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Clinical Ethics Consultation

HCEC Pearls and Pitfalls: Suggested Do's and Don't's for Healthcare Ethics Consultants

*Joseph A. Carrese and Members of the
American Society for Bioethics and Humanities
Clinical Ethics Consultation Affairs Standing Committee*

ABSTRACT

Members of the Clinical Ethics Consultation Affairs Standing Committee of the American Society for Bioethics and Humanities present a collection of insights and recommendations developed from their collective experience, intended for those engaged in the work of healthcare ethics consultation.

INTRODUCTION

Healthcare ethics (HCE) consultants play an important role in improving the quality of care for patients and family members when an ethics concern is present.¹ HCE consultation ("ethics consultation") is one of several services that HCE consultants may provide.² During ethics

case consultations, HCE consultants (HCECs) are invited to become involved in some of the most challenging issues facing clinicians as they care for patients. Accordingly, the stakes are often high when HCECs review a case and make recommendations. For example, they may be called in when there is uncertainty or conflict about the goals of care for a patient that affects decisions about aggressiveness of medical treatment at the end of life. Clearly, assuring that HCECs are adequately prepared and sufficiently skilled to undertake the complex challenges encountered in their work is a major priority for all stakeholders. In addition, HCECs have a responsibility to improve the quality of the ethics consultation service they staff.

The American Society for Bioethics and Humanities (ASBH) created the Clinical Ethics Consultation Affairs committee (CECA) to advise it with respect to issues related to improving the quality of HCECs. In addressing this broad mandate, CECA is interested in disseminating information to front line HCECs that will be useful as consultants do their work, and that will in turn facilitate the goal of improved quality and excellence with respect to HCECs and consultation services.

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It is with this in mind that CECA members present “HCEC ‘Pearls and Pitfalls,’ ” a collection of insights and recommendations developed from the collective experience of CECA members intended for those engaged in the work of HCE consultation. These “Pearls and Pitfalls” are not formally endorsed by ASBH. They are intended as a resource for HCECs who desire to improve professionally, in part by learning from the experience of others.

PROCESS

The 12 “Pearls and Pitfalls” presented in this article were generated by members of CECA through a process that included in-person discussion and other forms of communication (for example, phone, email) over a period of two years. This list is not intended to be an encyclopedic account of everything HCECs need to do or bear in mind in the course of their work. For a more comprehensive account of what HCECs need to be aware of, know, and what skills they need to have, access ASBH’s *Core Competencies for Healthcare Ethics Consultation*.³ With this qualification in mind, consensus exists among members of CECA about the importance of these 12 items. Our intent is to periodically disseminate additional “Pearls and Pitfalls” through published journal articles and postings on the ASBH website (<http://www.asbh.org/about/content/asbh.ceca.html>).

HCEC PEARLS AND PITFALLS

1. Don’t assume that the question you are asked to address is a matter of ethics, or that it is the primary issue or the only issue. Do take the time to clarify for yourself (and your team) the following: What are the relevant concerns, and are they a matter of ethics? Those requesting an ethics consultation recognize that a problem exists. However, they may not be able to accurately determine whether the problem is truly a matter of ethics or not, and even if they can, they may not be able to correctly articulate the precise nature of the ethical concerns (that is, the values about which there is uncertainty or conflict). Further, requesters may not appreciate that, in addition to the question(s) they

have raised, other important ethical concerns may be involved. One important task for HCECs, then, is to determine if the request is appropriate for ethics consultation and, if so, to clarify the ethical concern(s).⁴ If the request does not involve an ethics question (that is, what should be done in the face of uncertainty or conflict about values), it should be referred to other resources in the healthcare system that are better equipped to handle such requests. For example, if the requester is seeking a legal opinion, he or she should be referred to legal counsel. Similar to making a diagnosis in clinical medicine, where precision in diagnosis leads to appropriate intervention, clearly and accurately identifying and describing the ethical concerns in an ethics consultation will more likely lead to a correct and helpful analysis and appropriate recommendations. Another parallel to clinical medicine is that, as the case unfolds over time, new issues may emerge. An initial set of questions, even when addressed and resolved, may lead to awareness of new ethical issues as the case evolves. The consultant should be attentive and open to this possibility and revisit the ethics question(s) in the consultation, as needed.

2. Don’t conduct ethics consultations a different way each time. Do have a standardized and systematic approach for gathering, analyzing, and synthesizing information. “Excellence is an art won by training and habituation: we do not act rightly because we have virtue or excellence, but we rather have these because we have acted rightly; . . . we are what we repeatedly do. Excellence, then, is not an act but a habit.”⁵ Excellence in ethics consultation, as in any other pursuit, is not an accident. It is borne of commitment, training, and the habit of approaching our work with high standards and rigor, every single time we do a consultation. One strategy for facilitating high quality ethics consultation is to have a standardized process for conducting consultation that is thorough, systematic, and employed every time. Approaching one’s work differently each time increases the likelihood of omissions and mistakes. Many strategies for conducting healthcare ethics consultations have been suggested.⁶ We do not endorse a particular strategy; rather, we urge HCECs and consultations services to se-

lect and use one strategy consistently—that is, to make it a habit, so that quality is enhanced and excellence can be achieved. Another advantage of a consistent approach is that, over time, those who request assistance from HCECs learn what to expect.

3. Don't come to premature closure about the issues involved and the options available. Do take the time necessary to be thorough in each step of the consultation process. One basic rule in clinical medicine is resisting the temptation to arrive at a conclusion prematurely.⁷ Instead, the preferred approach is to be careful, deliberate, and thorough before arriving at a conclusion. The same applies to HCE consultation. Thoroughness in all phases of the consultation process may take more time, but this approach is more likely to result in sound recommendations. HCE consultants should adhere to a systematic approach for gathering information (such as one of those referenced in Pearl 2) that begins with careful chart review (for case consultation), proceeds to interviewing stakeholders, and includes careful reflection along the way. Similarly, a thorough approach should be employed when analyzing the gathered information and when identifying, and, in turn, evaluating, ethically acceptable options. One strategy to contemplate when considering this “Pearl” is to periodically ask oneself and others involved in the consultation the following questions: Have we missed anything? Is there anything we haven't considered or anyone from whom we haven't heard? Have we accounted for all relevant perspectives? Are we aware of our assumptions and have we assessed them? Are there other possible explanations for what is happening? Have any new issues emerged since we started the consultation? Have we challenged ourselves to think creatively to identify additional ethically supportable options?

4. Don't conduct informal “curbside” consultations when making recommendations about a specific patient. Do conduct formal case consultations that are documented in the patient's medical record. There are times when physicians and nurses ask HCECs for advice over the phone or in the hallway and there can only be a brief exchange of information and ideas.

Staff may desire a quick answer and may want to avoid initiating a consultation process that may take some time to complete. Forces conspiring to truncate the ethics consultation process can, at times, be very significant. A concern related to quick, curbside consultations is the possibility of incomplete appreciation by HCECs of all of the relevant facts and considerations. This in turn could lead to inappropriate or unfounded advice. In contrast, a formal, deliberate approach to gathering information and discussing the issues that have been raised enhances the likelihood that the process and outcome will be of the highest quality. In addition, a telephone or hallway conversation is not captured in the medical record, and is therefore not available for other members of the healthcare team to review and reflect upon. A carefully written formal consultation note placed in the medical record is available to others and serves as evidence that important issues in the case were carefully considered by HCE experts.

However, despite the preference for formal consultation, HCECs should be sensitive to the needs and limitations of those who may desire their services but are not willing or able to engage in a formal case consultation process. Consultants should develop strategies for being responsive, engaged, and helpful, even when a formal case consultation is not being requested.⁸ For example, it is acceptable for HCECs to educate and offer generic advice to colleagues. An HCEC might be asked by a colleague to review and explain the key steps in assessing decision-making capacity, as a point of general information. Similarly, an HCEC, before being invited to undertake a formal case consultation, might advise careful communication between key stakeholders (such as a meeting between staff and family members). The key issue here is role clarification. There is an important distinction between providing general education or coaching about communication principles and giving specific advice about a particular patient that may lead to important decisions about that patient's medical care. HCECs need to be aware of this distinction, be clear about their role, and avoid offering specific advice about a particular patient unless it is in the context of a formal case consultation.

5. Don't allow the HCE consultation discussion to be dominated by particular individuals. Do be facilitative, inclusive, and a good listener. The work of an HCEC, by definition, involves interaction with multiple parties, including patients, family members, and staff. Clearly, either in one's role as a member or as a leader of a consultation team, it is essential to ensure that all perspectives are given voice and that all stakeholders feel included and respected. If one person dominates the conversation, there is a risk that important information will not be communicated. Attention to core dialogue skills such as suspension of judgment, identification of the assumptions being made, skilled listening and inquiry, and reflection helps to create an inclusive, facilitative process.⁹ This "ethics facilitation approach"¹⁰ decreases the likelihood of missing crucial information and enhances the probability of arriving at an optimal understanding of the situation.¹¹

6. Don't assume your written consultation note will be understood without verbal communication. Do use the consultation as an opportunity to engage healthcare staff in direct conversation to explain and teach. One basic premise of optimal HCE consultation is optimal communication. Usually this means direct verbal communication with members of the requesting service to review key recommendations and associated reasoning, in addition to generating a written consultation note.¹² Direct verbal communication increases the likelihood that consult participants will understand the specific ethical concerns raised during the consultation, in part by creating an opportunity for questions to be asked and addressed. In this way, direct verbal communication reduces the risk of confusion or misunderstanding. In addition, many HCECs consider teaching and education to be part of their core mission—that is, to help those involved learn to work through ethical uncertainties and disagreements on their own.¹³ Engaging members of the requesting service in conversations throughout the consultation process is one way to fulfill the HCEC's teaching mission.

7. Don't assume you are doing a good job. Do invite evaluation of your consultations from those requesting and/or participating in them.

A basic principle of quality improvement is to evaluate what you are doing. One way to evaluate ethics consultation is by getting feedback from end users.¹⁴ While hard work and good intentions are important, they alone don't ensure that HCECs are doing the best job possible. For example, ethics consultants have blind spots like everyone else: interactions may be perceived by others as suboptimal in ways that HCECs cannot appreciate. Inviting feedback about specific aspects of the consultative process from those who requested and participated in the consultation is a useful way to better understand what is going well and what needs attention and improvement. The Department of Veterans Affairs Integrated Ethics initiative has many useful resources, including an evaluation tool that can be used to assess participants' perceptions of consultation performance.¹⁵ Using this tool or a similar evaluation instrument after every consultation, combined with periodic review and discussion of aggregated feedback results, is an important step toward making necessary adjustments and providing better ethics consultation services. Examples of domains about which HCECs might invite feedback include respecting the opinions of the requestor, giving useful information, explaining effectively, clarifying decisions to be made, clarifying appropriate decision makers, identifying and describing ethically supportable options, and being accessible and timely.

8. Don't assume that everyone who needs an ethics consultation will know that they need one, or even know that a consultation service exists. Do engage in outreach to raise awareness about the existence and role of the HCE consultation service. Fox and colleagues found that 80 percent of U.S. hospitals and 100 percent of hospitals with 400 or more beds have an ethics consultation service.¹⁶ However, patients, family members, and members of the hospital community who may be involved in patient care and who may be in a position to request an ethics consultation may not be aware that a consultation is needed, or they may not be aware of the existence of the HCE consultation service as a valuable resource. Lack of awareness that an ethics consultation is needed could be addressed by informational and educational out-

reach in a variety of forums in both the community and in the healthcare facility. The goal of these efforts should be to increase understanding about clinical ethics concerns and raise awareness about the HCE consultation service as a resource for addressing these concerns. HCECs should be mindful of how they describe and market the ethics consultation service to avoid the common misconception that requesting an “ethics consultation” means that someone has done something “unethical.” In this regard, it may be more useful and less threatening to describe an ethics consultation as a way of protecting a “moral space” for staff to reflect on complex issues.¹⁷

9. Don’t assume that everyone who wants an ethics consultation will feel empowered to ask for one. Do take action to reduce barriers to consultation requests. Individuals who may be in a position to request an ethics consultation may not feel empowered to request one. Lack of empowerment among healthcare providers to request a consultation may occur for a variety of reasons, including a suboptimal work environment, suboptimal relationships with colleagues, or fear of retribution for “rocking the boat” or “whistle-blowing.” Some of these potential reasons may be related to a staff member’s location in the organizational hierarchy.¹⁸ An unfortunate consequence of this situation is that moral distress is often suffered by staff members who believe that requesting an ethics consultation is the right thing to do, yet who feel uncomfortable requesting a consultation, either because the risks are too high or they are actively prevented from doing so.¹⁹ Lack of empowerment among patients or family members to request a consultation may relate to fears of offending members of the healthcare team. Strategies for addressing these barriers include clear institutional policies and procedures asserting open access to HCE consultation;²⁰ and ongoing outreach and education by HCECs. Education should be directed toward staff, who may desire an ethics consultation but who are not able or willing to request one over and against resistance by others, and those who are likely to be resisting a consultation request in the first place. Attention should be paid to how the ser-

vice is described and marketed, as mentioned in Pearl 8.

10. Don’t confuse legal considerations with HCE consultation. Do recognize the appropriate roles and contributions of legal considerations in HCE consultation. While legal considerations (including risk management and legal precedent) and ethical concerns related to a particular case may overlap considerably, they are not synonymous. This is not surprising, because their ultimate purposes differ, and the key stakeholders may be different. For example, in risk management, one goal is institutional protection, and the key stakeholder is typically the institution itself. For HCE consultation, the ultimate goal is arriving at healthcare decisions that are ethically optimal and defensible, and the key stakeholder (particularly in a case consultation) is typically a person, such as a patient or a staff member. Similarly, while legal considerations (such as case law or relevant state/federal legislation) may be very germane and inform ethical thinking about a case in important ways, what legal counsel might advise may differ from what the HCEC might recommend. Accordingly, the HCEC must resist the temptation to simply follow the guidance of legal counsel or risk managers, and instead arrive independently at positions and recommendations based on ethical principles and considerations.

11. Don’t be too sure of yourself. Do embrace the complexity of each case with a healthy dose of humility. Humility in an ethics consultant is a desirable, if not necessary, trait. Important features of humility are self-awareness, careful reflection, and a respectful attitude towards others. There are many reasons to embrace humility: the absence of a clear, right answer; the uncertainty often present in clinical medicine that permeates many cases for which HCE consultations are requested; the fact that reasonable people can and often do disagree about how to regard the same set of facts; the reality that consultants’ abilities to know and understand is limited and imperfect. Humility may have the added value of positioning a consultant to be open to and even actively seek alternative perspectives, which may lead to a more complete

process, and ultimately to better consultations. Finally, humility may help consultants appreciate the boundaries of their role and serve as a check to overstepping their authority during a consultation.²¹ Humility, therefore, is the proper disposition of consultants.

12. Don't do it all on a shoestring. Do advocate for adequate resources and support for yourself and your fellow consultants. In an era when most of us are accountable to someone for how we spend our time, and for how our time is supported, securing adequate resources for the important work we do is essential. Otherwise, the risk is that the time we are able to spend on this work is shortchanged, and the goal of conducting high quality consultations is threatened. There are many aspects of HCECs' work that could benefit from financial support. A partial list includes: continuing education related to ethics consultation, and to clinical ethics more broadly, for members of the consultation team; educational sessions provided by the institution's HCEC(s) for staff and for the greater community; compensation for time spent doing HCE consultations. HCECs should establish effective working relationships with institutional administrators to address the issue of adequate support for their work, broadly defined.

CONCLUSION

HCECs are involved in critically important work requiring unique awareness, particular attributes, and a demanding range of knowledge and skills. The mandate of ASBH's CECA committee is to take steps to improve the quality of HCECs and the work they do. One effort to address this mandate is for CECA to periodically share with other HCECs a collection of "Pearls and Pitfalls" with respect to approaching and conducting the work of HCE consultation. This article presents an initial list of such "Pearls and Pitfalls." In addition, space has been established on the ASBH website (<http://www.asbh.org/about/content/asbh.ceca.html>) for readers to view these "Pearls and Pitfalls," share feedback about them, and to offer their own HCE consultation suggestions, which could inform future iterations of "Pearls and Pitfalls."

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