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PART II

Clinical Ethics Consultation

This is the part that you've been waiting for—where ethical theory meets clinical reality. A key function of ethics committees is providing clinicians with an analytic framework for identifying and resolving ethical dilemmas that arise in the clinical setting. As discussed in part I, these challenges usually reflect the inherent tensions between and among the ethical obligations incumbent upon health care professionals. Sometimes the situations are matters of life and death, with elements of high drama. More often, they concern the rights and responsibilities of patients, families, and caregivers as they struggle to make decisions that are clinically, ethically, and legally valid. In that process, the perspective of the ethics committee is an invaluable resource.

Whether ethics committees assume responsibility for conducting clinical consultations on an ad hoc or rotating basis or periodically review the work done by a dedicated consultation service, members need a foundation in ethical analysis and a sense of why similar cases invoke certain reasoning. While consultation considers each case individually, the ethical concepts and principles that inform the process, presented in part I, provide analytic clarity and consistency. Part II begins with a discussion of the fundamentals of clinical ethics consultation, including the goals and descriptions of two different approaches that committees might adopt. Committees also may find it useful to compile a library of cases that can serve as analytic models. So, in addition to the case examples in part I, this section includes sample cases with the type of analyses they might receive in clinical ethics consultations.

9 Approaches to Ethics Consultation

KENNETH A. BERKOWITZ, M.D., AND
NANCY NEVELOFF DUBLER, LL.B.

Our goal in this chapter is to provide an introduction to health care ethics consultation, including a conceptual overview followed by descriptions of two very different consultation approaches. The CASES approach was developed by the Veterans Health Administration's National Center for Ethics in Health Care to set explicit standards for performing ethics consultation at nearly 160 Veterans Health Administration (VHA) medical centers nationwide. The second approach, bioethics mediation, reflects the work done during the past twenty-five years by the Bioethics Consultation Service at Montefiore Medical Center, Bronx, New York.

Ethics consultation is one way to help patients, care professionals, and other parties resolve ethical concerns in a health care setting and is now widely recognized as an essential part of health care delivery. The vast majority of U.S. hospitals have active ethics consultation services, usually a function of the institutional ethics committee, but these services vary widely in their approach, intensity, and effectiveness (Fox, 2002). In some places, such as Montefiore Medical Center, for idiosyncratic historical reasons, the ethics consultation service developed separately from the ethics committee.

Ethics consultation has been endorsed by numerous governmental and professional bodies, and is legally mandated under specific circumstances in several states (Tulsky and Fox, 1996). By providing a forum for discussion and a method of careful analysis, effective ethics consultation promotes health care practices consistent with high ethical standards, helps to foster consensus and resolve conflict in an atmosphere of respect, honors participants' authority while respecting their values and preferences in the decision-making process, educates providers to approach current and future cases according to agreed-upon principles, and fosters the notion of justice by ensuring that like cases will be treated in similar ways. Ethics consultation has also been shown to save health care institutions money by reducing the provision of nonbeneficial treatments, as well as certain hospital lengths of stay (Schneiderman et al., 2003; Schneiderman, Gilmer, and Teetzel, 2000; Dowdy, Robertson, and Bander, 1998; Heilicser, Meltzer, and Siegler, 2000). But these instrumental uses of bioethics consultation are welcome by-products of the intervention rather than the primary goal, which is to promote sound health care decision making, with respect for clinicians, patients, and families, and support for caregiver concerns.

As discussed in the introduction to this book, the three goals of most ethics programs and ethics committees are education, policy development, and case consultation. At the beginning of ethics committee development, most case consultation was retrospective, and that often remains the approach today for committees just starting to do consultation. Increasingly, as committee members gain experience with each other and with the ethical norms in their institution, and as the committee becomes comfortable with reflective analysis, real-time consultation becomes more customary. Thus, ethics committees and consultation services, to one degree or another, are involved in:

- retrospective review either of a case on which the consultation service consulted or a case handled without ethics participation
- prospective case consultation that involves members of the ethics consultation service intervening to affect the outcome of an active case

This chapter focuses on the latter of these tasks, prospective consultation on active patient cases.

THREE MODELS OF ETHICS CONSULTATION

Health care ethics consultations are typically performed by an individual ethics consultant, an ethics committee, or an ethics consultation team. As discussed below, each of these models has advantages and disadvantages. Although some ethics consultation services might rely exclusively on one of these three models, we generally recommend against this because each has its effective application under different circumstances. Instead, consultation services should determine which model is most appropriate for each consultation, depending on the ethical and clinical issues raised, the parties involved, the consultation skills required, and the staff available.

That said, it is important to note that a given institution may prefer one or another consultation model and be structured to facilitate that mode most easily. For example, at Montefiore, the bioethics mediation approach typically utilizes an individual consultant on each case. Whenever possible, however, the consultants prefer to work together so that they can co-mediate, a process that maximizes skills.

In this model, one person—either an independent "solo" consultant or a member of an ethics consultation team or committee—is assigned to perform a consultation alone. The advantages of the individual ethics consultant model are that it provides fewer logistical hurdles (e.g., scheduling meetings) and facilitates quick response to urgent consultation requests. The disadvantages are that the consultant must possess all required knowledge and skills to perform the consultation, and there are fewer checks and balances to protect against the intrusion of the consultant's own values and biases. One way to counter this problem is suggested by the Montefiore approach, in which the

consultant's initial meeting is with the entire involved health care team, making the collective knowledge and skills of the team available as the baseline for the consultation.

It is incumbent on the individual ethics consultant to recognize her strengths and limitations, and to get help when needed. The successful ethics consultant builds a web of strong, collegial relationships within the health care facility and network, and calls on others for assistance with particular clinical, ethical, legal, cultural, or religious concerns. Even the most highly trained and experienced ethics consultant benefits from confidentially discussing complex cases with other experts.

In addition, individual consultants should engage in systematic review of their consultations with colleagues. In the Montefiore approach, difficult cases are shared with the other ethics consultants on the service and retrospectively with the ethics committee. Another check on the process comes from entering a note in the patient's chart, where it can be read by clinicians, administrators, lawyers, and risk managers, alerting them to a developing problem. At Montefiore, the note is placed in the chart before perspectives are solicited from other persons who have different roles in the institution and may provide useful information and feedback to the consultant.

In the second model, a standing interdisciplinary committee—that is, a relatively stable group of typically between six and twenty people—jointly performs the consultation. The advantages of this model are that it facilitates collective proficiency and includes ready access to diverse perspectives and multidisciplinary expertise. Its disadvantages are that it requires a great deal of staff time, is not well suited to situations that require a rapid response, and diffuses responsibility among committee members, which can contribute to "groupthink." Most important, the potential for patients and family members to feel intimidated by a large group of white-coated professionals makes this model the opposite of a mediation approach, which seeks to "level the playing field." Using a small subset of the committee as the link between the committee and the patient or family can help to minimize this power imbalance.

The committee model may be especially useful for ensuring broad organizational input into difficult consultations, including those that might establish institutional precedent or end up in the media or the courts. This notion of consultation has less to do with solving the immediate problem and more to do with structuring the situation if the problem gets magnified or blows up. This model may also be useful to facilities that are relatively new to ethics consultation, handle a low volume of consultations, and/or lack specialized ethics expertise. Most committees are good at talking; some are proficient in analysis; and some, with experience, can bring perspective and wisdom to the enterprise.

In the team model, responsibility for the ethics consultation is shared by a small group of people selected from a pool of qualified consultants based on the knowledge and skills required by the circumstances of the case. The advantages of the consultation team model are that it lends itself to rapid responses and ensures diverse perspectives

and expertise because the members of the team can vary to meet the situation. Small groups can be less intimidating for patients and families, and the team itself provides a natural forum for support and reflection. Conversely, the team model is less efficient than the individual consultant model and provides fewer checks and balances than the committee model.

The team model allows tasks to be divided among members of the team, accommodates a wide range of situations and levels of consultant expertise, and is in some ways a compromise between the individual and committee models. It is the most common consultation model, used by more than two-thirds of hospitals in the United States (Fox, 2002).

CRITICAL SUCCESS FACTORS FOR ETHICS CONSULTATION SERVICES

Regardless of the consultation model(s) used, certain factors are critical for an ethics consultation service to achieve its goals and, for this reason, they should be formally incorporated into institutional policy. Ethics consultation services need to have integration, leadership support, expertise, staff time, and other resources. Access, accountability, organizational learning, and evaluation are also essential. These critical success factors are described below and, in greater detail, in the VHA primer *Ethics Consultation: Responding to Ethics Concerns in Health Care* (Fox et al., 2005).

The successful ethics consultation service must develop and maintain positive relationships with the various individuals and programs that shape the health care organization's ethics environment and practices. In this way, it serves the entire institution, not just a particular category of staff (e.g., physicians), a particular setting (e.g., intensive care), or a particular clinical service (e.g., surgery). A fully integrated ethics consultation service responds to the entire range of ethics concerns faced by the organization.

The ethics consultation service should look for opportunities to forge strong connections with other departments and services within the organization, share activities and skills, and identify and work toward achieving mutual goals. The integrated service can develop ongoing working relationships with programs and departments that commonly encounter ethics-related issues (e.g., pastoral care, patient advocacy, legal counsel, risk management, research, compliance, human resources). Collaborating with different services and programs will enhance staff understanding of each other's skills and roles and contribute to the overall organizational efficiency.

One critical element in the notion of integration is access to the consultation service. If the service is to be available to all staff and patients, it is useful to have a policy that encourages any member of the staff—subinterns to senior attendings, nurses and social workers—to request a consultation. Under such a policy, if the person calling for a consultation is not the attending of record, a call informing that physician about the consultation is an important early step in the process.

Explicit organizational leadership support is essential if the goals of ethics consultation are to be realized. Ultimately, leaders are responsible for the success of all programs, and health care ethics consultation is no exception. Organizational leaders establish institutional priorities and allocate the resources to implement those priorities. Unless leaders support—and are perceived to support—the facility's ethics consultation service, its function cannot succeed.

Health care facility leaders should ensure that ethics consultation services have the requisite expertise, including the knowledge, skills, and character traits necessary to perform competent and effective ethics consultation. Regardless of the consultation model used, the proficiencies outlined in *Core Competencies for Health Care Ethics Consultation* (American Society for Bioethics and Humanities, 1998) must be represented on the ethics consultation service.

Ethics consultants need adequate dedicated time to perform consultation activities, the requirements of which will vary depending on the types of consultations handled. Even a straightforward ethics case consultation typically takes several hours, while more complex cases—especially those that are novel or precedent setting—may continue for more than a week, requiring twenty or more hours of effort by multiple individuals. In addition, consultation services, often supported by their ethics committees, handle a variety of other activities, including requests for general information or education, clarification of policy, review of documents, ethical analysis of hypothetical or historical ("nonactive") cases or organizational ethics questions, or ethics teaching. Consultants should have a clear understanding with their supervisors that ethics consultation is not an optional or voluntary activity, but an assigned part of their jobs that requires dedicated time.

Ethics consultants need ready access to other resources, such as library materials, clerical support, training, and continuing education. Because many facility libraries lack a good selection of health care ethics references, a consultation service often needs its own core set of books and journals. A variety of useful ethics resources is also available online, making access to the Internet essential as well. Finally, ethics consultants need training and regular continuing education to develop, maintain, and improve their knowledge and skills.

As indicated earlier, an effective ethics consultation service must be readily accessible to all patients, families, and staff. The service should be available not only in acute care hospitals, but in all care settings. Ethics consultation services should take steps to ensure that patients, families, and staff in the various sites of health care delivery are aware of the ethics consultation service, what it does, and how to access it.

Like any other important health care function, ethics consultation must have a clear system of accountability to organizational leadership and be plainly situated within the reporting hierarchy. To ensure accountability, responsibilities relating to ethics consultation should be explicitly described in the performance plans of everyone involved, from senior leaders to frontline staff.

Ethics consultants should contribute to organizational learning by sharing their

knowledge and experience. Group discussion of actual cases (appropriately modified to protect the identities of participants) is an excellent way to engage and educate clinical staff. With relatively little effort, a consultation service note can be reworked into a newsletter article that summarizes an important ethics topic. Policy questions handled by the service can be turned into Frequently Asked Questions and posted on a website. Efforts such as these not only increase staff knowledge, they also enhance the visibility, credibility, and relevance of the ethics consultation service.

The success of the ethics consultation service requires ongoing evaluation, defined as the systematic assessment of the operation and/or outcomes of a program compared to a set of explicit or implicit standards, as a means of contributing to the continuous improvement of the program (Weiss, 1998). Evaluation efforts need not be elaborate or costly. Experts within the facility, such as quality managers, can assist in developing appropriate ways to assess these factors, ensuring that the measures used are valid and that data are collected and analyzed in a minimally burdensome fashion.

POLICY

The structure, function, and processes of ethics consultation should be formalized in institutional policy that addresses the following topics:

- the goals of ethics consultation
- who may perform ethics consultation
- who may request ethics consultations
- what requests are appropriate for the ethics consultation service
- what requests are appropriate for ethics case consultation
- which consultation model(s) may be used and when
- who must be notified when an ethics case consultation has been requested
- how the confidentiality of participants will be protected
- how ethics consultations will be performed
- how ethics consultations will be documented
- who is accountable for the ethics consultation service
- how the quality of ethics consultation will be assessed and assured

TWO APPROACHES TO CLINICAL ETHICS CONSULTATION

The following two approaches to ethics consultation reflect the quite different natures of the institutions that use them, as well the perceptions of the professionals involved regarding their expertise, authority, and responsibility. In the CASES approach, developed for use throughout the VHA system, ethics consultants are systematically guided through the process and practice of ethics consultations involving active patient cases. Bioethics mediation, the approach developed and used at Montefiore Medical Center, is

based on the consult team's experience that calls for ethics consultations are generally requests for help in resolving or managing conflict. Thus, it may be that the CASES approach will be very useful for certain medical centers or health systems, while the mediation approach may be more suited to others. Alternatively, some combination of these approaches or one of the several others not discussed here might prove useful, depending on the circumstances of a particular consultation.

The CASES Approach

The National Center for Ethics in Health Care is the primary office of the VHA for addressing the complex ethical issues that arise in patient care, health care management, and research. The mission of the National Center for Ethics in Health Care is to clarify and promote ethical health care practices within VHA, the country's largest integrated health care delivery system. Toward this end, the National Center for Ethics in Health Care developed the CASES approach to health care ethics case consultation, a systematic step-by-step approach to providing consistent and effective ethics case consultation at VHA facilities. Ethics consultants or committees wishing to learn more about the CASES approach and consider its applicability are encouraged to consult the comprehensive discussion, including tools, templates, sample cases, and other resources, presented in *Ethics Consultation: Responding to Ethics Concerns in Health Care* (Fox et al., 2005).

The CASES approach involves five steps:

Clarify the consultation request.
Assemble the relevant information.
Synthesize the information.
Explain the synthesis.
Support the consultation process.

These steps were designed to guide ethics consultants through the complex critical thinking needed to perform ethics case consultation effectively. They are intended to be used in much the same way clinicians use a standard format for taking a patient's history, performing a physical exam, or documenting a clinical case. Even when specific, observable action is not required, each step should be considered systematically as part of every ethics case consultation. Although the steps are presented in a linear fashion, *ethics consultation is a fluid process and the distinction between steps may blur in the context of a specific case.* At times, it may be necessary to repeat steps or perform them in a different order than presented here.

Clarify the Consultation Request

The first step requires the consultant to gather information from the requester to form a preliminary understanding of the circumstances and reasoning that prompted

an ethics consultation request. Two initial questions should help the consultant confirm whether the request is appropriate for ethics consultation:

Question 1: Does the requester want help resolving an ethics concern, that is, uncertainty or conflict over which decisions or actions are ethically justifiable? *If the answer is "no," and there is no uncertainty or conflict over which decisions or actions are ethically justifiable, the request is probably not appropriate for ethics consultation.* Requests that do not pertain to ethics concerns should be referred to other offices within the organization. *If the answer is "yes, there is an ethics concern," consider the second question.*

Question 2: Does the request pertain to an active patient case? *If the answer is "no," the request may still be appropriate for the ethics consultation service but not necessarily the CASES approach, which was specifically designed to address active cases.* Many ethics-related requests are for information or education, policy clarification, document review, or ethical analysis of issues or historical cases. Many of the CASES steps may also be relevant to other types of ethics consultation but, in noncase situations, the consultant should tailor the approach to the nature of the request. *If the answers to both Questions 1 and 2 are "yes, there is an ethical concern about an active patient case," the request should be handled through the CASES approach.*

Occasionally, a case-related question may appear so simple or the consultant may be so pressed for time that a formal consultation may not seem necessary. The temptation to cut corners should be resisted lest it undermine the quality of the consultation process. Ethics cases are often more complex than their initial presentation or perception, and each case deserves to be addressed systematically and comprehensively rather than handled through an "informal" or "curbside" approach. *If and when ethics consultants do comment informally on a clinical ethics question, they should be clear that they can only respond in general terms, and absolutely cannot give recommendations about a specific patient case without completing the CASES approach.*

After verifying that the request is appropriate for the CASES approach, basic information should be obtained, including the requester's demographics, role in the case, and understanding of the circumstances; the steps already taken to resolve the ethics concern; and the type of assistance sought. The consultant should establish with the requester realistic expectations about the consultation process and begin a preliminary determination of the personnel best suited to address the specific concern(s).

Next, the consultant should formulate the ethics question, a sometimes difficult but essential part of ethics case consultation. Clarity about the ethics question allows all participants to focus on the same concerns and work efficiently toward resolution, while an imprecisely formulated question can sidetrack or derail the consultation process. Accordingly, the consultant should formulate the ethics question early in the consultation process and examine it again once all the relevant information is assembled.

In a case consultation, *an ethics question asks what should be done in the face of an ethics concern, that is, in the face of uncertainty or conflict about values.* The initial formulation should not emphasize abstract concepts, but should state the question in a way that will focus and assist those who will participate in resolving the case. At the risk of reducing important issues to a formula, the ethics question might be constructed in one of the following two ways, with the consultant providing the case-specific information called for in the parentheses:

1. *Given (the ethical concern/uncertainty or conflict about values), what decisions or actions are ethically justifiable?* or
2. *Given (the ethical concern/uncertainty or conflict about values), is it ethically justifiable to (decision or action)?*

Assemble the Relevant Information

Next, the consultant assembles the information necessary to develop a comprehensive picture of the circumstances and work through the case to facilitate an answer to the ethics question. The CASES approach builds on the work of Jonsen, Siegler, and Winslade (2002) in defining topics that should be reviewed in every ethics consultation, but reframes relevant information into four categories (medical facts, patient's preferences and interests, other people's preferences and interests, and ethics knowledge).

Some cases can be resolved merely by clearing up factual misunderstandings among patients, families, and the health care team. In addition to examining the patient's medical record, ethics consultants should speak directly to involved health care providers and seek out other relevant documents, including advance directives, court papers, and health records from other providers. Consultants with advanced clinical training have an advantage over their nonclinical colleagues, who generally require more effort to identify, collect, and understand the salient medical facts.

Eliciting the patient's preferences and interests is critical because they are central to the consultation. Whenever possible, they should be obtained directly from the patient in face-to-face interaction, even if the patient is said to lack decisional capacity, as well as from advance directives or authorized surrogates. Other parties and medical record notes can also add important insights that put the patient's perspectives in context.

Consultants should collect information about the interests of family, friends, and other stakeholders who may be affected by the outcome of the case. Appreciating these diverse and potentially competing perspectives enriches the consultant's grasp of the situation's complexities and often leads to new insights and ideas.

Considering the ethics question requires a review of the relevant ethics knowledge, which might include codes of ethics, ethical standards and guidelines, consensus statements, scholarly publications, precedent cases, applicable institutional policy, and law. The ethics consultant will be helped by familiarity with ethics-related journals and texts and an ability to perform computer-assisted information searches. Depending on the

consultant's expertise, preparation may include selected readings or a literature review and sometimes discussion with a more experienced consultant.

Synthesize the Information

The consultant next analyzes and synthesizes the assembled relevant information into practical terms, applying the ethics knowledge to the other case-specific information and the ethics question. This difficult yet important proficiency requires a foundation of strong analytic skills, drawing on different approaches to moral reasoning and augmented by reading, study, and supervised practical experience.

Based on the circumstances of the case, the consultant should determine whether synthesis would be promoted by a formal meeting of the parties, separate face-to-face discussions, or, in simple situations, telephone or deidentified electronic communication. Formal meetings, conducted skillfully and professionally, require that the consultant set ground rules about respectful and fair interaction, and try to develop a common goal of answering the ethics question. During synthesis, the consultant should identify and guide the ethically appropriate decision maker in reaching decisions within an ethically justifiable range (American Society for Bioethics and Humanities, 1998). In the case of unresolved conflict, bioethics mediation or other conflict resolution techniques should be considered (Dubler and Liebman, 2004).

Explain the Synthesis

The completed synthesis should be made clear to others involved in the case through direct communication to key participants and documentation in both the medical record and consultation service records. The medical record note communicates important information to involved staff, promotes accountability and transparency, and serves an educational purpose. In consultation service records, consultants can record additional observations on power dynamics, workload data, performance improvement ideas, or comments on the ethics consultation process.

Support the Consultation Process

The consultant's final step is to support the overall process of ethics case consultation by following up with participants and learning what was done; completing a critical self-review after each case; soliciting feedback from peers; and assessing how the ethics consultation service is perceived by systematically surveying the participants in the case. Ethical issues that need to be addressed at the systems level should be brought to the attention of the appropriate individual or body.

Effective ethics consultation rests in part on sound consultation practices. The CASES approach is intended to help facilities respond appropriately to ethics concerns. By working systematically through the activities of clarifying consultation requests, assembling relevant information, synthesizing that information to identify morally acceptable solutions, explaining the synthesis to involved parties, and supporting the overall consultation process through follow-up and evaluation to refine its practices, the CASES approach helps the consultation service to ensure that ethics concerns are addressed consistently throughout the health care facility.

The Montefiore Medical Center Model: Bioethics Mediation

The following brief description is intended only to introduce bioethics mediation as one model for consultation services prepared to engage in the necessary training. Ethics committees wishing to learn more about bioethics mediation and consider its applicability are encouraged to consult the comprehensive discussion, including case analyses and role plays, presented in *Bioethics Mediation: A Guide to Shaping Shared Solutions* (Dubler and Liebman, 2004). (Much of this material appeared in an earlier form there.)

■

All bioethics consultation services, including yours, have creation narratives that describe their origins. The Montefiore Medical Center (MMC) Bioethics Consultation Service was established in 1978 and, by the mid-1980s, the original bioethics consultants (one lawyer and one philosopher) were responding to increasing requests for clinical ethics consultation. Over time they noted that the team's arrival at a consultation brought a particular value-added, which they came to think of as "neutral turf." The consultants had not previously been involved in the case, had not issued the care orders that, however wise and well-intentioned, might have contributed to the problem, had not been at odds with anyone on the care team, and had not antagonized either the patient or the family members. In addition, the consult team came fresh to the presentation of the case history and problems, and could ask the questions that had already been asked and answered, but this time eliciting different and more revealing responses.

The team's makeup also accounted for the way it developed and functioned. It was clear that one lawyer and one philosopher were not about to tell medical staff what needed to be done in the clinical setting. Therefore, the "facilitation" aspect of the discussion became both the method and the model, encouraging the consultation staff to think precisely about the dynamic of the discussion and the structure of the decision.

Initial discussion often revealed that some care team members had opposing notions of the patient's prognosis and different arguments for what should be the appropriate care plan. Often these conflicting opinions had been communicated either explicitly or implicitly to the patient and family. As you well know, different staff telling the patient and family different things is a sure recipe for confusion and discord. Sometimes the opportunity that the consultation service provided for all opinions to be presented, clarified, and discussed was, in itself, the beginning of conflict resolution. Once the staff was communicating the same information about diagnosis and prognosis, much of the conflict about the care plan disappeared. Often, although the staff may have reached consensus on the medical facts and the diagnosis, differing opinions about the prognosis remained. In those instances, the value added by mediation would

be identifying and clarifying the areas of agreement and disagreement. Over the years, we came to realize that, rather than providing ethics directives or even analysis, what we were doing was some form of alternative dispute resolution or mediation.

As we became more knowledgeable about and more trained in mediation, we realized that another huge benefit emerged from a mediation model for consultation—facilitation skills that could be taught. In addition to a mastery of the rights, interests, and agreed-upon principles of bioethics—an indispensable knowledge base—mediation adds techniques for managing and resolving conflict. Constructing a working hypothesis, framing and reframing issues, identifying underlying interests, concerns, and available options, supporting and stroking the parties, caucusing, and reaching incremental points of agreement are all skills that can be conveyed by training. It is all very well to say that a bioethics consultant mediator needs to be able to facilitate discussion and decision making, but the necessary skill set must be learned.

Fortunately, as mediation is increasingly valued for its effectiveness in resolving conflicts in many fields, its techniques are being taught in many forums around the country. Courses are given by mediation centers, as well as local and state bar associations, universities, and corporations trying to enhance employee productivity. The Internet provides an extensive array of options.

To further clarify this brief introduction to ethics mediation, consider the following questions:

1. Why mediation?

Mediation is a technique that is particularly well suited to conflict resolution in the health care setting. Bioethics mediation combines the clinical substance and perspective of bioethics consultation with the techniques of mediation and dispute resolution to:

- identify the parties to the conflict (although disagreements between family and care providers are common, most conflicts have more than two sides)
- understand the stated (presented) and latent interests of the participants
- level the playing field to minimize disparities of power, knowledge, skill, and experience (to the degree possible) that separate medical professional, patient, and family
- help the parties define their interests
- help maximize options for a resolution of the conflict
- search for common ground or areas of consensus
- ensure that the consensus can be justified as a 'principled resolution,' compatible with the principles of bioethics and the legal rights of patients and families
- help to implement the agreement
- conduct follow-up (Dubler and Liebman, 2004, p. 10).

> Bioethics mediation is different from bioethics consultation. *Bioethics consultation* refers to a directed substantive process. The consultant listens to the parties and helps move them toward a principled resolution of the dispute by explaining ethical principles and legal rules, applying them to the facts, and presenting the social consensus on the permissibility of different practices. *Bioethics mediation* refers to the use of classical mediation techniques to identify, understand, and resolve conflicts. Bioethics mediation and bioethics consultation may both be employed in a particular case at different points in the process. Mediation is more inclusive and empowering, and consultation is more authoritarian and hierarchical; either or both may be required in any complex case, even within a single meeting. (Dubler and Liebman 2004, p. 14)

2. Why is bioethics mediation well suited to the resolution of conflicts in the health care setting?

In difficult cases, the real question is, which is the "least bad" process for drawing out and resolving the issues? Conflict must and will be resolved because the delivery of care demands that physicians, nurses, and other care providers be guided by a coherent plan. If necessary, that plan can be imposed by the medical or the administrative staff.

But the bioethics mediator, in contrast to an authoritarian decider, will more often be able to ensure that the options are based on respect for the interests and rights of patients and families, regard for the parties' differences, and awareness of cultural and religious imperatives, within the framework of bioethics theory. Because of its focus on "leveling the playing field," it is more likely that a meditative process will be just and will ensure that similar cases are treated in like ways. Ideally, mediation can produce a solution agreed to by all parties who feel a sense of ownership in and responsibility for the plan.

One of the greatest advantages of using the mediation process in bioethics disputes is its flexibility. The general structure of mediation can be altered and adapted to fit the needs of the participants and the clinical realities. But the starting point is always the same: respect for the patient, the family, and the care providers, and an impartial stance regarding what should be the outcome in any particular case.

One exception to the extended flexibility is the need to reach a "principled resolution." This requires that the rights of the parties, as distinct from their interests, be protected. Thus, it would not be possible to agree that a decisionally capable and adequately informed patient should be excluded from a decision about discontinuing life-sustaining treatment. It might, however, be possible to postpone that decision, until one or more of her family members has had time to adjust to the inevitable outcome. It is key to this intervention to remember that the process is a part of the product.

3. What are the limitations of bioethics mediation?

Bioethics mediation is not for every situation. Parties to a mediation must want to reach agreement. In some cases, the patient or family members may not have the

emotional strength to face difficult facts or make hard choices. They may need to have some decisions *made for them*. But most often there are three reasons that mediation fails:

- Sometimes the conflict is out of control before it comes to the attention of the mediator.
- In many cases, some psychological problem or psychiatric diagnosis affects one of the parties and is at the heart of the disagreement. In such cases, reason and argument will be ineffective because of illness and distortion.
- Outsiders may have an interest in augmenting conflict. This is especially evident in prominent end-of-life cases, such as the tragedy of Terri Schiavo, where the use of legal process and the press to make political points dooms private reconsideration and resolution.

4. Why should bioethics consultants try techniques of mediation?

In the experience of the Montefiore Medical Center Bioethics Consultation Service, mediation often works for the reasons discussed above. Even when it does not work, it often helps to define and delineate the conflict. Finally, after the consultation service is experienced and has integrated mediation into practice, its collegial process may mean that medical staff will be more willing to call for help. This is especially the case when experience indicates that the bioethics consultant "doesn't generally make it worse and sometime makes it better."

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