AN ANALYSIS OF ETHICS CONSULTATION IN THE CLINICAL SETTING

JOY D. SKEEL[a] AND DONNIE J. SELF[b]

[a] *Program in Medical Humanities, Department of Psychiatry, Medical College of Ohio, C.S. 10008, Toledo, OH 43699, USA*
[b] *Humanities in Medicine Department, Texas A&M University College of Medicine, 164 Medical Sciences Building, College Station, TX 27843, USA*

ABSTRACT. Only recently have ethicists been invited into the clinical setting to offer recommendations about patient care decisions. This paper discusses this new role for ethicists from the perspective of content and process issues. Among content issues are the usual ethical dilemmas such as the aggressiveness of treatment, questions about consent, and alternative treatment options. Among process issues are those that relate to communication with the patient. The formal ethics consult is discussed, the steps taken in such a consult, and whether there should be a fee charged. We conclude with an examination of the risks and benefits of formal ethics consults.

Key words: charting, ethicists, ethics consults, fee-for-service, hospital ethics committees, medical ethics

INTRODUCTION

In the last two decades there has been a dramatic increase in the teaching of medical ethics, both at the college level and in medical school, but particularly in the preclinical years of medical education ([1], pp. 8–19). More recently, interest has arisen over the formal teaching of ethics during the clinical years of medical education and during the postgraduate residency period [2–8]. This interest has been strong enough to lead to the formation of a Residency Training Interest Group in the Society for Health and Human Values. While medical ethics has presumably been taught informally for centuries by role modeling, and has been codified through various codes of ethics, the recent concern with formal teaching of ethics has led to the inclusion of qualified faculty in medical schools and in the clinical settings of hospital and clinics. A recent study indicates that the vast majority of the individuals teaching medical ethics have backgrounds in either theology or philosophy.[1] As part of the teaching in the clinical setting (i.e., in either hospital in-patient setting or in the ambulatory out-patient setting) the teachers of ethics – or ethicists, as these individuals are often designated – frequently participate in hospital teaching rounds conducted by physicians in the various specialties, such as internal medicine, pediatrics,

Theoretical Medicine **10:** 289–299, 1989.

surgery or family medicine. In the course of these teaching rounds, the ethicist may provide informal ethics consultation by identifiying problems, raising questions, analyzing issues or giving an opinion when asked.

Issues most commonly discussed with the ethicist fall into two categories: content issues and process issues. The content issues include: how aggressive to be with treatment; whether treatment ought to be terminated; questions regarding consent, e.g., whether the patient understands the options, what the alternative treatment possibilities with their specific consequences are; and utilization of scarce resources such as intensive care beds, and organ donations. The process issues relate to communication and include: whether too much technical jargon has been used in the process of the explanations to the patient about his/her condition; clarification of the patient's wishes; difficulties experienced by the physician, patient and the family in relating to each other and difficulties experienced by members of the health care team in relating to each other.

THE FORMAL ETHICS CONSULTATION

A new phenomenon has surfaced recently in medicine and medical ethics in some institutions: the formal ethics consultation. While this type of consultation is still in its infancy, according to data obtained in the previously mentioned study by Skeel and Self [9], they are being provided in a growing minority of institutions. This type of formal consultation is requested about a specific patient. While it is almost always requested by a physician, occasionally it is requested by a patient's family or specifically by the patient. In some instances nurses or other individuals such as the chaplain may recommend that an ethics consult be obtained. It should be noted that these consultations are separate from the consultations requested of an ethics committee, although frequently the person providing the clinical ethics consult may be a member of the institution's ethics committee and may, in particularly complex or difficult situations, refer a consult request to the ethics committee. An ethics consultation is different from the work of the ethics committee in that the ethics consultation is usually provided by an individual ethicist instead of a committee. In addition, the ethics consultant in many institutions is likely to know the patient about whom the consultation is requested from prior participation on hospital rounds. It is possible that the ethicist might have discussed some of the issues raised by the patient's care in the context of rounds and then the physician(s) chose to ask for a formal consultation both for the purpose of further clarification of the issues and to have a written record of the ethicist's recommendations. In a formal consultation, the ethicist is asked to assess or analyze a situation in which a difficult ethical dilemma exists. The most common reasons for which an ethics

consultation is requested are likely to be the same as those listed for informal consults on teaching rounds.

While an ethics consultant may be asked to assess or to help analyze a specific situation, this individual is not likely to make recommendations in isolation. One of the real values of an ethics consultation is the discussion which the ethics consultant generates in the process of performing the consultation which has led Glover, Ozar and Thomasma to designate "decision facilitator" as one of the roles of the clinical ethicist [10].

It is not always entirely clear for whose benefit an ethics consultation is requested, whether for the patient's or the physician's. In the majority of cases the consult is likely to be of benefit to both the patient and the physician. For example, the patient is likely to receive improved care, if the physician requests a consult to improve communication or to help clarify the wishes of the patient. The physician is apt to benefit from a consultation by feeling more secure in either proceeding with treatment or stopping treatment when a consult has assisted in clarifying what the patient does or does not want done.

With all the concerns regarding defensive medicine and the litigious atmosphere surrounding the practice of medicine today, physicians also may request ethics consultations to try to prevent legal action against them. This is not intended to diminish in any way the physician's concern for the patient, but rather acknowledges the realities of medicine at this time. It is certainly not clear that having gotten an ethics consultation will protect a physician or other health professionals if malpractice claims are made. On the other hand, it can be argued that since the physician did request an ethics consultation the physician's intention was to try to determine what was best for the patient from an additional source.

Most consultations obtained in medicine can be viewed as being sought by the physician but for the patient. That is, consultations are usually provided to the requesting physician by the consultant for the patient. The consultant rarely provides a direct consultation (firsthand information) to the patient, rather the information is given to the primary physician who then relays or interprets it to the patient. As Goldman and colleagues note in their article on how to be an effective medical consultant, the consultant, while having an obligation to the patient, should carry out this responsibility by communicating with the primary physician "and not by competing for the attention and loyalty of the patient" [11]. Furthermore, if a consultant consistently breaches this part of the etiquette of consulting, he or she is unlikely to be called upon by colleagues. This same reasoning may be applied to ethics consultations.

Ruth Purtilo raises questions as to whether consultants in ethics are comparable to other clinical consultants in medicine [12]. She contends that they are not, insofar as the ethics consultant is not able to step into the role of primary

caregiver, should the need arise, as the cardiology or surgery consultant could. She notes that when she provides ethics consultations, she, like other consultants, "Provides professional advice or services regarding matters in the field of his or her special knowledge or training" ([12], p. 984). Nevertheless, it could be argued that other medical subspecialists would not be capable of assuming the role of primary caregiver in many complicated cases either.

BASIC STEPS OF AN ETHICS CONSULTATION

The procedure for performing ethics consultations is often quite similar to the way in which other types of consultations are performed in medicine.

1. The Request. A request for consultation is written, usually on the patient's order sheet, and the ethicist is informed of the request by phone from the ward clerk, a medical student, resident or, occasionally, directly from the attending physician. When the request is communicated, it is necessary for the consultant to determine how urgent the request is; that is, whether it need be done immediately or whether it can wait until later in the day. If it is requested as urgent, then the ethicist needs to discuss the case immediately with either the senior resident or the attending physician in order to determine what issues need to be addressed.

2. Reason(s) for consultation. If the consultation request is designated as urgent, the reason for the request should be clarified directly with one of the senior physicians, or the physician who requested the consult. It is useful and common for the reason for the request to be written on a consultation form. Sometimes, however, the reason for the request may be quite vague, e.g., "please evaluate situation". It is difficult for consultants in these instances to know what is expected of them even if they have frequently worked with the physicians involved in the case. Sometimes the physician making the request has not thought through what the question is or what issues are problematic, and once again it will be necessary for the ethicist to deal directly with the referring physicians to clarify expectations of the consultation.

Once the reason for the consultation has been established, it is important that the ethicist address it. Few things are more frustrating to a physician than to request a consultation and then find that the consultant has not dealt with the problem but has gone off on some tangent. Of course, in the process of trying to determine where the problems lie or what values are in conflict, other issues may surface which may relate only tangentially to the original problem. But these issues need to be discussed with the primary caregivers apart from this particular consultation. In writing the consultation note, it is useful for other persons who review the patient's chart to have the consultant begin by stating

why the consultation was requested, such as "called by physician to speak with this 68 year old male with severe chronic obstructive pulmonary disease to help determine his wishes regarding aggressiveness of further treatment".

3. Data gathering. After clarifying the nature of the request, pertinent information should be gathered by reading the patient's chart, including the nursing notes which are an important source of information, and talking with the patient when possible. If the ethicist has not yet talked with the physicians caring for the patient, that should be done, as well as gathering information from other caregivers, such as nurses and social workers. In some instances it will be necessary to talk with the family and/or close friends, particularly if the patient is not able to communicate. In some situations talking with the patient's pastor or the hospital chaplain will prove helpful.

4. Writing the consultation note. The consultant should begin by stating the reason the consultation was requested, and then describing the ethicist's perception of the problem as gained from talking with the patient and/or family, the caregivers and from reviewing the patient's chart. After clarifying the issues involved, the consultant should briefly discuss alternative courses of action and why certain recommendations are being made. Sometimes it is helpful to include references to articles from the medical ethics literature. However, care must be taken not to be condescending when doing this. These references may be particularly helpful to medical students, physicians in training, and to the nursing staff. The written consultation should be concise and clear; the jargon of philosophy or theology will not endear the ethics consultant to those requesting the consultation. Whenever possible it is wise not to write more than the one page the consultation sheet allows. It is appropriate to make an entry in the ongoing progress notes that the consultation has occurred. In the progress notes the reason for the consultation should be noted and the reader referred to the consultation sheet. The recommendations are most readily visible if listed and numbered with a brief statement next to the recommendation as to why that recommendation was made. For example:

Recommendations:

(A) Patient not be placed on ventilator. Both patient and family state Mr. X has been adamant he would not want to have mechanical ventilation again. Patient aware that he may die sooner if his request is followed.

(B) Patients states that he does not want CPR in case of cardiac arrest.

Patients may change their minds about their resuscitation or other treatment status, and recognition of this possibility is usually built into the discussion and often into the recommendations. Once again, care must be taken by the ethics consultant not to be condescending toward the primary care staff when making

such a statement, i.e., language must be chosen with care.

5. Teaching and follow-up with primary caregivers. Calling the physician who requested the consultation, as well as the attending physician for the patient is important. This direct contact provides an opportunity for clarification of the consultant's recommendations and for education. Occasionally a conference of all the caregivers involved in the patient's care may be requested by the attending physician or recommended by the ethics consultant so that difficult issues may be dealt with openly with everyone present. This may be especially helpful when the underlying problem appears to be inadequate or poor communication.

6. Patient follow-up. In some instances the primary physicians will request that the ethics consultant continue to work with the patient and/or the physicians and nurses when further problems are expected to arise. Under these circumstances the ethics consultant needs to write progress notes in the patient's chart when necessary.

CHARGING FOR FORMAL ETHICS CONSULTATIONS

While formal ethics consultations may be described as being in their infancy, charging for them appears to be embryonic. There are persons, however, who are and have been charging for them for some time. We know several physician ethicists who have been billing for these consultations regularly under the "Initial Consultation" billing code of the *Physicians' Current Procedural Terminology*.[2] This is the same billing code physicians would use for any initial consultation they might be called upon to provide, e.g., a cardiology consultation, hematology consultation, surgical consultation, or others.

Non-physician clinical ethicists are also charging in some instances. Some of these individuals charge only the physicians who are outside the ethicist's institution who request a consultation, and they bill them directly. Physicians within the ethics consultant's own institution, however, are not billed for formal ethics consultations. Other consultants who are faculty members of universities not associated with hospitals provide consultations to local hospitals when requested. These individuals bill the hospital for their services. Purtilo noted she was aware that some institutions had developed fee scales for ethics consultations, which were used like those of other clinical consultants ([12], p. 984).

Many questions surround the issue of charging for ethics consultations. In the first place, there is no unanimity among clinical ethicists that these consultations should be billed for as other clinical consultations are. Even if there were unanimous thinking among ethicists that they ought to be charging for these consultations, many questions remain. For example, who should pay: the

patient? the physician? the hospital? third-party payers? How should fees be established? Since there currently are no straightforward billing mechanisms available to non-physician ethics consultants through third-party payers, should ethics consultants be able to charge through the physician involved in the case, as social workers and psychologists do in some settings? We recommend that a study should be undertaken by a major third-party payer along with a group of persons performing ethics consultations to try to determine whether such consultations lead to better patient care and more thoughtful use of resources, thus deserving their own mechanism for charging.

Questions regarding charging for ethics consultations raise additional questions about certification for those persons providing ethics consultations. If third-party payers developed a fee scale for ethics consultants as well as mechanisms for charging, would they not require that these individuals be certified as having some basic body of knowledge available to them along with particular skills to use such knowledge?

The issue of certification is being discussed among ethics consultants, and, as might be expected, there are strong proponents on both sides of the issue. Some of the arguments for certification include the following: First, there is a defined body of knowledge which ethics consultants should have. Second, there ought to be a means for assessing the mastery of this knowledge, similar to the board examinations required of physicians entering the various specialized areas of medicine. The third argument for certification is that it would provide a means of quality control within the profession, i.e., the only persons who would be technically allowed to perform ethics consultations would be those who had demonstrated, via some type of examination, an adequate familiarity with the designated body of knowledge.

The arguments against certification include the following: First, while it may be possible to define a body of knowledge with which persons performing ethics consultations ought to be familiar, the paths by which these individuals attained this knowledge are so diverse that it would be very difficult to test adequately and/or fairly. That is, the majority of persons performing ethics consultations in hospitals today have been educated in two primary areas: either theology or philosophy (or a combination of the two disciplines). The educational process for persons coming from these two backgrounds is quite different, and, therefore, developing a test which would assess their ability to function as ethics consultants may be impossible. A counter argument might be that there could be three paths to certification: (1) philosophical, (2) theological, and (3) other. The second argument against certification focuses on the body of knowledge itself. It can be argued that the body of knowledge which is necessary for ethics consultations is not objective in nature and does not lend itself to clear answers, and therefore cannot be readily tested. A third argument against certification notes

that certification certainly provides no guarantee for quality control, and those who think it does are merely deluding themselves. This lack of quality control via certification is evidenced in medicine. Just because someone has passed a certifying examiniation in some particular area, such as internal medicine, does not guarantee that that person is a competent physician. This issue of certification for medical ethicists providing ethics consultations is certain to be debated vigorously in the future.

At the present time relatively few ethics consultants in medicine seem to be charging for consultations over and above their salary. We do not know whether departments where ethics consultants are based receive any remuneration for the time the individuals spend providing consultations. Since ethics consultations are time-consuming to provide, it would not be surprising to find that either individual consultants or the departments where they are based claim that there ought to be some remuneration for these consultations. In order to justify this renumeration, persons providing ethics consultations should keep a record of the time spent on individual consultations along with the reason for the consultation request, the outcome of the consultation, and, where possible, whether the ethics consultation had any influence on the decision-making and the final outcome, i.e., whether the recommendations were followed.

RISKS AND BENEFITS OF FORMAL ETHICS CONSULTATIONS

There are several risks to ethics consultations. The most prominent ones are the issues of values conflicts between the patient and the ethics consultant and between the physician and ethics consultant. If an ethics consultant is called upon to assist in decision-making in a difficult situation, it is possible that the consultant's values regarding what would be a 'good' decision in the case might be quite different from that of the patient.

For example, an ethics consultant might arrive at a recommendation that the most appropriate use of resources – such as a bed in the intensive care unit – would preclude the admission to the ICU of a medically indigent 65 years old man with severe liver disease and the other complications which accompany many years of alcoholism. The patient, however, may want to be treated in order to have another opportunity to try to overcome his alcoholism. If an ethics consultant has a bias against some type (or types) of diseases, this may influence the primary caregivers who requested the consultation originally to proceed in a particular direction without the patient's consent (or occasionally without the patient's knowledge). While this example may appear extreme, there are certainly times when the consultant's views and values will run counter to those of the patient and the physician.

It can be argued that an ethics consultant, in order to provide effective consultations should be aware of his/her value system and be sensitive to the possibility that those values may be impeding what is best for the patient – from the patient's perspective – in a particular situation. If such situation arises, one would hope that the ethics consultant would either be able to be more objective after identifying the value conflict or to remove himself/herself from the case. A value conflict between the physician and the ethics consultant has the potential for creating feelings of animosity which may be transmitted to the patient. Such a situation might hinder effective decision-making and increase the stress which patients already feel in the hospital setting.

The second risk of ethics consultations revolves around privacy and confidentiality, although this risk is no different for ethics consultations than it is for any other type of clinical consultation which brings another individual into the case. By becoming involved in a case to the point of reviewing the chart, the ethics consultant has moved into the patient's private sphere, often without the patient's knowledge or consent. These problems can be averted by the physician's informing the patient that she/he believes an ethics consultation would be useful, and asking the patient for consent to proceed.

A third risk involves conflicts of interest for the ethics consultant. Ethics consultants who are unfamiliar with the hospital setting and inexperienced in working with health care professionals, may find themselves outwardly agreeing with a physician's point-of-view in order to gain acceptance and to avoid appearing disagreeable to the physicians. This appeasing type of behavior is unlikely to be to anyone's benefit for very long, but can be particularly detrimental to patients. It is likely to be more useful to everyone if the ethics consultant spends more time in the hospital or ambulatory care setting becoming more at ease, and learning that it is appropriate to ask questions, as well as to disagree with physicians and other health care professionals without so much personal involvement.

Another type of conflict of interest may occur if the ethics consultant believes there is a need to protect the physician, who may be a friend, or the institution which is paying his/her salary. An example of this type of conflict may occur if the ethics consultant becomes aware that a patient is not being given complete information, such as when a wrong medication is given and the patient has a serious reaction. Most often the role of the ethics consultant in this type of situation has been to provide support to the physician whose duty it is to tell the patient what occurred rather than assuming the role of "whistle-blower". However, if nothing is done to remedy the situation, it would seem appropriate for the ethicist to refer the case to the hospital ethics committee.

A fourth risk is one that almost every ethics consultant will face at one time or another and that is being viewed as the 'answer person'. Some health care

professionals have the unrealistic – and inappropriate – expectation that ethics consultants, vis-a-vis their education and experience, will provide the right answer in difficult situations. William Winkenwerder recently described a more appropriate view of the ethics consultant: "The function of this person should not be to make the actual decision, but to help the primary caretakers, patient and family reach a mutually agreed-on decision" [14].

There are several benefits which may occur from ethics consultations both for the patient and for the physician. The first is that the patient's wishes regarding treatment (or non-treatment) are more likely to be clarified and patient autonomy upheld. Second, in promoting patient autonomy, the ethics consultant is likely to promote the principle of non-maleficence – not harming the patient – as well. Third, in the process of providing an ethics consultation, the consultant may find that communication is improved among the primary caregivers which may then lead to improved communication with the patient. An additional benefit arising from an ethics consultation is that resources may be used more thoughtfully, particularly when patients are involved in the decision-making.

It remains unclear whether ethics consultations will be of benefit to physicians when claims of malpractice have arisen. What, if any, impact these consultations will have on the decision-making of the courts remains to be seen.

CONCLUSION

Formal ethics consultations, while a relatively new phenomenon in hospitals and ambulatory care settings, are being utilized with increasing frequency by physicians and other health care professionals, particularly in teaching settings. While the ethicists who provide these consultations may vary the model they use, at least some ethicists follow a model very similar to that used for other types of medical consultations. This includes the use of a consult form and, when requested, follow-up notes in the progress notes of the patient's chart.

While these consultations are being used more often, there are some risks associated with them which need to be recognized, such as value conflicts between the ethicist and the patient, questions regarding privacy and confidentiality and conflicts of interest for the ethicist. It could be argued, however, that the benefits of these consultations to the patient and the physician outweigh the risks, since they are likely to promote patient autonomy and improve communication between the patient and those who care for him or her.

There are questions which remain unanswered regarding the role of ethics consultants. These questions can be dealt with as ethics consultants, physicians and others in the institutions continue to work together to clarify expectations and issues regarding ethics consultations. Answers will evolve to: what might

make these consultations more useful to patients and health care professionals, particularly to physicians; how to protect patient privacy and confidentiality; and whether charges should be made for consultations. Finally, individuals who provide ethics consultations need to explore the questions which arise from the issue of certification.

NOTES

[1] For a preliminary report on this survey data, see [9].
[2] See Initial consultation 90605 and its description on p. XVII in [13].

REFERENCES

1. Pellegrino ED, McElhinney TK. *Teaching Ethics, The Humanities and Human Values in Medical Schools: A Ten Year Overview*. Washington, DC: Society for Health and Human Values, 1982.
2. Bickel J. *Integrating Human Values Teaching Programs into Medical Students Clinical Education*. Washington, DC: Association of American Medical Colleges, 1986.
3. Self DJ, Lyon-Loftus GT. A model for teaching ethics in family medicine residency. *J Fam Pract* 1983;166:355–9.
4. Sun T, Self DJ. Medical ethics programs in family practice residencies. *Fam Med* 1985;17:99–102.
5. Geyman JP. Expanding concerns and applications of medical ethics. *J Fam Pract* 1980;10:595–6.
6. Dayringer R, Paiva RE, Davidson GW. Ethical decision making by family physicians. *J Fam Pract* 1983;17:262–72.
7. Carson RA, Curry RW Jr. Ethics teaching on ward rounds. *J Fam Pract* 1980:11:59.
8. Brody H. The current status of humanities in family medicine education. *Fam Med* 1982;14:3–8.
9. Skeel J, Self D. Ethics in the clinical setting. In: Fletcher J, ed. *Ethics Consultations in Health Care*. Ann Arbor: Health Care Administration Press, (in press).
10. Glover J, Ozar D, Thomasma D. Teaching ethics on rounds: the ethicist as teacher, consultant, and decision-maker. *Theor Med* 1986;7:13–32.
11. Goldman L, Lee T, Rudd P. Ten commandments for effective consultations. *Arch Intern Med* 1983;143:1754.
12. Purtilo R. Ethics consultation in the hospital. *N Engl J Med* 1984;311:983–6.
13. Fanta C, Asher J, Kirschner C, Perlman J, AMA Editorial Staff. *Physicians' Current Procedural Terminology*. 4th ed. Chicago: American Medical Association, 1986.
14. Winkenwerder W Jr. Ethical dilemmas for house staff physicians: the care of critically ill and dying patients. *JAMA* 1985;254:3456.