Female	54%	52%	51%
Race (%)			
Caucasian	62%	80%	66%
African-American	29%	14%	25%
Hispanic	6%	2%	6%
Other	3%	3%	2%
Age (years)			
Range	0-103	0-105	0-103
Median	61.5	65	67
Died in index hospitalization (%)	44%	44%	70%
Average consults per month	3	31	1
Total consults over the 42-month study period	126	1,308	47

RESULTS

We identified 47 dual consultations over the 42-month period, representing 37 percent of the total ethics consultations during that period (126) and 4.3 percent of the total palliative care consultations (1,092). In these 47 cases, 70 of the patients died in the index hospitalization. Table 1 summarizes the demographic characteristics of patients who received dual consultations during the study period.

Table 2 lists the main diagnoses associated with the dual consultations. Most of these patients had very advanced disease with a poor prognosis or a life-threatening, acute event or injury, also with a poor prognosis. Table 3 concerns the life-sustaining treatments at issue in the consults. Not surprisingly, whether or not to provide (or continue) cardiopulmonary resuscitation (CPR), ventilatory support, and/or feeding tubes, which are among the most common life-sustaining treatments considered in acute hospitals, head the list.

CLINICAL QUESTIONS

We identified four clinical questions around which conflict or questions centered. The most frequent clinical context was a patient with a severe, probably terminal illness in which the burdens of

Table 2. Main Diagnosis of Patients Who Received Both Ethics and Palliative Care Consults 2002 - 2005

Main Diagnosis	<i>n</i>	%
Cancer	11	23.4
Multisystem failure	8	17.0
Trauma	8	17.0
Neurological	4	8.5
Congenital malformations/ prematurity	3	6.4
Dementia	3	6.4
Cardiac	2	4.3
COPD	2	4.3
ESLD	2	4.3
Sepsis	2	4.3
AIDS	1	2.1
ESRD	1	2.1

treatment appeared (usually to the clinical staff but not to the patient/family) to outweigh the benefits. Most of these 43 cases involved uncertainty about how to proceed in this setting of what the staff considered "near futility." Less-frequently encountered clinical issues were related to patients' capacity to make decisions (13 cases), discharge planning (seven cases), and guardianship or proxy determination (seven cases).

Table 3. Main Treatment(s) in Question Given to Patients Who Received Both Ethics and Palliative Care Consults 2002 - 2005

Treatment	<i>n</i>	%
CPR	18	38.3
Artificial ventilation	16	34.0
PEG	15	31.9
Dialysis	7	14.9
Tracheostomy	6	12.8
Surgery	3	6.4
Transfusion	3	6.4
Antibiotics/other medications	2	4.3
Chemotherapy	2	4.3
Transplantation	2	4.3
BIVAD	1	2.1
Sedation	1	2.1

Table 4. Main Issues and Questions Involved in Consultations Cases that Had Both Palliative Care and Ethics Consultations (*N* = 47)

Main Issue/Question	<i>n</i>	%
Clinical context		
Terminal illness (limited utility of treatment)	43	91.4
Medicolegal	13	27.7
Discharge planning	7	14.9
Question about decision maker		
Capacity	13	27.7
Guardianship/proxy	7	14.9
Decision-making support needed	16	34.0
Mediation of conflict between		
Family and staff	30	69.7
Family and other family	17	36.2
Staff and staff	8	17.0
No mediation of conflict necessary	9	19.1

Many cases posed several of the above dilemmas at once (see table 4).

Another lens through which we viewed the cases was the type of interpersonal work required of the consultation teams. A frequent role of the consultants was that of conflict mediator, although in nine cases (19 percent) no mediation was required, as the consultations focused more on decision-making support for families and/or medicolegal assistance (many consultations were complex and had more than one focus for interpersonal work).

PARADIGMATIC CASES

We now present five paradigmatic cases to illustrate how this dual consultation process worked in practice. Most cases involved multiple concurrent clinical issues. For example, there might be interpersonal conflict both around treatment with high-perceived burdens and low-perceived benefits, and simultaneous disagreement about who was the proper surrogate decision maker. Through these cases, we illustrate in more detail how ethics and PC consultants collaborated with each other, and the differing agendas of the medical teams in consulting the two services.

Case 1

Conflict between family and staff about treatment with high burden and low benefit in the setting of terminal illness. A common reason for calling either consultation was when the expectations of the patient or surrogate clashed with that of the attending or floor team. Frequently, the medical team recommended limiting or withdrawing treatment while the family disagreed. The case below is a typical example, but it also illustrates how the two services were used by the medical staff to address the same issue. In this case, when palliative care "failed" to achieve the desired objective, ethics was consulted.

Mr. S was a 67-year-old man who had had multiple myeloma for several years and had relapsed several times after chemotherapy and a bone-marrow transplant. He had briefly been referred to hospice, but changed his mind and opted for salvage chemotherapy, completed by the time of his admission. He was admitted to the hospital for

shoulder pain and shortness of breath and was found to have bacteremia and renal failure, as well as a demand-mediated myocardial infarction. When admitted to the hematology/oncology unit, he had a do-not-resuscitate (DNR) order. Dr. Z, the attending hematologist, initially consulted PC for both symptom management and goals of care (with the hope of setting further limits on treatment). The patient's mental status waxed and waned; some discussions were conducted with him, whereas at other times family members were needed to make decisions. Initially, there was little conflict about the goals of care — the plan was to change back to hospice status. The patient was to continue antibiotics and transfusions as long as they contributed to a quality of life he found acceptable, after which they too would be stopped. An initial palliative care note read:

Spoke with patient's wife — she is looking into hospice options, has spoken with [social worker]. . . . Wife interested in knowing "how long" — likely days-weeks rather than weeks-months. She is accepting of diagnosis.

However, a few days later, a new hematology attending physician, Dr. X, took over the service and wanted to stop the antibiotics. A social worker described the change of direction:

A meeting at 5:30 occurred. Two of their children expressed concern with the discontinuation of antibiotics if we were to switch to hospice. They still concur with their father's decision about DNR, but do not believe that he would wish to discontinue antibiotics. . . . Emotionally Mrs. S appears to have come to terms with the circumstances. She understands that we are gradually moving closer to the end of his life. The children have a more difficult struggle with this than she does, but they are becoming more aware of the changes. . . . I do not believe that they will come to a realization that hospice is the right mode of care for Mr. S.

At that time, the patient's wife told the team she was feeling "pressured" to accept hospice and she wanted her husband to have continued antibiotic treatment. A week later, with the patient's condition clearly deteriorating despite continued antibiotics, a conflict between the attending oncologist and the family was growing. Palliative care continued to meet with the family, but shortly thereafter, Dr. X called an ethics consultation. The ethics consultant met with the attending, the patient and family, and the palliative care consultant. The ethics consultant's note read in part:

Unclear if patient has full capacity, but is able to give assent to current treatment and wife reports she and her 3 children want to continue antibiotics and possible transfusions. Dr. X clearly feels that further aggressive diagnostic or therapeutic trials are unwarranted. Patient family reports they wish continued supportive care. . . . Dr. X does not have to provide medical care which will have no further benefit (e.g., chemotherapy while pancytopenia exists). It is possible that continued antibiotics could extend Mr. S's life for a brief period, and he remains somewhat interactive with his family. It is possible that PRBC transfusion may decrease symptoms of fatigue and dyspnea, so may be included in a palliative regimen.

In this case, an attending physician first consulted PC with the expectation that they would facilitate transition to hospice care. However, when conflict developed between the family and a new attending physician, PC consultants supported the family's wish that antibiotics and transfusions be continued if they contributed to his quality of life. An ethics consultation was requested to convince the family otherwise. The conflict that the ethics team then had to mediate had expanded to include the oncologist and the palliative care consultants as well as the family and patient. The ethics consultant supported the approach outlined by the PC team and family, and helped the attending understand the underlying principles of this decision. A week later, Mr. S's condition declined further. One night, he became alert enough to express a preference for a purely comfort-oriented approach, and made that transition before he died soon thereafter.

Case 2

Absence of a suitable decision maker to represent the patient. This case involved a difficult medicolegal issue around choosing an appropriate surrogate decision maker for a patient who had never had capacity. There was little or no conflict between any of the parties involved. Here, palliative care and ethics consultants had roles that were well demarcated into the respective domains of symptom management and the navigation of the legal system.

Mr. G was a 55-year-old man who had been institutionalized since childhood for profound mental retardation who was found to have large B-cell lymphoma. Potential treatment included chemotherapy, but his behavior was difficult to manage, and he could not sit still for the infusions that would be required. Mr. G had no identified family members or established guardian. Treatment with chemotherapy had a reasonable chance of providing a remission for the patient; there was a consensus that treatment directed at his cancer was in his best interests. The head nurse on the oncology unit was the one who called for the ethics consultation, with the agreement of the treatment team. The initial ethics note addresses the issues of guardianship:

1. It appears the treatment goal is not under dispute here. It is in Mr. G's best interest to receive timely chemotherapy.
2. As long as the situation is urgent according to medical opinion of attendings, hospital policy would permit going ahead with treatment. This would cover all necessary treatment-related procedures to accomplish the goal of administering the chemotherapy safely.
3. There is clear need for a stable, surrogate decision-making process that is legal, readily available, and flexible since the chemotherapy course will be several months, and there will be many unforeseen eventualities that cannot be pinned down in a document ahead of time. I would recommend pursuing legal guardianship.

The next day, the palliative care team was consulted for help managing the practical aspects of Mr. G's care such as how to control his behavior enough so that he could receive the treatment directed at his cancer. The palliative care consultant eventually recommended intubation and sedation as the only way that Mr. G could receive treatment safely, and held a multidisciplinary meeting to discuss how this would be carried out. The PC note read:

I will not reiterate the ethical issues previously addressed by Dr. K. I think that successful administration of chemotherapy will require at least a state of conscious sedation. Given the nursing team's observation of aspiration on Seroquel (which did not control agitation) I think he'll need to be sedated and intubated for the week of follow-up care after chemotherapy. This is clearly a very aggressive plan but without it we can predict an agonizing death for this patient which will require terminal sedation to achieve comfort.

Mr. G's course was not as simple or effective as predicted. He received chemotherapy but then developed respiratory failure and sepsis. The guardianship process recommended by the ethics consultant had to be completed before a subsequent decision could be made to pursue a comfort care approach (a complex logistical process that takes several weeks to months). Two months later, Mr. G died in the intensive care unit (ICU) after having received aggressive treatment.

In this case, ethics and PC were consulted on separate questions. PC assisted with palliation of agitation and planning for controlling behavior and symptoms during chemotherapy, while ethics was consulted with regard to legal and ethical issues about making complex decisions in patients with mental retardation. Once plans for guardianship and chemotherapy with intubation and sedation for this patient were in place, his further care and the process for establishment of a guardian were managed by the primary team. Both palliative care and ethics weighed in later in his course when decisions about treatment withdrawal had to be considered.

Case 3

Conflict between medical staff and family around plans for discharge and then around benefits and burden of treatment. In many cases, central issues changed over time. This case initially involved a family's wish to take a hard-to-manage patient home, and the staff's belief that the plan was both unrealistic and unsafe. The central issue later evolved into conflict between the family and the medical staff around the use of heavy sedation to control behavior.

Mr. E was an 81-year-old retired farmer admitted to the psychiatric floor for agitation and aggression; he had a history of depression and vascular dementia, stroke, and a seizure disorder. He lived at home with his wife; both required 24-hour care. Professional caretakers provided care and supervision during the week, but the patient's two daughters provided care on the weekends. There had been two mental health arrests in the prior weeks for violent behavior toward his wife and talk of suicide. After Mr. E had been in the hospital for two months, palliative care was initially called for assistance. Although the initial consult question was framed as assistance in managing the patient's depression, it became clear that the true question of the attending psychiatrist was whether Mr. E's dementia qualified him for discharge to hospice. The consultant wrote:

Depressed, fluctuating course, refuses to eat and intermittently agitated and combative. States at times wants to die. Currently wants to go home. Family very stressed and are themselves suffering to have him suffer so much.

However, Mr. E was still independent in his daily activities and showed no sign of dying within six months, and the palliative care consultant's assessment was Dementia — mild/moderate. At present, does not meet hospice criteria. Later palliative care notes mentioned that although Mr. E's visits with his daughters were difficult and his wife rarely visited, Mr. E was interactive with his grandson, and they appeared to enjoy each other's company. The role of the palliative care consultant became helping the daughters cope with their guilt about their inability to take him home, and assistance with managing his verbally and physically abusive behavior. The PC and the psychiatric attending service worked together to manage the patient's agitated depression; ultimately, the patient received electroconvulsive therapy.

However, nearly a month later, Mr. E was still in the hospital because of difficulty finding a suitable placement for him given his difficult behavioral problems, and the daughters were again in conflict. One daughter requested heavy sedation for her father, who remained confused and at times agitated despite multiple medication trials. The attending physician felt this would be inappropriate, equating it with euthanasia, and the palliative care team felt that Mr. E's symptoms were not severe or intractable enough to warrant heavy sedation. The daughter then independently initiated an ethics consultation. The ethics consultant had a lengthy family meeting with the patient's four children, and wrote in the chart:

Discussed palliative sedation — family does not want patient to continue to suffer. He has had violent agitation at times. Discussed patient is sometimes distressed, but not having physical pain, and not imminently dying, so does not meet general criteria for when terminal sedation might be considered. Discussed — spiritual suffering — might benefit from increased chaplain/priest involvement.

Thereafter the ethics consultant assumed the role that palliative care held previously, as a mediator in the internal conflict between family members and with the attending physician. The patient was not heavily sedated, and ultimately was transferred to a behavioral unit in another city.

In this case, PC and ethics were consulted sequentially at separate times in attempts to deal with a worsening clinical and interpersonal situation. Initially, PC helped the family come to grips with the fact that the patient could not return home, and then helped manage his agitation while alternative plans for placement were developed. Later, the possibility of heavy sedation was brought up by one daughter who was having particular difficulty dealing with her father's behavior. The issue was framed as concern about the patient's suffering, but the family's distress also prompted the request. Although PC redirected the case

toward symptom management and an appropriate disposition, the conflict continued to escalate as the patient's hospital stay lengthened. When a request for heavy sedation was "turned down" by palliative care, the family requested an ethics consultation and made the same request. The ethics consultation was able to support the PC team's recommendations and help find a solution to the patient's discharge plans.

Case 4

Decision making when a patient's capacity was uncertain. Another common setting for dual consultations occurred when there was difficulty with the decision-making process due to uncertainty regarding the patient's mental capacity. In some instances, surrogates had difficulty making decisions; in others there was no suitable surrogate decision maker or guardian. Case 2 above (Mr. G) is an example of a guardianship case.

Mrs. P was an 83-year-old woman who had been in an assisted living facility, admitted to the hospital with decreased responsiveness. She had a meningioma, which was worsening and causing increasingly debilitating symptoms. She was found to be severely thyrotoxic and needed a biopsy to rule out thyroid cancer. With her limited overall prognosis, it was uncertain if she would benefit from or want treatment for a thyroid cancer. When she was more capable of making decisions, she had been allowing her potentially curable meningioma to progress naturally without treatment, but at this point, it was unclear whether Mrs. P had full decision-making capacity. For the past several months at the nursing home, she had sometimes been confused, but at other times she was able to answer yes or no questions and to make simple decisions for herself. Her ability to speak English was also limited. Several messages were left for the patient's son, who replied that he did not want to participate in her care.

An ethics consultation was called first to explore treatment and consent issues. The initial note summarized the issues in question:

Several ethical issues are evident. First, she has no advance directive, proxy, or POA [power of attorney], and has not stated to her PMD [primary MD] or to [the nursing home] staff any requests for end-of-life care. She also has no DNR order at [the nursing home] or in the hospital. Second, it is not certain how to address her thyroid crisis. A medically invasive procedure (biopsy) is required to rule out cancer. The biopsy alone is risky; it can send her into a fatal thyroid storm. . . . According to [the nursing home], Mrs. P has limited capacity: she was able to make simple decisions for herself with "yes/no" answers. She can probably consent to medical procedures that are simple, low-risk, and high-benefit. It is unlikely, however, that she was able to make major decisions regarding her medical care, such as brain surgery or other high-risk procedures even before this hospitalization. In these situations, a high decisional capacity is desired to ensure a complete understanding of risks and benefits.

The consultant concluded by recommending guardianship and medical treatment of thyrotoxicosis until a decision for or against thyroid biopsy could be made by the guardian. Two days later, the patient's mental status continued to decline and a two-physician DNR was signed based on the lack of utility of cardiopulmonary resuscitation, as well as her past statements and decisions about treatment of her meningioma. The attending physician requested a PC consultation to help with symptom management. Their recommendations included morphine drip, scopolamine patch, and Ativan around the clock. Based on Mrs. P's poor prognosis, high level of suffering, and prior statements, the consultant recommended:

Consider change to comfort approach only — i.e., discontinue decadron, tube feeds, antibiotics, nasal trumpet, etc. As 2 physician DNR has been invoked, would consider extension to 2 physician consensus to provide medically appropriate care (as recommended above).

In this case, ethics was involved first to assist in identifying a suitable surrogate decision maker. The guardianship process was initiated, and the ethics consultant also recommended medical treatment of Mrs. P's thyrotoxicosis, hoping that her decision-making ability would return with treatment. Palliative care was involved in a different phase of the case; its role was assisting with symptom management, but also to

maximize the patient's mental capacity, and to also assist with medical decision making in the absence of a surrogate decision maker. PC supported the ethics opinion that a DNR decision could be made in the interim without a surrogate, while awaiting the conclusion of the guardianship process based on the patient's prior wishes and the lack of utility of CPR in her current condition.

Case 5

Decision-making support. There were 16 dual consultation cases that involved families who needed varying degrees of support or help in clarifying values to make decisions on behalf of a family member who had become incapacitated. These cases fell on a continuum: in some cases, the family was noted to be "vacillating" (frustrating the staff by changing their decisions or refusing to make a decision); in others, there was disagreement within a family about the proper way to proceed; and in still others, as in the case below, the family needed time and support before it could make difficult medical decisions.

JB was a full-term, eight-week-old infant born with several serious cardiac and other anomalies. She was admitted to the tertiary care hospital for surgery, but after two weeks it became clear that she was not a candidate for repair of her defects. JB's mother and extended family were overwhelmed by these new developments. While JB's grandmother expressed a willingness to allow treatment to be stopped, JB's 23-year-old single mother was at times angry with the staff, at other times tearful, and required repeated explanations of the situation. One physician noted that she seemed "uninformed and ill-prepared," despite multiple meetings. Clinicians in the neonatal intensive care unit called an ethics consultation to help the family understand the situation. At this meeting with the ethics team, JB's family seemed to understand that the infant could not survive for long, but, according to the chart note:

They did express the belief that stopping or withholding interventions would feel to them like deciding JB should die. They were encouraged to review with Dr. S the entire list of interventions currently being provided, and, for each one, to understand its purpose and whether it contributes to JB's comfort.

The mother was not ready to agree to a DNR order or to any other limitation on treatment. After continued discussions, the ethics consultant suggested that palliative care become involved. The palliative care clinician then also began discussions with the mother and the rest of the family. Her note read in part:

Lengthy discussion re: JB's current health status, discussed chest compressions as they would be associated with JB's eventual decline. [The mother] stated: "I know JB is terminal. I am not ready to do a DNR — I just want to be able to hold her if that happens."

In this case, both palliative care and ethics consultants served as added supports to the family, helping them follow the recommendations of the team to avoid putting the infant through medically futile CPR that would not bring her back, would only add to her suffering, and would take her out of the mother's arms at the very end of her life. A few days later, the family had received enough support to be able to make the decision, and JB died without receiving a futile attempt at cardiopulmonary resuscitation.

Here, not only did the infant's mother and other family members need support, but the clinical team needed help dealing with the patient's mother, who often took her anger and grief out on them, as well as dealing with their own grief over the loss of a child. This case illustrates how palliative care and ethics can work jointly. With overlapping roles, the two services can provide the assistance needed to help family members to understand a medically devastating situation and to provide support to family members and clinical staff when a decision is not easily reached.

LIMITATIONS OF THIS REPORT

Initial palliative care and ethics consultation notes were analyzed retrospectively for this report, and no additional information was gathered from the medical staff or the chart except for the five cases presented in more depth. There are significant limitations to this approach. First, the consultation notes from the ethics service in particular did not use a template, and varied considerably in their depth and detail. Although both services provide consultations independent from one another, they both reside in the same administrative center, and this might introduce bias and minimize conflict between consultants. The main descriptive analysis was limited mainly to a review of initial consultation notes, which may not have fully reflected some of the more sensitive issues that might have emerged with a more extensive chart review or interview of additional consultants or family members. Staff-staff conflict is probably underrepresented in this regard, as it was likely played down in the official chart notes. In addition, some members of our research group were themselves involved in the cases as ethics (JG and RD) or palliative care (TQ) consultants. They may have been able to provide a better sense of where the conflicts lay, but their personal biases might have influenced the description and analysis. This bias is minimized by the fact that the author who performed the chart reviews, conducted the interviews, and selected the cases and quotations from chart notes (JC) was not personally involved in any of them.

A more objective in-depth study would include longitudinal review by an independent rater of all cases from time of consult to disposition, augmented by interviews with staff and patients or families about their perceptions of conflict and reasons for consulting the two services.

IMPLICATIONS

In these cases, both palliative care and ethics services were called to manage often-overlapping domains of concern affecting patients, families, and medical staff. By far, the dominant concern involved questions about offering or continuing treatments with high burden and low benefit in the context of advanced terminal illness. The usual conflict was patient/family desire to continue aggressive treatment, and medical staff who thought it was more appropriate to withhold or withdraw. In more than 80 percent of the cases, some kind of conflict mediation was involved, most commonly between family and staff, but also within families and sometimes among different elements of the medical staff. The distribution of clinical issues involved in dual consultations parallels previously identified studies of ethics consultations that have found that end-of-life considerations, communication issues, and conflict resolution predominate.

If these dual consultation cases often deal with issues that usually are managed by either consultant service alone, why use both services? Some of the illustrative cases above show how the clinicians and even families may consult the two services in sequence, at times because they are not satisfied with the resolution provided by the first consultation (as in cases 2 and 3). In other cases, the addition of a second consultation may provide additional assistance in a clinical situation that is escalating in difficulty. The additional consultation service could provide another level of support and expertise in handling conflict. This is shown in the case of the infant JB (Case 5), in which the palliative care and ethics consultants were called because of the emotional and medical complexity of the case to help support and assist both family and staff. In cases when roles overlap, PC and ethics teams functioned best when there was clear communication and collaboration between the two services.

On other issues the palliative care and ethics consultants had distinct roles. Assisting with symptom management and/or addressing practical clinical issues around treatment withdrawal most sharply defined palliative care's distinct role. In contrast, the ethics team was exclusively involved with requests to assist with obtaining guardianship for someone who clearly did not have capacity or when other medicolegal questions were at issue. These disparate roles played out most clearly in Case 2, where ethics was called to establish a legal guardian and palliative care was involved to help with the logistics of managing symptoms and the behavioral challenges the patient faced in receiving chemotherapy.

Since conflict of one kind or another was central in more than 80 percent of these cases, the role of the dual consulting teams was often to try to resolve this conflict and help medical decision making move forward. Many times, the themes identified within a given consultation overlapped and were multidimensional. These consultations were complex and frequently did not yield a simple or straightforward resolution. These overlapping consultations have raised questions for further research. Applying ethnographic interviewing techniques with patients, families, and staff going through these dual processes in real time, or perhaps focus groups with patients or families and medical caregivers after the fact may help tease apart the multilayered factors that contribute to the complexity of these cases. The importance of such future research is underlined by the challenging nature of these cases for all involved, as well as the relative lack of knowledge about the dual consultation processes.

NOTES

1. R.S. Morrison and D.E. Meier, "Palliative Care," *New England Journal of Medicine* 350, no. 25 (June 2004): 2583-90; J.A. Billings and S. Pantilat, "Survey of Palliative Care Programs in United States Teaching Hospitals," *Journal of Palliative Medicine* 4, no. 3 (September 2001): 309-14; S.E. Morrison et al., "The Growth of Palliative Care Programs in United States Hospitals," *Journal of Palliative Medicine* 8, no. 6 (December 2005): 1127-33.

2. S.J. Youngner et al., "A National Survey of Hospital Ethics Committees," *Critical Care Medicine* 11, no. 11 (November 1983): 902-5; D.F. Kelly and J.W. Hoyt, "Ethics Consultation," *Critical Care Clinics* 12, no. 1 (January 1996): 49-70.

3. C.F. Von Gunten et al., "Prospective Evaluation of Referrals to a Hospice/Palliative Medicine Consultation Service," *Journal of Palliative Medicine* 1, no. 1 (March 1998): 45-53.

4. V. Srijnemaekers et al., "A Comparison between Telephone and Bedside Consultations Given by Palliative Care Consultation Teams in the Netherlands: Results from a Two-year Nationwide Registration," *Journal of Pain and Symptom Management* 29, no. 6 (June 2005): 552-8; K. Virik and P. Glare, "Profile and Evaluation of a Palliative Medicine Consultation Service Within a Tertiary Teaching Hospital in Sydney, Australia," *Journal of Pain and Symptom Management* 23, no. 1 (January 2002): 17-25; D.E. Weissman, "Consultation in Palliative Medicine," *Archives of Internal Medicine* 157, no. 7 (April 1997): 733-7; J. Way, A.L. Back, and R. Curtis, "Withdrawing Life Support and Resolution of Conflict with Families," *British Medical Journal* 325, no. 7636 (March 2002): 1342-5; P.L. Manfredi et al., "Palliative Care Consultations: How Do They Impact the Care of Hospitalized Patients?" *Journal of Pain and Symptom Management* 20, no. 3 (September 2000): 166-73.

5. American Medical Association, Opinion E-9.115, "Ethics Consultations," in *Code of Medical Ethics*, 2008-2009 ed. (Chicago: AMA, 2008).

6. 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, no. 2 (November 1998): 252-9.

7. R. Forde and I.H. Vandvik, "Clinical Ethics, Information, and Communication: Review of 31 Cases from a Clinical Ethics Committee," *Journal of Medical Ethics* 31, no. 2 (February 2005): 73-7.

8. G. DuVal et al., "What triggers requests for ethics consultations?" *Journal of Medical Ethics*, suppl. 1 (April 2001): i24-9; K.M. Sweitz et al., "Report of 255 Clinical Ethics Consultations and Review of the Literature," *Mayo Clinic Proceedings* 83, no. 6 (June 2007): 686-91.