Special Section: Coming of Age in Clinical Ethics Consultation: Time for Assessment and Evaluation

Guest Editorial: Encouraging the Dialogue

GEORGE J. AGICH and STELLA REITER-THEIL

Ethics consultation is the most engaged aspect of clinical ethics, a field focused on ethical issues, questions, and conflicts arising in the course of patient care and delivery of healthcare services. Despite the skepticism of some academic bioethicists and criticism expressed by social commentators,[1] clinical ethics, which began in North America, has expanded to Europe and many other parts of the world with the proliferation of healthcare institution ethics and ethics consultation support services.[2] Along with the development and implementation of ethics policies and guidelines for patient care through work on hospital ethics committees, clinical ethicists are increasingly involved in the ethics of healthcare organizational structures and processes and the day to day provision of ethics consultative services to health professionals, patients, and families. These activities bring the larger field of bioethics into the context of clinical practice in ways that demonstrate the practical relevance of the entire field.

This section on clinical ethics was planned to encourage the dialogue between European and North American activities in the field. It includes papers drawn from plenary lectures that were originally delivered at the Second International Conference on Clinical Ethics Consultation held in Basel, Switzerland, March 17–20, 2005; additional papers were invited from individuals involved in this and other international conferences focusing on clinical ethics and consultation.[3] Collectively, these papers illustrate the dimensions in which the field has matured. They also point to the complexity and vibrancy of this burgeoning field. Although still in a formative and dynamic phase of development, clinical ethics is now sufficiently mature to be open to critical self-examination, including empirical investigation.[4]

The section begins with a paper by George J. Agich on "Why Quality Is Addressed So Rarely in Clinical Ethics Consultation." Agich argues that although quality was raised as a central concern early in the history of the field, it has generally been ignored by the clinical ethics consultation literature since. Arguing that attention to accountability has been dominated by preoccupation with external accountability instead of the internal pursuit of quality, Agich accepts a recommendation by John Fletcher that credentialing should be established at the institutional level within which the ethics consultation services are provided. This locates accountability for assuring that individuals who provide ethics consultation meet basic qualifications for providing the service at the institutional level. Agich focuses on the pursuit of quality in ethics consultation, which he sees as a central requirement internal to the practice itself. Quality has not been

Cambridge Quarterly of Healthcare Ethics (2009), **18**, 333–337. Printed in the USA.
Copyright © 2009 Cambridge University Press 0963-1801/09 $20.00
doi:10.1017/S0963180109090537

https://doi.org/10.1017/S0963180109090537 Published online by Cambridge University Press

a focus for the field, he surmises, because conflicts over goals and techniques of ethics consultation have impeded attention to the actual processes involved in the performance of ethics consultations. He argues that quality can only be pursued practically within the concrete settings of ethics consultation, and he suggests that the theoretical characterizations of ethics consultation and clinical ethics must also come to terms with the everyday details of the actual activities that comprise the field, which is the ideal locus for addressing the important question of quality.

Stella Reiter-Theil, in her paper "Dealing with the Normative Dimension in Clinical Ethics Consultation," addresses a central and foundational question for ethics consultation, namely, the degree to which clinical ethics consultation involves normative judgments and decisionmaking. Previous discussions of normativity in clinical ethics have been framed in terms of the authority or expertise of the clinical ethicist not only in ethics consultation, but in contexts of public policy and law.[5] Reiter-Theil, instead, offers a grounded schema for understanding how normativity actually emerges from and is used in clinical ethics consultation. She shows that what we might properly term *morally normative judgment* is actually rarer in clinical ethics consultation than the debates over the use of normative judgment in ethics consultation imply. Normativity certainly has a cardinal place in clinical ethics, but its functions and permutations are far more subtle than commentators have previously observed. This is made clear by the interpretive framework that she develops. This framework differentiates different senses of dealing with the normative dimension that is involved in the various complex actions and processes that make up the engagement with practical ethical questions and conflicts arising in the course of patient care and case discussion. Such a framework can help to overcome the confusion that characterizes the recent discussion and debate about the legitimacy of clinical ethics consultation and might help to better focus future discussions. Like Agich, she argues that one has to attend to the contextual analysis and demands of the authentic case example or practice setting if one is to fully and accurately understand the complex types of normatively relevant attitudes and actions ("normativity") that are involved in the practice of ethics consultation.

The attention to the clinical context is also reiterated in the paper by Gerd Richter, "Clinical Ethics as Liaison Service: Concepts and Experiences in Collaboration with Operative Medicine." Richter argues that consultative activities that focus on conflicts and dilemmas provide an inadequate model for building and providing clinical ethics services. In the domain of surgical practice, he reports the use and experiences of an ethics liaison service to a surgical critical care unit that creates a role for the clinical ethicist that is far more engaged and more like being a member of the team.[6] The design of the ethics consultation liaison service is integrated with the ordinary processes common in the unit, which helps to establish a collaborative relationship with physicians and critical care providers. This relationship is focused less on crises or conflicts than the ethical concerns and questions that arise in the everyday course of care. Richter argues that this type of relationship is a central prerequisite for developing an environment that is fertile for clinical ethics.

Advancing an argument for cultivating an environment fertile for ethics consultation is further developed in the paper by Mark P. Aulisio et al., "Clinical Ethics Consultation and Ethics Integration in an Urban Public Hospital." Aulisio

https://doi.org/10.1017/S0963180109090537 Published online by Cambridge University Press

et al. reflect on the evolution of ethics consultation at an urban public hospital, arguing that the changes in the consultation model and processes that were adopted reflect important attitudinal changes within the institution toward clinical ethics and consultation. These changes, they argue, reflect a greater maturity in not only the hospital ethics committee and consultation service, but in the attitudes of the medical staff and other health professionals toward ethics generally. A key lesson is drawn that the resolution of single cases should not be an isolated preoccupation of clinical ethics services because it is only a part of the larger ethics mission of the ethics consultation service and committee within the organization. Thus, integration of clinical ethics activities within the organizational culture should be included as an important goal for all ethics consultation services.

Questioning tacit assumptions underlying ethics consultation is an important feature of the paper by Stuart G. Finder, ''Is Consent Necessary for Ethics Consultation?'' Given the prominence of informed consent in bioethics literature, some readers will find it surprising that Finder is willing to challenge this assumption in the context of ethics consultation. He does so on three grounds: vulnerability, role, and experience. Without disputing the importance of informed consent in protecting the vulnerability of patients, Finder argues that healthcare professionals are also vulnerable, at least, if vulnerability is regarded in broad ethical terms, and so they are subject to distress. He defends the view that patient consent should not prevent healthcare staff from getting support to address their ethical distress through ethics consultation; emphasizing patient informed consent runs the risk of denying staff necessary help in addressing their need for ethics consultation. He also argues that some requests by health professionals for ethics consultation are prompted not only by the ethical quandaries associated with discharging their role-related responsibilities but by the experiences of the person in the clinical role. These considerations support his conclusion that consent for ethics consultation is more complex than we might first think and that the decision about consent should not be made universally, but should be determined based on the specific clinical circumstances that give rise to the consultation request.

Anne Slowther's ''Ethics Case Consultation in Primary Care: Contextual Challenges for Clinical Ethicists'' shifts the typical focus of ethics consultation from the institutional or unit setting to the much neglected challenges that arise in providing case consultation in the context of primary care. Focusing on the general practice setting of the United Kingdom's National Health Service, she argues that the ''four-alarm'' paradigmatic cases that dominate the clinical ethics literature understandably derive from its focus on secondary and tertiary care settings. However, a different range of ethical questions arise in primary care settings that create unique opportunities and needs for clinical ethics consultation. Because the bulk of medical care is delivered in such settings, these settings present both unique opportunities for clinical ethics and also significant challenges. Slowther argues that the underlying methodology and commitment of clinical ethics consultants often involve commitments that reflect the institution-focused contexts within which ethics consultation first developed. Beyond attention to the standard range of classical problems of ethics, she notes that greater attention to the social contexts and settings within which care is delivered as well as the social structures that affect the way that patient problems are presented to healthcare providers are necessary components for any clinical

https://doi.org/10.1017/S0963180109090537 Published online by Cambridge University Press

ethics services in the primary care context. This lesson reinforces the conclusion of Aulisio et al. about the need for integration of clinical ethics into a wider vision of the organization within which it operates.

Taking up the theme of assessing ethics consultation that Agich framed in terms of quality improvement, the next paper, entitled ''Evaluating Clinical Ethics Consultation: A European Perspective'' by Margarete Pfäfflin, Klaus Kobert, and Stella Reiter-Theil, addresses the problems and challenges associated with evaluating ethics consultation. On the basis of a literature review, they point out an imporant connection between the organizational and operational features of ethics consultation services and the prospects for effective evaluation of the services provided. After categorizing and discussing the measurable outcome criteria for some of the early attempts at evaluation into four broad content domains, ethicality, satisfaction, resolution of conflict, and education, they propose a new set of criteria: content-, structure-, process-, and outcome-oriented critera that reflect their efforts to develop empirical assessment of ethics consultation. Given that sound (empirical) evaluation of and research on ethics support services depend heavily on infrastructure and resources that are often scarce in the European setting, they argue in favor of following minimal standards of evaluation and suggest an approach to record keeping that should provide a realistic basis for effectively developing the evaluation of ethics consultation.

The final paper in this section, Paul Schotsmans and Chris Gastmans' ''How to Deal with Euthanasia Requests: The Palliative Filter Procedure,'' addresses an increasingly common and difficult clinical ethical problem, namely, how to handle patient requests to terminate their life through a medical intervention. Schotsmans and Gastmans report on their experience working under the permissive Euthanasia Act in Belgium and argue that, what they call the *palliative filter approach*, which is based on a Roman Catholic view, offers an ethically sound procedure for making explicit how medical and nursing expertise can be employed to achieve the best care possible for patients. Their analysis focuses only on terminally ill and competent individuals who make requests for euthanasia. Persons not terminally ill or incompetent are regulated by other Belgium laws and are not addressed in this paper. Schotsmans and Gastmans' contribution reminds us that clinical ethics consultation, although anchored within normative structures that are embedded within the practice of clinical medicine and clinical ethics, is also shaped by societal norms and legal standards and that the ethical justification and evaluation of its practices may need to reach beyond secular bioethics. It also raises the question of how approaches like the palliative filter can be implemented in other societal contexts.

Collectively, these papers reiterate the question of how normative elements and structures function throughout the activities that make up the practice of ethics consultation. Attending to these processes is an important prerequisite for evaluating clinical ethics. A recurrent theme in these papers is that the important questions about the assessment and justification of clinical ethics require significant attention to the concrete settings in which ethics consultation operates.

Notes

1. Ackerman TF. The role of an ethicist in health care. In: Anderson GR, Glesnes-Anderson VA, eds. *Health Care Ethics*. Rockville, MD: Aspen Publishing Company; 1987:308–20; Avorn J. A

https://doi.org/10.1017/S0963180109090537 Published online by Cambridge University Press

physician's perspective. *Hastings Center Report* 1982;12(3):11–2; Baker R. The skeptical critique of clinical ethics. In: Hoffmaster B, Freedman B, Fraser G, eds. *Clinical Ethics: Theory and Practice*. Clifton, NJ: Humana Press; 1989:27–57; Barnard D. Reflections of a reluctant clinical ethicist: Ethics consultation and the collapse of critical distance. *Theoretical Medicine* 1992;13:15–22; Beauchamp T. What philosophers can offer. *Hastings Center Report* 1982;12(3):13–4; Noble CN. Ethics and experts. *Hastings Center Report* 1982;12(3):7–9; Noble CN. Response. *Hastings Center Report* 1982;12(3):15; LaPuma J, Schiedermayer DL. The clinical ethicist at the bedside. *Theoretical Medicine* 1992;12: 285–92; Scofield GR. Ethics consultation: The least dangerous profession? *Cambridge Quarterly of Healthcare Ethics* 1993;2:417–48; Singer P. Ethical experts in a democracy. In: Rosenthal DM, Shehadi F, eds. *Applied Ethics and Ethical Theory*. Salt Lake City, UT: University of Utah Press; 1988:149–61; Wikler D. Ethicists, critics, and expertise. *Hastings Center Report* 1982;12(3):12–3; Wildes KM. Healthy skepticism: The emperor has very few clothes. *Journal of Medicine and Philosophy* 1997;22(4):365–71.

2. Aulisio MP, Arnold RM, Youngner SJ. Health care ethics consultation: Nature, goals, and competencies. A position paper from the Society for Health and Human Values—Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation. *Annals of Internal Medicine* 2000;133:59–69; The report of the American Society for Bioethics and Humanities. Core competencies for health care ethics consultation. In: Aulisio MP, Arnold RM, Youngner SJ, eds. *Ethics Consultation*. Baltimore: Johns Hopkins University Press; 2003:165–209; Fournier V, Pousset M. [Cochin Hospital Clinical Ethics Center: The first two years] (in French). *La Presse Médicale* 2006;35:960–6; Glasa J. Establishment and work of ethics committees in central and eastern European countries. *Medical Ethics & Bioethics* 2002;9:9–12; Hurst SA, Reiter-Theil S, Perrier A, Forde R, Slowther AM, Pegoraro R, Danis M. Physicians' access to ethics support services in four European countries. *Health Care Analysis* 2007;15:321–35; Reiter-Theil S. Ethics consultation on demand: Concepts, practical experiences and a case study. *Journal of Medical Ethics* 2000;26:198–203; Reiter-Theil S. Ethics consultation in Germany: The present situation. *HEC Forum* 2001;13:265–80; Slowther A, Bunch C, Woolnough B, Hope T. Clinical ethics support services in the UK: An investigation of the current provision of ethics support to health professionals in the UK. *Journal of Medical Ethics* 2001;27:12–8; Steinkamp N, Gordijn B. Ethical case deliberation on the ward. A comparison of four methods. *Medical Health Care and Philosophy* 2003;6:235–246; Steinkamp N, Gordijn B, Borovecki A, Gefenas E, Glasa J, Guerrier M, et al. Regulation of healthcare ethics committees in Europe. *Medical Health Care and Philosophy* 2007;10:461–75.
3. This conference in Basel was part of a series of International Conferences on Clinical Ethics and Consultation (ICCEC) that began in Cleveland, Ohio, April 4–6, 2003, followed by a meeting held in conjunction with the Canadian Bioethics Society in Toronto, Canada, on June 1–3, 2007; in 2008 the series continued with a conference in Rijeka, Croatia, September 4, 2008, in conjunction with the Ninth World Congress of Bioethics.
4. Reiter-Theil S, Agich GJ, eds. Thematic section on research on clinical ethics and consultation. *Medicine, Health Care and Philosophy. A European Journal* 2008;11(1):3–42.
5. Agich GJ, Spielman B. Ethics expert testimony: Against the skeptics. *Journal of Medicine and Philosophy* 1997;22:381–403. See note 1, Avorn 1982, Beauchamp 1982, and Noble 1982; Paris JJ. An ethicist takes the stand, *Hastings Center Report* 1984;14(1):32–3; Pellegrino ED, Sharpe VA. Medical ethics in the courtroom: The need for scrutiny. *Perspectives in Biology and Medicine* 1989;32:547–64; Sharpe VA, Pellegrino ED. Medical ethics in the courtroom: A reappraisal. *Journal of Medicine and Philosophy* 1997;22(4):373–9; Spielman B, Agich GJ. The future of bioethics testimony: Guidelines for determining qualifications, reliability, and helpfulness. *San Diego Law Review* 1999;36(4):1043–75. Also see note 1, Singer 1988, Wikler 1982, and Wildes 1997.
6. Agich GJ. Joining the team: Ethics consultation at the Cleveland Clinic. *HEC Forum* 2003;15(4): 310–22.

https://doi.org/10.1017/S0963180109090537 Published online by Cambridge University Press