

Preconference: Clinical Ethics Consultation Workshop

2nd Annual NSHEN conference
March 25, 2009

Overview

- Getting started - assumptions and goals
- Two cases
- Setting the context
- Different approaches?
- Skills, knowledge?
- Considering a clinical ethics consultation (CEC) transcript
- CEC process
- Where to from here?

Assumptions and goals

- Domain of clinical ethics
 - Overview of CEC as a form of ethics support
 - Content via workshops, NSHEN activities
- Focus on learning, applying, reflecting
- Social justice and relational grounding



Two cases

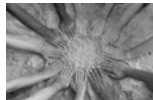
- Introducing...
 - “Should Steve Go Home?”
 - “Challenging Changes in Goals of Care”

Setting the context

Why do we want to do clinical ethics consultation?

Why do we need clinical ethics consultation?

“Need” CEC?



- Complexity of health care
- Values heterogeneity
- No substantive definition of the good

Aulisio 2003

Possible goals of CEC include...

- Facilitation of communication among involved parties
- Ethics-based analysis and recommendations
- Building of ethics awareness and sensitivity
- Ethics education

What is the role of a CEC?

- How would you describe a clinical ethics consultant?
- How is the role of a CEC unique from other roles in health care and how is this expressed?
- What should the authority of a CEC be?

Accountability

- Who should the Ethics Committee and/or CEC(s) report to?
- To whom is the CEC accountable?
- Consider conflicts of interest, organizational supports

Legal considerations

- Verify coverage by health region's insurance policy (as committee, as volunteers)
- Importance of having appropriate terms of reference, a well-constructed process and following this process

What are common barriers for clinical ethics consultation?

Potential barriers include...

- Minimal awareness of availability of service
- Lack of understanding of CEC process
- Uncertainty and/or lack of trust in process
- Uncertainty as to whether process will be helpful

Potential barriers include...

- Time required is too great (by health care providers and/or committee members)
- Lack of organizational support
- Concern about competency or expertise

Key factors influencing choice of goals include...

- Expectations of your health care organization
- Availability of health care ethics expertise
- Availability of other sustainable resources: people, time & finances

How does being in a rural, urban, or 'mixed' context influence or shape clinical ethics consultation?



Considerations related to...

- “Who knows who”
 - Ethics of familiarity and of strangers
 - E.g., confidentiality, team dynamics, sense of community, definition of health and quality of life
- Process aspects
 - E.g., use of power, who should be involved

Upshot?

Regardless of context...

- Ethical reflection and deliberation are of value
- Still accountable for gathering all facts, following a good process, considering options, and evaluating what happens
- Able to contribute to building a moral community

What are different approaches to clinical ethics consultation?



Some CEC models

- Single clinical ethics consultant
- By committee
- Small team approach
- Ethics mentors/influentials

Single clinical ethics consultant

- Typically is a person hired to provide ethics support
- Often is a person with advanced learning and education in ethics
- Frequently carries a pager
- May tend to be more directive

**Single clinical ethics consultant
Advantages**

- Consultations usually easier to arrange in a timely fashion
- Well suited to 'bedside' consultation
- Sense of similarity with other types of consults

Single clinical ethics consultant

Disadvantages

- Looks authoritarian/paternal with consultant positioned as primary moral decision-maker
- Sends wrong organizational message that ethics, value clarification, etc. are only for 'experts'
- High cost of hiring health care ethicist full time

By committee

- The whole ethics committee receives requests, deliberates on the issues, and responds with recommendations

By Committee

Advantages

- Diverse, multidisciplinary perspectives brought to process
- Opportunity for ethics education of committee members
- Diffusion of responsibility for recommendations

By Committee

Disadvantages

- Logistical difficulties getting committee together in timely fashion
- Costly in terms of time spent by committee members away from their primary responsibilities
- Potential greater emotional cost to involved parties (larger audience) and greater risk of confidentiality breaches
- Not well suited to 'bedside' consultation

Small team approach

- A small group of CECs or ethics committee members responds to requests and shares responsibilities for ensuring all aspects of the consultation process are addressed

Small team approach

Advantages

- Less authoritative looking than single consultant
- Consultations easier and faster to arrange than with whole committee
- Team members can collectively provide relevant ethics education and experience

Small team approach

Disadvantages

- Requires roster of interested/competent individuals (usually committee members)
- Less diversity of input than with full committee
- Possibly slower process than with single consultant model

Ethics mentors/influentials

- Less formal approach
- Focus is on identifying and providing ethics education/training for key persons in different locations throughout health region
- Function as form of 'local' support and leadership with respect to ethics
- 'First response' to ethics concerns

Ethics mentors/influentials

Advantages

- Develop network of mentors
- Visible commitment and awareness of ethics
- Over time, more persons with ethics training
- Potential decreased burden on clinical ethics consultation process and ethics committee members


Ethics mentors/influentials

Disadvantages

- Initial, higher demands for ethics education and training
- Difficulty of maintaining contact between mentors
- Possible high rate of turnover - questions about replacements
- Potentially more difficult to evaluate

**What skills, knowledge, etc.
are important for clinical ethics
consultation?**

One approach...

- “Core competencies for health care ethics consultation”
 - Recommendations of the American Society for Bioethics and Humanities (May 1998)
 - Currently being updated
- Canadian version/approach to “core competencies” is being planned 

Core ethics competencies (ASBH)

- Skills – basic and advanced
 - Ethical assessment
 - Process
 - Interpersonal
- Knowledge – basic and advanced
 - Nine core areas

Questions about character and CEC...

ASBH core competencies talk about:

- Tolerance & compassion
- Patience
- Integrity
- Honesty & forthrightness
- Courage
- Self-knowledge
- Prudence & humility

Looking at a CEC transcript:

**“HIV and Postsurgical Complications
in the ICU”**

What are the different steps of the clinical ethics consultation process?

CEC process

- Access
- Intake
- Triage
- Notification
- Discussion/deliberation/
reflection/analysis
- Documentation
- Debriefing
- Evaluation

Process: Access

- Who gets to use CEC?
- Awareness of CEC
- How to get in touch
- How long to wait for response

Process: Intake and Triage

- Gather information
 - Develop standard form/approach
 - Who should be involved, what is the relevant clinical information, etc.
- Identify the issue(s)
 - Is it a clinical ethics issue?
 - Does it need a full ethics consultation?

Process: Notification

- Prepare people for the CEC process and their roles in it
- Prepare the ethics team (if applicable) – who will be involved and what is expected of them

Process: Notification

- Typically the patient and the attending physician are informed that an ethics consultation has been requested (if not the initiators or already informed)
- Permission from the patient and the attending is not required for the ethics consultation to proceed
 - Controversial

Process: Discussion/deliberation

- Possible roles for clinical ethics consultants
 - Facilitator – everyone gets a chance to talk, engage different participants
 - Ethical analysis facilitator – introduction of relevant ethics information, development of ‘best’ arguments, clarifying and correcting any ethics-related confusion
 - Recorder – maintain a summary of issues discussed and any recommendations reached

Process: Discussion/deliberation

- Opening statement (ritual)
 - Introductions
 - Objectives or goals of process
 - ‘Ground’ rules (already explained in notification)
- Clarification/overview of the clinical situation

Process: Discussion/deliberation

- Focus on the process
 - Attention to who gets to speak first
 - Allow sharing of affective responses
 - Attention to creation of optimal, inclusive ‘moral space’ for reflection & deliberation
 - Focus on engaged participation
 - Be prepared for tension and possible conflict
 - Ensure communities of meaning (for patient) are included, if appropriate

Process: Analysis/reflection

- Focus on the process
 - Draw on what was learned during the intake process
 - Work on clarifying the relevant issue(s)
 - Identify, deliberate and reflect on the ethics features
 - Discuss courses of action/inaction and their ethical aspects
- Be prepared to sum up, repeat, and check what points people are making – help make best case

Process: Analysis/reflection

- Wrap-up
 - Recorder sums up discussion and any recommendations arrived at by the group
 - Asks for agreement on this record (becomes part of documentation)
 - Formal thank you for participants
 - Offer of additional support extended, if appropriate

Process: Documentation

- Record of presenting issue and any additional issues discussed, as well as who was involved in the consultation
- Record of recommendations and/or consensus reached, as applicable

Process: Documentation

- Place on patient's chart?
 - Many places do indicate an ethics consultation took place, the issues discussed, and any recommendations – but is still somewhat controversial
- Maintain records for consultation service
 - Develop retention and disposal policies
 - High level reporting

Process: Debriefing

- Important for CECs to discuss how the process went, what could be done better next time, what worked, etc.
- Focus on process, not necessarily content
- Share learning with other members of ethics committee or CECs
- Identify any learning issues or broader issues for region/organization to address

Process: Evaluation

- By participants in consultation
 - Immediately after/3-6 months later
 - Survey or phone call
- Option of tape-recording consultation?
 - For further evaluation of process, learning for CECs

Some 'tools'


Ethical decision-making frameworks:

- "A Method for Ethical Deliberation: RICE"
by Andrea Frolic
- Local/provincial frameworks that are available (e.g., AVH, IWK, NSHEN)
 - Includes targeted frameworks

Where to from here?
Quick summary

Six key elements of an effective CEC service:

- Capacity-building
- Accessible
- Sustainable
- Accountable
- Reflective
- Responsive



Where to from here?
Quick summary

- Develop what makes sense for you and build skills, knowledge, experience over time
- Case for practice
 - How would you work your way through the CEC process?
 - How will it work in your health region?

Final thought...

“Do not be too moral. You may cheat yourself out of much life. Aim above morality. Be not simply good; be good for something.”



Henry David Thoreau
