Effectiveness of an Ethics Consultation Service

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Background. Ethics consultation is a relatively new service in clinical medicine. Most such services have been developed in departments of internal medicine. Few studies have evaluated the results of such consultations, and none have examined whether a family practice perspective enhances the consultation process.
Methods. An ethics consultation service was established in the Department of Family Medicine at Loma Linda University School of Medicine in 1990. Data were collected from the consultations performed during the first year. A questionnaire was sent to the attending physicians for their evaluation of the service.
Results. Ethics consultations were provided to the health care teams of 46 patients in five clinical departments. The attending physicians found the consultations to be important in clarifying ethical issues, educating the team, increasing confidence in decisions, and in patient management in more than 90% of the cases; however, the consultations resulted in significant changes in patient management only 36% of the time.
Conclusions. It is feasible to establish an ethics consultation service within a department of family medicine in a university hospital and to provide consultations to physicians in other specialties.
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Clinical ethics involves the identification, analysis, and resolution of moral problems that arise in the care of individual patients.[1] Although such activity has been an integral part of the practice of medicine for centuries, only recently have some authors called clinical ethics a distinct discipline.[2–4] It has developed as an application of philosophical medical ethics at the bedside.[5–7] The scope of clinical ethics includes patient consultation,[8] education,[9] and research.[10] In this article, we offer the first report of an ethics consultation service developed in a department of family medicine, and analyze the results of its first year of operation.

It has been stated that the goal of ethics consultations is to "assist the primary physician, the patient, and the family to reach a right and good clinical decision."[11] Preliminary analyses of the results of ethics consultations have begun to appear in the literature.[12–15] Such consultations have been shown to affect patient care.[13,16]

The key elements in clinical ethics are establishing mutually agreed upon therapeutic goals and practicing shared decision making.[17] These elements are a part of the practice of medicine, a part that has always been emphasized by family physicians. An ethics consultant can sometimes facilitate this process, especially in the complex atmosphere of a large medical center, and can help the physician and patient reach an appropriate decision.[18] This facilitation of decision making is even more likely if the ethics consultant has a family physician's perspective on the practice of medicine.

Most ethics consultation services have been started in departments of internal medicine[13] or as an interdisciplinary service of an ethics committee.[3] There is a growing awareness that ethics training and consultation also should be available in family medicine.[19,20] Orr and Moss[21] have recently suggested that family physicians are uniquely qualified to address ethical problems that arise in their own practices and should be encouraged to seek additional training in ethics in order to offer ethics consultations on a formal basis.

An Ethics Consultation Service in a Department of Family Medicine

In August of 1990, a family physician–ethicist (R.D.O.) was recruited by the Department of Family Medicine of Loma Linda University School of Medicine to serve both on the faculty of the department and as director of clinical ethics for Loma Linda University Medical Center (LLUMC), a 625-bed tertiary care teaching hospital. He

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spends 40% of his time in the teaching and practice of family medicine and 60% of his time teaching clinical ethics in the various clinical departments as well as providing bedside ethics consultations to the medical team on any clinical service in the medical center.

When an ethics consultation is requested, the consultant first discusses the case with the person making the request in order to identify the problem and to determine if the attending physician is aware of and in agreement with the request for an ethics consultation. If the attending physician objects, the consultant offers informal advice to the requestor without further involvement in the case. Helping the requestor to articulate the perceived ethical dilemma often proves to be the most difficult part of the consultation, as the clinical care team may not have clearly formulated the ethics question.

The consultant next reviews the chart and talks individually with various members of the care team, as well as with the patient and the family. He may perform a brief examination on the patient. If he needs more information, he talks with other appropriate consultants, both medical and nonmedical (legal, administrative, spiritual), or reviews the pertinent literature of medicine, ethics, or law. In some cases, he requests a management conference at which all parties may convene for further discussion of the case, including further management options.

After his evaluation is complete, he writes a consultation report in the patient's chart, including the history and examination, an assessment, an ethical analysis and discussion, and specific recommendations. The recommendations rarely state which management option should be pursued, but usually delineate which options are ethically permissible.[22] Sometimes new options are suggested such as referral to hospice, obtaining second (or third) medical opinions, or requesting current prognoses. No professional charge is made for providing these consultations. After the consultation is completed, the consultant maintains contact with the patient or staff, or both, as long as the patient remains in the hospital, and occasionally after discharge as well.

Methods

The authors conducted a retrospective analysis of the first year's consultations to study the effects of the consultation procedure and results. A research assistant (E.M., fourth year medical student) reviewed the charts of all patients for whom consultations were provided. The ethics consultant retrospectively listed the ethical issues he had identified in each case.

Using the evaluation method first described by LaPuma et al,[13] a brief questionnaire was sent to the attending physician of each patient along with a copy of the consultation report. The physicians were asked to assess how important the consultation was in clarifying the ethical issues of the case, in educating the team, in increasing their confidence in patient management, and in making patient management decisions. They were also asked if the consultation resulted in a change in patient management. Their responses to these questions were recorded on a three-point scale. They were then asked to select from a list all of the ethical issues that they perceived were involved in the case. Finally, they were asked if they would request ethics consultations in the future. Their responses were mailed directly to the research assistant, who then reviewed and tabulated the results. One repeat mailing of the questionnaire was made to nonresponders.

Table 1. Age Distribution of 46 Patients for Whom Ethics Consultations Were Requested

Age	No. of Patients
<6 mo	8
6–12 mo	5
1–2 y	5
2–10 y	6
10–20 y	2
20–40 y	3
40–60 y	5
60–80 y	10
80 + y	2

Results

Between August 1, 1990, and July 31, 1991, ethics consultations were requested for 46 patients under the care of 27 physicians in the following departments: pediatrics (24), medicine (11), family medicine (5), surgery (5), and gynecology (1). Thirty-one consultations involved a patient in an intensive care unit setting, 14 involved a patient on the wards, and one involved an outpatient.

The patients' ages are shown in Table 1. Of the 26 patients under the age of 20, 24 (57%) were under the care of the pediatric service and 2 were cared for by the pediatric surgical service. The average age of the 46 patients was 28.4 years. Seven of the 20 (35%) patients who were over the age of 20 years and 1 of the 26 patients who was younger than aged 20 were believed to have decision-making capacity.

No requested consultation was prevented because of objection from the attending physician. Forty-three of the 46 consultations (93%) were requested by physicians

Table 2. Persons Interviewed in the Course of Ethics Consultations on 46 Patients

Persons Interviewed	No.
Attending physician	42
House staff	38
Nurse	29
Family members	23
Social worker	18
Consulting physician	13
Attorney	9
Patient	7
Chaplain or primary clergy	7
Patient representative	1
Outside primary care physician	1

(26 by attending physicians, 17 by resident physicians), and one each from a nurse, medical student, and chaplain. The consultant interviewed a variety of persons as indicated in Table 2. In the one instance in which an adult with decision-making capacity was not interviewed, the question involved the physician's obligation to inform a patient of his terminal prognosis over the objections of his family. This was managed by discussion with the care team alone.

The consultant examined 41 of the patients (89%) and held a management conference in 23 cases (50%). Follow-up visits were made by the consultant to 23 of the patients (50%). Twenty-one of the patients (46%) died during the same hospitalization during which the consultation occurred. The length of time involved in completing the consultations ranged from 1.5 to 8.5 hours, with an average of 3.2 hours.

The ethics consultant made specific recommendations in 36 of the 46 consultations (78%). In the remaining 10 cases, ethical issues were clarified and discussed in the consultation report. An incomplete list of consultation recommendations is presented in Table 3. Sometimes the conclusion was reached that there was no ethical dilemma.

Table 3. Most Common Recommendations Made by Ethics Consultant

The consultant helped the team to:

- Evaluate patient's decision-making capacity
- Assess the moral standing of various persons
- Designate an appropriate surrogate
- Differentiate between obligatory and optional treatments
- Differentiate between standard and investigational therapies
- Determine the limits of patient's or surrogate's autonomy
- Recognize the right of patient or surrogate to refuse physician recommendations
- Establish the levels of certainty needed regarding the patient's previously spoken requests
- Discuss the levels of certainty needed about prognostic possibilities
- Assist with the timing of decisions to limit treatment
- Assist with the appropriate wording for specific orders
- Assist with discharge or disposition plans

Table 4. Responses of the Attending Physician on Evaluations of 43 Ethics Consultations

Question	Response, %		
	Very Important	Somewhat Important	Not Important
How important was the consultation in:			
Clarifying ethical issues?	74	21	5
Educating the team?	70	30	0
Increasing confidence?	65	28	7
Patient management?	58	37	5

Evaluation questionnaires were returned by the attending physicians for 43 of the 46 consultations (93%). Their evaluations of the consultations are presented in Table 4. Over 90% of the physicians who responded found the consultations to be either "very" or "somewhat" important in clarifying ethical issues (95%), educating the team (100%), increasing confidence (93%), and managing patients (95%). All 43 attending physicians indicated that they would request an ethics consultation in the future.

The ethical issues identified retrospectively by the consultant and by the attending physician are tabulated in Table 5. The consultant identified an average of 3.1 issues per consultation, whereas the attending physicians identified an average of 2.3 issues. Significant conflict was identified in approximately one third of the cases by both the consultant and the attending physician.

Table 5. Issues Identified by the Consultant and the Attending Physician in 46 Cases Involving an Ethics Consultation

Ethical Issues	Consultant No.	Attending Physician No.
Withdrawing or withholding therapy	38	35
Appropriateness of current treatment	28	20
Resuscitation	22	6
Conflict resolution	17	14
Legal issues	5	6
Discharge disposition	5	1
Competency	4	3
Surrogacy	2	4
Withholding information from patient	2	1
Cost of care	2	0
Allocation of resources	2	3
Patient refusal of ventilator	3	3
Patient refusal of fluids and nutrition	3	1
Patient refusal of blood	2	0
Family demand for ventilator	5	1
Family demand for rehabilitation	1	0
Family demand for CPR	1	1
Family demand for surgery	1	0
Autonomy	1	0

Discussion

This is the first series of ethics consultations to be reported in which the majority of cases involved pediatric patients. The percentage of pediatric patients in this series (57%) is significantly higher than that previously reported by LaPuma, and the average age of 28.4 years is significantly lower. LaPuma reported in his first series that 2 of 26 patients (8%) were under 18 years of age, and he found a median age of 48.1 years[12]; in his second series the average age was reported to be 51 years,[13] and in his third series only 2 of 104 patients (2%) were under 10 years of age.[15] Brennan's series of 73 ethics committee consultations on terminally ill patients had a mean age of 61.89 years.[14] The high proportion of pediatric patients in our series reflects the volume of pediatric patients at LLUMC, and the high level of ethical sensitivity of the directors of the neonatal and pediatric ICUs at our institution. It also reflects the frequent occurrence of management dilemmas in very ill children.

The small number of consultations provided to patients under the care of the family medicine service is because the service is new and relatively small. Moreover, the ethicist makes weekly rounds with the family medicine house staff and discusses many of the staff's ethical problems in a more informal manner.

Thirty-one (67%) of our 46 consultations occurred in ICUs. This is similar to the findings of Brennan (69.9%) and is higher than the percentage reported by La Puma (19% to 41%). These percentages serve as a reminder that the application of technology is a frequent source of ethical tension.

Requests for assistance with treatment decisions are more common in adult and pediatric patients who lack decision-making capacity. Eight of the patients in our series (seven adults and one adolescent) had decision-making capacity, demonstrating that even when the physician is able to speak with the patient, ethical dilemmas are not automatically eliminated.

The ethics consultant spoke with a family member or other surrogate in 50% of the consultations. This is less than the 69% reported by LaPuma,[13] and seemed lower than desirable. Further examination of those cases where there was no discussion with the family showed, however, that four of the consultations were requested specifically because there was no identifiable family or surrogate; in six cases the team was requesting assistance in deciding how to respond to what they believed was an inappropriate request from the family; and in nine cases the reason for the consultation was a difference of opinion among members of the care team about patient management or about the best approach to the family.

The ethics consultant did not see or examine 5 of the 46 patients. One of these was a patient hospitalized out of state, about whom questions were asked concerning the appropriateness of referral for an investigational procedure. One consultation was prompted by the question of whether to disclose information to the patient. In the remaining three cases, there was no disagreement about either the medical facts or the recommended management options.

In 23 cases (50%), by the time the data were collected and the appropriate persons were interviewed, it was determined that either there was no ethical dilemma or resolution of the question had already been accomplished or could be accomplished by following specific recommendations. In the other half of the cases, the consultant felt that a management conference with all the involved persons would help to resolve the questions. Such management conferences could be viewed as ad hoc ethics committees with representatives from several disciplines, all of whom had direct contact with and an interest in the patient. This approach established an atmosphere that was conducive to resolution of conflict. It also proved to be a forum where principles of family medicine (the biopsychosocial model, continuity of care, shared decision making, the family as a unit of care, etc) could be emphasized.

That 54% of the patients survived to discharge should remind physicians that ethics consultations can be of value not only to dying patients but for those who have a prognosis for continued life. This finding is similar to the 61% and 62% survival rate to discharge reported by LaPuma. Brennan's series[14] reported a much lower survival rate (18.8%), but his ethics committee as originally constituted[23] was designed to provide consultations for patients who were deemed "hopelessly ill" and for whom limitation of treatment was being considered.

The average of 3.2 hours involved in the consultations in this series is less than the 4.8 hours previously reported by LaPuma.[13] The reason for this difference is not evident from a comparison of the procedures or content of the consultations.

Although 58% of the attending physicians found the consultation to be very helpful in patient management, only 36% of those who answered that question believed that it changed patient management significantly. This suggests that the consultation increased their confidence in the decision they had already reached or would have reached without an ethics consultation.

The attending physicians identified an average of 2.3 ethical issues per case and the consultant identified 3.1 issues per case, which suggests that even after going through the consultation process, the attending physicians may not have thoroughly understood the issues involved. Similarly, in 1988 LaPuma and colleagues[13]

found that the requesting physician identified an average of 2.4 issues and the consultant identified 3.0 issues per consultation. This is compatible with the conclusion drawn by Lo and Schroeder[24] from their empirical study, which found that ethical problems are frequent, but are underidentified by physicians.

Conclusions

We have demonstrated that it is feasible to establish an ethics consultation service within a department of family medicine in a university hospital and to provide consultations deemed to be of value to physicians in other specialties.

We have also confirmed that bedside ethics consultations can play a major role in clarifying ethical issues and in educating the patient care team about these issues. Although attending physicians perceived the ethics consultations as important in patient management, we demonstrated that such consultations did not result in significant changes in patient management in the majority of cases.

We attempted to help physicians, patients, and families identify their treatment goals, and we strongly encouraged joint decision making. We further attempted to educate all of the involved parties about the principles of primary care as well as about established precedents and standards in clinical ethics. When limitation of therapy was chosen, we encouraged compassionate and intensive hospice care in whichever setting seemed most appropriate to all parties concerned. We also emphasized providing continued support and comfort for the family.

Identification of the ethical issues in patient care remains difficult for many physicians. Experienced clinicians and clinical ethicists should devote more time to teaching students and house staff what constitutes an ethical issue and how these issues should be articulated, analyzed, and resolved.

The effect of ethics consultations on patients, families, and the health care team needs further study. Because a consultation usually involves input from several people, outcome measures are difficult to assess, and controlled studies may be impossible to conduct. The salutary effect of consultations elicited by this analysis and evaluation suggests that this is a valuable service to the health care team. Of particular interest would be a follow-up study of patients and families after an ethics consultation has been done to learn their perception of its effect.

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