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## Introduction

In Germany ethics consultation is increasingly regarded as a quality criterion for hospitals and nursing homes. In certification programs as per KTQ (Cooperation for Transparency and Quality in Health Care) or proCum Cert (confessional certification company) it is explicitly asked for. More than 200 hospitals have already established such services.[2] The *Zentrale Ethikkommission* (ZEKO) of the German Bundesärztekammer welcomes this development in their statement of January 2006 as a practice-oriented contribution towards an improved medical care for patients and asks institutions, with no such structures existing yet, to establish them.[3]

Due to the increasing significance of clinical ethics consultation the question arises concerning the quality of these services. An empirical study among confessional hospitals in Germany in the year 2000 revealed rather sobering results: Only half of the 30 ethics institutions existing at that time had worked out rules of internal procedure; the staff responsible for consultation was frequently bad or not at all prepared for their task; it was only taken advantage of external help in the implementation of ethics consultation by less than half of the hospitals.[4]

Since mid of the 1990s there is a lively debate in the USA on the standards for ethics consultation. The *American Society for Bioethics and Humanities* (ASBH) published a report in 1998 where it defines the core competencies for ethics consultation in health care.[5] Although this report poses an important milestone in the effort towards quality control of ethics consultation, it avoids certain important aspects, as will be shown in the first section of this contribution. In the following, own suggestions for quality standardization in ethics consultation will be brought up and discussed.

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[1] This article is a shortened and revised version of the chapter *Qualitätssicherung und Evaluation von Ethikberatung* of the book *Klinische Ethikberatung. Ein Praxisbuch* (Simon [2008]).

[2] Dörries, Hespe-Jungesblut [2007].

[3] ZEKO [2006].

[4] Simon, Gillen [2001].

[5] ASBH [1998].

## 1. Core Competencies for Ethics Consultations

The first medical ethics consultations emerged in the USA in the mid of the 1970s. Decisive for the almost exhaustive implementation of medical ethics consultation was the fact that from the beginning of the 1990s on hospitals had to prove a structure on how to deal with ethical conflicts in order to receive their accreditation.

On the occasion of this guideline an (intensified) debate on standards in the ethics consultation came up. In a contribution titled *Ethics Committees: Time to Experiment with Standards*, published in 1994, the medical ethicist John Fletcher and the lawyer Diane Hoffmann concluded that the time of the "laissez-faire-approach" to ethics consultation was over.[6] At the same time they demanded to define standards for ethics committees and to test them in practice. The standards were to regulate the following areas:

1) access to the committee and its services,
2) education and training of committee members,
3) case consultation procedures,
4) documentation of consults,
5) review of committee processes and recommendations.

In the mid of the 1990s the *Society for Health and Human Values* and the *Society for Bioethics Consultation* appointed a joint task force in order to develop standards for ethics consultation in health systems. This task force was interdisciplinary and multi professional. Apart from members of the two bio-ethical specialist societies, representatives of the accreditation company, of the different professional organizations in health care, and consumer advocates were involved. After two years of intensive debate the task force completed their work with a report that was passed by the newly founded *American Society for Bioethics and Humanities* (ASBH), which emerged from the union of the two mentioned specialist societies (and others), and was published titled *Core Competencies for Health Care Ethics Consultation Core Competencies for Health Care Ethics Consultation*.[7]

The report starts by defining the tasks and objectives of ethics consultation. Ethics consultation is understood as a service of a single person or a group aiming to support patients, relatives, representatives on the patient's behalf, employees, and other involved persons, who find themselves confronted with uncertainties and conflicts when dealing with value-laden issues. The consulter shall be enabled

[6] Fletcher, Hoffmann [1994].

[7] ASBH [1998].

by the consultation to a better analysis and understanding of the uncertainties concerning values or conflicting values; at the same time the consultation shall contribute to a practical solution to the uncertainty respectively to the conflict. This so-called *ethics facilitation approach* is given preference over two other possible approaches to consultation: the *authoritarian approach* understands ethics consultation as a moral expertise; that is, the ethics consultant qua expert for questions of morality gives the "right" or the "best-possible" answer according to his point of view to the problem he is confronted with. This approach involves the risk that the ethics consultant gives higher preference to his own attitude to morality than to the ones of the other participants, and it involves the risk that not every person or group of persons involved in the conflict can contribute to the decision-making process. The *pure facilitation approach* on the other hand is exclusively concerned with reaching a consensus; it fails to see that not every consensus is equally morally acceptable (like the consensus between doctors, carers, and relatives to ignore the clearly articulated wish of a patient stated in a living will while the patient is not able to decide anymore). In other words: ethics consultation in terms of the ethics facilitation approach is about helping to find a solution in the context of morally acceptable possibilities that can be shared by each of the parties. This may take place through case-by-case consultation, through the implementation of guidelines (like instructions or recommendations for hospitals or nursing homes) or by offering further education or trainings in ethics.

In order to carry out this form of consultation, the ethics consultants have to possess certain skills, knowledge, and traits of character. The detailed description of these "core competencies for ethics consultations" makes up the main part of the report. Summarizing the different abilities and knowledge, you can say according to the *Core Competencies*: Who is working in ethics consultation should be able to recognize and analyse an ethical problem as well as to organize and to guide the process of consultation. In addition he or she should be familiar with bioethical topics and concepts, with questions concerning the health care system, with questions concerning the religious attitudes of patients and staff, as well as with the relevant legal guidelines (criminal law, civil law, etc.), or other guidelines (vocational or professional law, rules of accreditation, hospital directives, etc.). Furthermore, he or she should create an atmosphere of mutual trust and respect by his or her personality; it is helpful for that purpose to possess features like tolerance, patience, compassion, honesty, courage, prudence, and integrity.

The above mentioned core competencies relate primarily to clinical ethics consultation, that is, giving advice to patients, relatives, and representatives as well as to the nursing staff in questions of ethical concern, directly resulting from

concrete issues in patient care. When performing organizational ethics consultation, that is, the consultation of a hospital or a caring institution on matters of ethical principles (e.g.: Which attitude does our institution represent in questions concerning issues like "prenatal diagnostics and abortion", "information of patients and relatives", "dealing with the patients living will", or "distribution of resources within the institution"?), according to the task force other knowledge is needed (e.g. of topics of health management), about what the report is held quite general and provisional.

The question concerning the evaluation of ethics consultations is mentioned in the report, but is dealt with very briefly. On the whole, the task force emphasize that the consultants as well as the process and the outcome of the consultation have to be evaluated. It is not mentioned how such an evaluation could be performed.

Altogether the report entails lots of important suggestions on quality control of ethics consultation. The detailed list of skills and knowledge is helpful for the single consultant to make out own deficits in competencies and to correct them with the help of appropriate training measures. When developing educational training programs, hospitals, nursing homes, and external providers can orient on the mentioned core competencies.

When comparing the report with the original purpose of the task force, namely, to develop standards for ethics consultations in health care, you have to notice that the *Core Competencies* do justice to this order only partly. Of the five areas for standardization in ethics consultation[8] only the section education and training of ethics consultants is mentioned explicitly. Other areas, like access to ethics consultation, procedure of consultation, documentation of the results of consultation, and evaluation of consultation, are either not mentioned at all or treated insufficiently. Also the task force explicitly repudiate against understanding their Core Competencies in terms of standards (e.g. for accreditation of ethics consultants or for certification of education programs for ethics consultants). Edmund Pellegrino, a well-known American medical ethicist, concluded in a comment: „Future reports must confront the problem of standardization more directly. [...] Some standardization of expertise is unavoidable".[9]

[8] Fletcher, Hoffmann [1994].

[9] Pellegrino [1999].

## 2. Quality Standards for Ethics Consultations

In the following, some suggestions of the US-American debate shall be picked up in order to name some concrete proposals for quality standards against the background of own experiences in ethics consultation and guidance of institutions in implementing ethics consultation. It is made use of the typical distinction in quality management between the quality of structure, process, and outcome.

### *2.1. Quality of the Structure of Ethics Consultation*

*It should be possible in any hospital as well as in any nursing home to address ethical questions to staff on ward level and to staff on management level and to talk it over with the participants. Any institution has to decide for itself which structures best to apply to make this possible and promote it.*

Often hospitals decide to implement a clinical ethics committee, for example within the context of an certification, without even considering whether such a committee provides the appropriate structure to promote the debate on ethical questions at the own institution. Besides the consultation in ethics committees there are other models, like ward consultation by a clinical ethicist, by specially trained guides, or by single members of the ethics committee.[10] On which of these models to decide should be dependent on local conditions and on the expectations that staff and management link with the implementation of ethics consultation. Further, each institution should ask itself whether ethics consultation is (at present) desired and useful at all. Especially at institutions where ethics haven't been an issue so far, other offers could be more suitable, like regular ethics meetings, teams on ethics, or accessible case discussions, to increase the sensibility of team members and other participants of questions of ethical concern and to strengthen their competencies in dealing with such issues.

*The implementation of ethics consultation requires professional guidance.*

The decision on a suitable model of ethics consultation and its successful implementation calls for specific knowledge (e.g. of tasks and models of ethics consultation and of the processes of organizational development). When implementing ethics consultation, it is advantageous to benefit from other institutions' experiences in order to avoid certain pitfalls and not to reinvent the wheel all over again. Some institutions will already have staff members who are appropriately experienced and competent. Other institutions will have to get external professional help. When ethics consultation is successfully implemented and the mem-

[10] Neitzke [2008].

bers concerned are appropriately trained, they will be able to run the ethics consultations without constant guidance from outside.

*Ethics consultation has to be wanted and supported by both the management and the staff of the institution.*

In some institutions the management initiate the implementation of ethics consultation (top down), whereas in other institutions the staff give the impulse (bottom up). In both cases the success of the implementation is depending on whether it succeeds to get the other party on board. Ethics consultation, which is wanted by the management only, will not be used by the staff members. On the other hand staff members, who engage for an ethics consultation, but are not supported by the management, will give up frustrated at a point. Where there is a lack of support from one of the parties, you have to consider how to win the other side over. This is where external guidance may be helpful, too.

*An appropriate qualification of consultants is a necessary pre-condition to ethics consultations.*

The quality of ethics consultations is depending highly on the qualification of the consultants. Ethic consultants have to be prepared by suitable internal and external education and have to be trained continuingly on their tasks. This is a matter of institutional as well as of individual responsibility: An institution that is not ready to provide the necessary resources should refrain from offering ethics consultation. An employee who cannot or does not want to raise the time needed should consider if he or she is the right person for this task.

In Germany, a task force of the *Akademie für Ethik in der Medizin*, an interdisciplinary scientific society for medical ethics, developed a curriculum on ethics consultation in hospitals (Simon/May/Neitzke 2005). Based on this curriculum, more than 300 members of clinical ethics committees from different professional backgrounds (medicine, nursing, pastoral care, social services etc.) have been trained in clinical ethics consultation.[11]

*Tasks and procedures of ethics consultations as well as the question of responsibility should be laid down in statutes or in an agenda.*

The statutes describe the internal quality standards for ethics consultation. They contribute to transparent decision making structures and serve the orientation of consultants as well as of people looking for advice. Furthermore, they contribute to a conscious consideration on tasks, procedures, and responsibilities.

[11] Dörries et al. [2009].

*2.2. Quality of process in ethics consultations*

*The statutes should deal with the following questions concerning the procedure of ethics consultations:*

*a) Which questions, problems, or conflicts may be topics of the ethics consultation?*

When ethics consultation shall be perceived as a consultation service and shall be effective, it has to state clearly, how it differentiates from other counselling services in hospital (e.g., specialist councils, supervision, social services, and pastoral care). Sometimes there is the mistaken idea with consultants and consulters that ethics consultation is in charge of all problems that are not solely medical or matter of care. Then the failure of ethics consultation is predicted. You can meet this risk with a clear definition which tasks and objectives an ethics consultation does pursue. If this is not the case, you should consider together with the person looking for advice whom to address instead.

*b) Who can take advantage of ethics consultation?*

In principle anyone who is confronted with an ethical problem in the context of patient care at the institution should be allowed to use the services of ethics consultations. Next to doctors and carers these are patients, their relatives and representatives as well as the management of the hospital or the nursing home, and other staff members. It is possible to restrict the account to ethics consultation, but it should be justified on the prevailing specific circumstances of the particular institution, especially on the resources of staff.

*c) Who has to be involved in or informed about the consultation process?*

The answer to this question depends on the concrete circumstances of consultation. When discussing on a closed case in retrospective in order to learn from it for future similar cases, you should avoid mentioning names, time, ward etc. for protection of the patient and participants. Whenever possible you have to ask for the patient's or representative's approval, especially in cases where the patient is still present at the caring institution. You should also inform the staff involved in that case, and ask if they mind the discussion of that particular case, especially when it is not long ago.

When consulting on actual cases, you have to distinguish: As soon as the subject is an ethical conflict any person (or group of persons) involved in that conflict has to be included in the consultation. When the subject is the clarification of the course of action instead, then the process of consultation can be limited on the person or group that wishes advice. The following example will make it clearer: The son of a patient, who is in a persistent vegetative state for over a year, asks in his function as his mother's legal guardian to end artificial feeding. The responsible doctor and the nurses feel insecure how to behave towards a request like this.

There are uncertainties whether, and if so, under which conditions, it is allowed to end artificial feeding. The staff members therefore turn to the ethics consultation. In a situation like this it may be wise to limit consultation on the team for the clarification of ethical and legal conditions for the cessation of artificial feeding in general. Whether these conditions are fulfilled in the actual case is a question that has to be subject of a discussion between the team and the son. When it comes to different opinions, and no consensus is reached, another ethics consultation may take place, where the son has to be involved in.

Please note in this context: When persons who are not part of the nursing team are included in ethics consultation it has to be made sure that they are bound to maintain confidentiality, e.g. by signing an appropriate declaration.[12]

*d) How to document the results of the consultation?*

The results of an ethics consultation should be documented in writing and in a manner that they are comprehensible for persons not involved in the actual consultation. This includes the ethical questioning, the relevant medical, caring, social, and other facts, the possible alternatives in acting and their normative evaluation as well as the joint decision.

When consulting on actual cases, the written documentation should be added to the patient's documents, a copy of the documentation should be deposited at the person in charge of the ethics consultation (e.g. at the chairman of the ethics committee).

When consulting on cases in retrospective, where the particular case often serves as the occasion to discuss a more general or returning issue, you should provide an estranged documentation, where the underlying question and the solutions to it are described. In addition, it can be useful to point out to that issue some general outcomes of the ethics consultation in the staff journal. Thus, it can encourage the staff to deal with that issue exceeding the actual ethics consultation on that case.

### 2.3. Quality of Outcomes of Ethics Consultation

*The outcomes of ethics consultation as well as the actual changes caused by ethics consultation should be documented on a regular basis.*

In order to evaluate the outcome of a particular consultation, you can ask the following questions:

- Were the participants content with the consultation process?

[12] Neitzke [2007].

- Could all the participants contribute with their point of view to the decision-making process?
- Was a consensus reached?
- Were the participants satisfied with the outcome of the consultation?
- Was the consensus within the boundaries set by societal values, law, and institutional policy?
- Was the consensus implemented?

Anyway, you have to be aware that these questions just pose indications for the evaluation of the quality of the outcome, and should always be regarded together. The failure to reach a consensus or the failure to implement the outcome does not necessarily indicate an insufficient consultation. Some problems are regarded so controversial that it is not possible to reach a consensus amongst all participants. As the last responsibility always lies within the agent, it can happen that he actually decides in a different way than the one proposed in the consultation (maybe because of slightly changed circumstances). Also the satisfaction among the participants as such is not the most appropriate scale to measure quality of ethics consultations. So it is conceivable that the doctors, the nurses as well as the husband, who is not belonging to this religious community, are quite happy with passing a blood donation to an unconscious member of Jehovah's Witnesses against their explicitly and repeatedly stated will. Still this would be a poor outcome of the consultation because it disregards the woman's right of self-determination and oversees that any treatment against the patient's will is legally regarded as a personal injury.

The easiest way to evaluate the outcome of ethics consultation as such is to regularly compile reports and discuss them with the members of the ethics consultation, the nursing staff, and the staff management. In the context of those periodic reports the following things could serve as parameter: number and topics of case consultations, medical units and professions involved, share of the cases where a consensus could be reached, share of the cases where the reached consensus was implemented, level of satisfaction among the participants. The two last parameters can be surveyed by enquiring as a matter of routine one or two weeks after consultation what has become of the case.

Additional to the periodical reports quantitative and qualitative evaluations of different groups of persons (management, staff members, patients, etc.) can take place. As those surveys are usually connected with high efforts, you should use them purposefully, e.g. to evaluate the work of the ethics consultation after the

first three years. Furthermore, they are only reasonable when their results enter in the further development of ethics consultation services.[13]

## Final Remark

Ethics consultation in hospital lives from the dedication of the persons involved. Yet dedication alone is no guarantor for the services' quality. Rather, certain structural and procedural conditions have to be met in order to perform ethics consultation successfully, effectively, and efficiently. Most of all these are an appropriate qualification of the consultants as well as the fixation on objectives, tasks, and procedures of ethics consultation in statutes or in an agenda. A professional guidance in implementation and evaluation of ethics consultation is useful and recommendable.

## References

ASBH [1998] – American Society for Bioethics and Humanities: Core Competencies for Health Care Ethics Consultations. Glenview, II, 1998.

Dörries, Hespe-Jungesblut [2007] – A. Dörries, K. Hespe-Jungesblut, *Die Implementierung klinischer Ethikberatung in Deutschland. Ergebnisse einer bundesweiten Umfrage bei Krankenhäusern*, „Ethik in der Medizin" 19, 2007: 148–156.

Dörries et al. [2009] – A. Dörries, G. Neitzke, J. Vollmann, A. Simon, *Qualifizierungsprogramm Hannover „Ethikberatung im Krankenhaus" – Konzeption und Ausblick*, in: J. Vollmann, J. Schildmann, A. Simon (ed.), *Klinische Ethik. Aktuelle Entwicklungen in Theorie und Praxis*, Campus, Frankfurt/New York, 2009: 125–138.

Fletcher, Hoffmann [1994] – J.C. Fletcher, D.E. Hoffmann Ethics Committees, *Time to Experiment with Standards*, "Annals of Internal Medicine" 120, 1994: 335–338.

Grossmann et al. [2002] – R, Grossmann, K. Heimerl, G. Zepke, *Die Evaluation von Prozessen der Organisationsentwicklung*, in: R. Grossmann, K. Scala (ed.), *Intelligentes Krankenhaus. Innovative Beispiele der Organisationsentwicklung in Krankenhäusern und Pflegeheimen*, Wien/New York, Springer 2002: 156–178.

Neitzke [2007] – G. Neitzke, *Confidentiality, secrecy and privacy in ethics consultation*, "HEC Forum" 19, 2007: 290–299.

Neitzke [2008] – G. Neitzke, *Aufgaben und Modelle von Klinischer Ethikberatung*, in: A. Dörries, G. Neitzke, A. Simon, J. Vollmann (ed.), *Klinische Ethikberatung. Ein Praxisbuch*, Kohlhammer, Stuttgart 2008: 58–75.

Pellegrino [1999] – E.D. Pellegrino, *Clinical Ethics Consultations: Some Reflections on the Report of the SHHV-SBC*, "Journal of Clinical Ethics" 10, 1999: 5–12.

[13] Grossmann et al. [2002].

Simon, Gillen [2001] – A. Simon, E. Gillen, *Klinische Ethik-Komitees in Deutschland. Feigenblatt oder praktische Hilfestellung in Konfliktsituationen?*, in: D. von Engelhardt, V. von Loewenich, A. Simon (ed.), *Die Heilberufe auf der Suche nach ihrer Identität. Münster*, „LIT", 2001: 151–157.

Simon [2008] – A. Simon, *Qualitätssicherung und Evaluation von Ethikberatung*, in: A. Dörries, G. Neitzke, A. Simon, J. Vollmann (ed.), *Klinische Ethikberatung. Ein Praxisbuch*, Kohlhammer, Stuttgart 2008: 167–181.

Simon et al. [2005] – A. Simon, A.T. May, G. Neitzke, *Curriculum „Ethikberatung im Krankenhaus"*, „Ethik in der Medizin" 17, 2005: 322–326.

ZEKO [2006] – *Zentrale Ethikkommission bei der Bundesärztekammer. Ethikberatung in der klinischen Medizin*, „Deutsches Ärzteblatt" 103, 2006: A1703–1707.