Acute clinical ethics consultation: the practicalities

Andrew W Gill, Peter Saul, John McPhee and Ian Kerridge

ABSTRACT

- In Australia there has been only limited experience with ethics consultation, and there are no reports of practical details.
- In 1999, the Institutional Clinical Ethics Committee at John Hunter Hospital, Newcastle, initiated an Acute Clinical Ethics Service (ACES) to formalise a perceived need within the hospital for ethics consultation. This need had previously been met by ad-hoc councils of "wise men".
- The ACES approach uses a team of people with different perspectives to provide an ethics consultation in a timely manner.
- Our initial experience of ACES has shown that
  - a formal process of ethics consultation may be preferable to informal approaches in many circumstances;
  - even when genuine consensus is not possible, an ethics consultation nevertheless provides an opportunity to share different points of view and helps to avoid practices that may be unacceptable.
- The specific implications of acute ethics consultations are not yet fully elucidated.

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When faced with decisions that take them outside their moral "comfort zone", clinicians have traditionally turned to their respected colleagues for guidance. While practical, this "three wise men" approach can be criticised on several grounds: it is unrepresentative of non-clinical views, it is likely to reinforce the values of the clinician who seeks the consultation, it misconstrues questions of value as questions of technical expertise, and it assumes that medical expertise confers the capacity to make difficult moral decisions. Moreover, informal approaches are becoming less tenable as surveillance of professional practices continues to increase.

To address these criticisms, more formal processes of ethics consultation are being developed.[1,2] However, these consultation processes have provoked controversy because of perceived problems with legal liability,[3] definition of the skills required,[4] erosion of professional responsibility,[5] and lack of formal evaluation.[6] These objections are countered by assertions that consultations contribute to patient safety,[7] that they may be seen by courts as contributing to "due process",[6] and that they may "support and enrich the clinical process".[5]

Experience with clinical ethics consultation in Australia is limited and there are no reports of practical details. This is important, as the success or failure of ethics consultations is likely to hinge on practical details of process. The John Hunter Hospital Institutional Clinical Ethics Committee in Newcastle, NSW, undertook to provide an ethics consultation service in 1999 after a staff survey demonstrated in-principle support for such a service.[8] The organisational principles of the John Hunter Hospital Acute Clinical Ethics Service (ACES) are outlined in the Box. Since its inception, ACES has dealt with about 12 cases each year. Three cases are summarised here to illustrate the variety of consultations, and to provide a basis for discussing potential benefits and pitfalls of a hospital-based ethics consultation service.

Case 1: Withdrawal of treatment from an elderly patient

Mrs A, aged 83, was admitted to hospital after a stroke that left her paralysed on the left side and requiring enteral nutrition via a jejunal feeding tube. She had a decreased level of consciousness and was only rarely able to sustain brief conversations. Her chances of survival or successful rehabilitation were believed to be extremely poor. Given her circumstances, members of Mrs A's family and the clinical team raised the question of withdrawing or withholding treatment. This discussion prompted the treating neurologist to request an ethics consultation.

The ACES team established that the main goal of treatment for Mrs A was not curative but palliative, aimed at ensuring maximum comfort and minimum suffering. The team also noted that one of the major difficulties in this case was in ascertaining the true burden of her condition to Mrs A, as opposed to the perceived suffering witnessed by her family and caregivers. The ACES report recommended that it may be appropriate to observe her progress without escalating medical intervention (a "trial of life"), that enteral feeding could be withdrawn, and that analgesia be provided as required. The family and staff were provided with a written copy of the consultation and expressed satisfaction with the negotiated outcome. The patient subsequently died of hypostatic pneumonia. In this instance, the ACES consultation assisted in resolution of conflict between the healthcare team and the patient's family and enabled the omission of unwanted or likely non-beneficial treatment.

Case 2: Late termination of pregnancy involving Down syndrome

A pregnant woman was referred to the prenatal service at 25 weeks' gestation, during her third pregnancy. Ultrasound examination at 25 weeks indicated the fetus had duodenal atresia and was possibly affected by Down syndrome (trisomy 21). This diagnosis was subsequently confirmed by amniocentesis, prompting the parents to request that the pregnancy be terminated. At this point the treating obstetrician requested an ACES consultation. The

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Women's and Children's Health Service, King Edward Memorial Hospital, Subiaco, WA.
Andrew W Gill, FRACP, Neonatologist.
Intensive Care Unit, John Hunter Hospital, New Lambton Heights, NSW.
Peter Saul, MRCP, FRCA, FFICANZCA, Intensive Care Physician; and Director, Clinical Unit in Ethics and Health Law, University of Newcastle.
Centre for Values, Ethics and the Law in Medicine, University of Sydney, Sydney, NSW.
John McPhee, BCom(Hons) (LegStud), Legal Academic; Ian Kerridge, MPhil(Cantab), FRACP, FRCPA, Associate Professor in Bioethics; and Haematologist, Westmead Hospital, NSW.
Reprints will not be available from the authors. Correspondence: Dr Andrew W Gill, Women's and Children's Health Service, King Edward Memorial Hospital, Bagot Rd, Subiaco, WA 6008.
andy.gill@health.wa.gov.au

ACES team subsequently met with the obstetrician, the obstetric social worker and a labour ward midwife. Although supporting the process, the parents declined direct involvement.

After reviewing the case, the ACES team elected to support the mother's request for a termination of pregnancy, placing emphasis on maternal autonomy. However, the team advised that this course of action would only be acceptable if the woman received further counselling and provided the labour ward staff were willing to carry out the procedure. The ACES team also recommended that the case be referred to the hospital's Chief Executive Officer (CEO), on the grounds that it had wider implications for the staff and hospital.

The referring obstetrician followed this advice. The CEO asked for a formal psychiatric opinion (the pregnancy was not considered to represent a risk to the mother's mental health), and asked that the full body of the Institutional Clinical Ethics Committee (including the original ACES team) meet to review the case. During this subsequent meeting, consensus was not achieved, despite lengthy debate. The Committee concluded that this reflected broader disagreement within the community over abortion, and that the case review had nevertheless clarified the clinical and moral dimensions of the case.

After taking advice from several different sources, the CEO declined to authorise termination of pregnancy. When informed of this decision 2 weeks after their original request, the family accepted the result and expressed appreciation of the way in which their request had been handled. Despite advice that they could seek care elsewhere, the family chose to have obstetric care and subsequent delivery at the same hospital.

While, in this case, the ACES consultation did not resolve moral differences between the patient and the healthcare team, or between members of the hospital community, it did have other benefits. Firstly, it enabled clarification of the relevant ethical issues and elucidation of points of moral convergence and points of difference. Secondly, it ultimately improved the process and outcomes of patient care by ensuring that the decision-making process was inclusive, educational and mutually respectful.

Case 3: A "do not resuscitate" order for an intellectually handicapped child

A paediatric surgeon had been asked to schedule a gastrostomy for an 8-year-old boy who was severely intellectually and physically disabled. At the initial consultation, the child's mother requested a "do not resuscitate" (DNR) order be in effect at the time of this procedure. The surgical and anaesthetic team were apprehensive about this request and consulted the ACES team to discuss the issues raised.

The ACES team facilitated a meeting of the clinical staff. The parents were informed of the process but not included at this stage. Agreement was reached on certain key points: that decisions should be made in the best interests of the child (there was very strong supporting evidence that the maternal request for a DNR order was made from this standpoint), and that implementing some form of DNR order was appropriate in this case. A significant portion of the meeting was spent discussing the specifics of a DNR order. The anaesthetist was reluctant to consider not resuscitating in the event of anaesthetic complications, and the surgeon felt compelled to correct any unforeseen surgical complications. Finally, it was agreed that the details of the DNR order should be formulated in consultation with the family and should take into account the limitations requested by the anaesthetist and surgeon.

The healthcare team was generally appreciative of this process and spoke with the boy's mother, providing her with a copy of the consultation report. She was satisfied both with this and with the process of ethics consultation. The operation proceeded uneventfully.

The satisfaction expressed by both the healthcare team and the mother illustrates one of the potential benefits of ethics consultation — the capacity to facilitate solutions that are respectful of differences in values and/or perspectives and that satisfy the relevant stakeholders.

Organisational principles of the Acute Clinical Ethics Service (ACES) at John Hunter Hospital, Newcastle, NSW

- ACES consultation is available to all health service staff, patients and their families and surrogates.
- Referral to the ACES is optional.
- All relevant stakeholders, including patients and their families, should be informed that an ACES consultation was requested.
- Where possible, consent for ethics consultation should be obtained from the patient or patient's surrogate.
- An ACES consultation would not provide a single clinical decision, or act as a de-facto court and jury, but would leave final responsibility for clinical management with the healthcare team and patient.
- An ACES consultation would review decision-making processes and the relative merits of all management options after considering the facts of the case and the values and preferences of all stakeholders.
- An ACES consultation would be performed by a team of three to four members of the John Hunter Hospital Institutional Clinical Ethics Committee (ICEC), with team membership reflecting medical, non-medical and community perspectives.
- The deliberations of each ACES consultation would be reviewed at the subsequent ICEC meeting.
- Consultation would be performed as quickly as possible after receipt of a referral, and a written summary of the consultation team's deliberations would be made available within 48 hours of the consultation. This written summary would be filed in the patient's medical record and supplied to the major stakeholders involved in the consultation.

Discussion

Our experience suggests that acute clinical ethics consultation services may have a role to play within Australian hospitals. Despite initially being unfamiliar with the notion of ethics consultation, we found that the hospital community, patients and their families were generally supportive of the ACES and expressed high levels of satisfaction with its processes and outcomes. Consultations varied widely in origin, content, purpose and motivation.

In each of the cases described here, ethics consultation helped to resolve an ethical problem by providing referring clinicians with opportunities to reflect on proposed courses of action. The process by which the ACES consultation ultimately improved patient care differed in each case.

In some cases that have been referred to the ACES team, merely initiating the consultation process has been enough to precipitate a resolution. In other cases, the benefit has come from mediation or

dispute resolution; from the elucidation of factual detail; or from external review, facilitated discussion or the ACES team's report.

Our experience has highlighted a number of questions that persist about clinical ethics consultation. What legal liability attaches to the advice provided by such services? Do they have a responsibility to critically evaluate or report unethical or illegal actions? What is the role of patient consent in the process of ethics consultation? How should ethics committees relate to hospital administration? Who has authority to review decisions made by ethics services? Who should be represented on ethics committees? What skills should ethics "consultants" have?

While professional "ethicists" are now part of the landscape of healthcare institutions in the United States,[1] we opted for an ethics consultation team rather than appointing a single expert. Our aim was to strike a balance between availability, speed of response and moral pluralism. In an effort to avoid some of the pitfalls of the "three wise men" approach, we also endeavoured to engage as wide a variety of participants as possible, and we deliberately sought differing views. Where possible, the ACES team included someone with a legal perspective, someone from the healthcare professions, a member of the "non-health" community and a representative of the chaplaincy.

Many theories have been advanced or updated to take account of clinical ethics and to describe the expertise required of ethics consultation. These include principle-based ethics, casuistry, discourse ethics, virtue ethics, process ethics and situationism. Of these, the first three are perhaps the most valuable, because they propose a practical method for resolving or mediating bioethical disputes. Although no single theory can provide an all-encompassing explanation of clinical ethics or the process of ethical decision-making, each provides tools that may help resolve ethical conflicts in healthcare.

Principle-based ethics[9] provides a framework for describing conflicting principles in clinical decision-making (autonomy, beneficence, non-maleficence, justice, veracity and confidentiality), and thereby a language for describing the ethics of medicine.

Casuistry[10] is an ancient form of reasoning that considers similarities and differences between emergent cases and previous "paradigm cases". Possible courses of action are then ranked according to their moral strength.[11] Its advantage lies in its reference to experience, common morality and the clinical context ("moral truth resides in the details"[12]).

Discourse ethics[13] sees ethical disputes as a "disruption of consensus". According to this approach, the task of ethics consultation is one of rebuilding consensus, by taking as many different perspectives into account as possible and, through an iterative process of consultation, ensuring that all parties agree with the final recommendations.[13] Discourse ethics rests on a belief in the moral power of communication and the validity of discourse and experience. In practice, it provides an effective means of mediating between widely divergent perspectives to generate agreement. (The ACES service reflected this general approach in that it was constructed not around a single ethics "expert", but around working groups composed of members with widely varying skills, insights and "world views".)

We believe that each of these moral frameworks may help working groups to examine and mediate ethical conflicts and generate conclusions that are rigorous, valid, inclusive and morally defensible. However, ethics consultations will not resolve all ethical tension or uncertainty in clinical practice. Nor will they vouchsafe outcomes that are beyond critical examination. Because ethics committees are guided by the values and biases of those who comprise them, they may reach different conclusions when confronted with the same or similar cases, and they may be unable to reach any form of consensus when conflicting viewpoints based upon long-held and deeply felt moral views are brought to bear, as occurred in the case involving the termination of a pregnancy.

But it would be a mistake to interpret variability in decisions or failure to reach consensus as evidence that ethics consultations are pointless.[14,15] Our own experience shows that, even when genuine consensus is not possible, ethics consultation may benefit clinicians and the hospital community by encouraging communication; by clarifying what is and is not "accepted practice"; and by facilitating transparency, veracity and critical reflection on shared values and on points of difference between patients and health professionals. Indeed, ethics consultation may serve as much to highlight moral differences as to resolve them.[16]

Ethics consultation is not easy, and setting up an ethics consultation service should not be undertaken lightly. Such a service may have many benefits, but, if implemented poorly and without the support of the hospital community, is likely to be underutilised, ineffective or destructive.[17] If, however, it is powerful, inclusive, plural and independent enough to provide a critical voice, then it may ultimately contribute to ethical practice and become a valuable hospital resource, rather than simply an elaborate tool for risk management.

Competing interests

None identified.

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