IMPROVING QUALITY AND PROFESSIONALISM
OF CLINICAL ETHICS EDUCATION & CONSULTATION

ICCEC 2015
11th Annual International Conference on Clinical Ethics & Consultation
NEW YORK CITY May 20-22, 2015

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The Bioethics Program of Union Graduate College and Icahn School of Medicine at Mount Sinai offers Masters and Certificate training in clinical ethics, research ethics, and bioethics policy. The Bioethics Program provides competency- and skills-based education through a combination of onsite and online courses.

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ICCEC 2015 Schedule

Tuesday, May 19th, 2015

8:30  Registration  Annenberg North Lobby

9:00-12:00  Pre-Conference Workshops
1. Publishing in Bioethics  Annenberg 10-72 (Levy Library enter from 11th floor)

2. Communication Skills  Annenberg 10-70 (Levy Library enter from 11th floor)

1:30-4:30  Pre-Conference Workshops
3. Publishing in Bioethics  Annenberg 10-72 (Levy Library enter from 11th floor)

4. Bioethics Education: Synthesizing Theory and Practice in Training and Assessment  Annenberg 10-70 (Levy Library enter from 11th floor)

Workshops 1 & 3: Publishing in Bioethics Faculty
Robert Baker, PhD, Professor of Philosophy, Union College; Professor and Founding Director, The Bioethics Program Union Graduate College and Icahn School of Medicine at Mount Sinai
Mark Cherry, PhD, Editor, Hospital Ethics Committee (HEC) Forum and The Journal of Medicine and Philosophy
Ted Hutchinson, MA, Vice President and Publication Director, American Society of Law Medicine and Ethics; Editor, The Journal of Law Medicine and Ethics
Sean Philpott-Jones, PhD, MSB, Former Executive Editor, American Journal of Bioethics
Gregory Kaebnick, PhD, Editor, The Hastings Center Report
Udo Schuklenk, PhD, Co-Editor, Bioethics; Editor, Developing World Bioethics

Workshop 2: Communication Skills Faculty
Terry Sommer, Director, Morchand Center for Clinical Competence, Icahn School of Medicine at Mount Sinai
Ellen Tobin, Communications Skills Training Specialist, Morchand Center for Clinical Competence, Icahn School of Medicine at Mount Sinai

Workshop 4: Bioethics Education: Synthesizing Theory and Practice in Training and Assessment Faculty
Terry Sommer, Director, Morchand Center for Clinical Competence, Icahn School of Medicine at Mount Sinai
Ellen Tobin, Communications Skills Training Specialist, Morchand Center for Clinical Competence, Icahn School of Medicine at Mount Sinai
Rosamond Rhodes, PhD, Professor of Medical Education and Director of Bioethics Education, Icahn School of Medicine at Mount Sinai; Associate Director, The Bioethics Program of Union Graduate College-Icahn School of Medicine at Mount Sinai
Nada Gligorov, PhD, Associate Professor of Medical Education, Icahn School of Medicine at Mount Sinai; Associate Professor, The Bioethics Program of Union Graduate College-Icahn School of Medicine at Mount Sinai
Wednesday, May 20th, 2015

8:00  Registration  
      Annenberg North Lobby

8:30  Conference Welcome  
      Annenberg Stern Auditorium
Welcome from the ICCEC 2015 Conference Directors  
Robert Baker and Rosamond Rhodes
Welcome ICCEC Founders  
George J. Agich and Stella Reiter-Theil
Welcome from Icahn School of Medicine at Mount Sinai  
David Muller, MD, Dean for Medical Education, Professor and Chair of the Department of Medical Education.

9:00  Plenary Session I  
      Annenberg Stern Auditorium

Developing Standards for Clinical Ethics Consultation  
Joe Fins, Ellen Fox, Marion Danis  
Moderator:  Robert A. Pearlman

10:30  Coffee break/Book-Journal-Program Display  
      Annenberg West Lobby

11:00  Plenary Session II  
      Annenberg Stern Auditorium

Developing a Code of Ethics for Clinical Ethicists  
Anita Tarzian, Robert Baker, Bette Crigger  
Moderator:  David Muller

12:00  "Social Lunch"  
      New York Academy of Medicine, Reading Room
"Bring a Case to Lunch"  
      New York Academy of Medicine, 20 A&B
a. Sandra Collins, Nicola Crowther  
   SimEthics: Teaching Medical Ethics through Simulated Patient Cases
b. Jean Hermele  
   Whose Autonomy is it?
c. Benjamin Herreros  
   Implementation of advance directives in the hospitals of Madrid
d. Selena Knight  
   "I want to go home." Challenges in assessing capacity and managing risk in elderly patients
e. Brigitte Rul & Marta Spranzi  
   I prefer to die with my leg rather than to live without it: A dilemma in Nursing Ethics
f. Vicki Xafis
Caring Decisions: The development of a written resource for parents facing end of life decisions

g. Margot M. Eves
   Damned if you Do . . . A Surrogate's Struggle to Choose between the Patient's Conflicting Values

h. Katherine Mendis
   Treatment v. Enhancement and the Struggling Pre-Med Student

i. Victoria Dobrova
   Healthy volunteers’ opinions regarding discomfort factors and inconvenience in clinical trials

j. Phoebe Friesen
   Youth at Risk and Confidentiality
A. **INVITED PANEL: Principles of Medical Ethics Explained**

*Guggenheim Pavilion 2 Hatch Auditorium*

**Moderator:** Robert Baker

**Tom Beauchamp, James Childress, Raanan Gillon**

**B. Panel - The Roles and Responsibilities of Clinical Ethics Consultants**

*Annenberg 12-62*

**Moderator:** Jules E. Garbus

**David Adams, PhD; Christopher Meyers, PhD; Stuart Finder, PhD**

When moral disagreement or ethical confusion and uncertainty arise in the care of the sick, physicians and families typically seek the advice and assistance of healthcare ethicists. How can ethicists help? The answer increasingly supported in America conceives of healthcare ethics consultation as fundamentally a process for managing and resolving moral conflict and identifying shared values and norms as a framework for consensus solutions. As ethics experts, healthcare ethicists should seek to resolve disputes by facilitating dialogue and working toward consensus, leading to a “principled resolution” of a moral disagreement or concern—a resolution falling within an ethically acceptable range of outcomes or options. Prevailing law and standards of practice, relevant literature, and pertinent institutional policy define the boundaries of a principled resolution. These norms form the necessary normative backdrop for the consultative process.

While broadly accepted, this view of ethics consultation gives rise to neglected questions, some of which the members of our panel will address: Can ethicists rightly be seen as having ethics expertise? If so, can they also consistently function both as ethics experts and conflict managers? Does the generally received understanding of ethics consultation downplay moral reasoning and ethical reflection in favor of conformity with a moral status quo? If so, how does an ethics consultant make sure the status quo is not just a reflection of the most powerful institutional voices? If the ethically acceptable options in a given case are not clear, what ought the consulting ethicist do? When established norms are themselves the subject of controversy must the ethicist divulge that reality, even though doing so may exacerbate rather than diminish conflict? Does the widely endorsed model make the ethicist responsible to established norms in ways that might compromise his or her own integrity?

**C. Panel - Education in Clinical Ethics: Embedding a Clinical Ethicist**

*New York Academy of Medicine 20 A&B*

**Moderator:** Henk Ten Have

**Evan DeRenzo, PhD; Nneka Mokwunye, PhD; Mark Hofmeyer, MD; Laura Johnson, MD; George Ruiz, MD**

Embedding, or what our group informally refers to as clinical ethics ‘zone defense’, is having a clinical ethicist assigned as a consultant to a therapeutic group or place in a hospital. This is different from, for example, the clinical ethicist on call, who is expected to cover everywhere in a hospital. Rather, this is deployment of clinical ethicists to specialized places in a hospital, and in so doing creating clinical ethics consultants who are specialized in one therapeutic or operational area or another.

In some ways this is not different from having a psychiatrist consultant, social worker, or a palliative medicine physician consultant attached to a specific group or service in a hospital. The specialized areas we present here include

1. an Advanced Heart Failure team that performs heart transplants and provides other advanced heart failure interventions such as surgical placement of Ventricular Assist Devices (VADs), and
2. a burn service and its corresponding Surgical Intensive Care Unit(s) (SICUs).

The focus of each panel members’ presentation will be to discuss, from each one’s perspective, how having an attached (ie embedded) clinical ethicist:
1. is instructive about clinical ethics and clinical ethics consultation by all team members,
2. is used by attending physicians as a clinical ethics teaching resource, and
3. requires the embedded clinical ethicist to be both an insider and an outsider to the particular therapeutic team or unit.

The relevant panel member(s) will also present information about how this calls for a sophisticated clinical ethics consultation program, one that is trusted throughout the hospital. Problems of objectivity for clinical ethics consultants will also be discussed including approaches applied to protect against decay of objectivity for purposes of professionalization of the clinical ethicists involved.

D. Workshop - Evaluation Strategies for Clinical Ethics Consultations

Moderator: Kenneth A. Berkowitz

Julija Kelecevic, MD; Sandy Andreychuk, RN(EC), BScN., MHSc., MSc.; Andrea Frolic, PhD

An abundant amount of literature exists on the development of ethics consultation services and its utilization across healthcare sectors. Intuitively we believe that ethics consultation is effective, however there is minimal published data to clearly demonstrate that ethics consultation is beneficial, harmful or neutral for healthcare professionals and patients. This workshop will explore the challenges experienced by ethics programs regarding the evaluation of their services (including both new and long-standing programs). The audience will become acquainted with the existing evaluation tools in an acute care academic center, with long-standing ethics consultation service and the emerging ethics programs in a community healthcare organization and smaller, rural hospitals.

During the workshop the presenters will:

- provide an overview of the current literature available on evaluation in ethics consultation practice
- describe a well-established ethics consultation programs that utilizes a mediation model and how this program is evaluated
- describe how evaluation data informs leaders within an organization for quality improvement purposes, to foster innovation and to support organizational decision-making
- describe the challenges and opportunities to utilize evaluation tools in practice within smaller rural hospitals and community care organizations
- Introduce a comprehensive, robust toolkit for evaluating ethics services i.e. consultations, education, policy development and committee membership

In an interactive portion of the workshop lead by the presenters, the audience will:

- have an opportunity to view a pre-taped ethics consultation
- be asked to evaluate the ethics consultation using a tool introduced by the presenters
- describe what it was like to use the tool
- discuss outcomes and possible next steps for healthcare organizations using this tool
- provide final comments and personal reflections on the evaluation process of clinical ethics consultations.

E. Panel - Seeing Is Believing? Reflections on always seeing the patient

Moderator: David Alfandre

Joseph A. Raho, PhD; James A. Hynds, LL.B., M.Th., PhD; F. Daniel Davis, PhD; Ellen M. Robinson, RN, PhD

A primary role of clinical ethics consultants is to facilitate an ethically principled resolution to conflict in the hospital setting. Accordingly, although clinical ethics consultants should ensure that the multiple voices to that conflict are heard—e.g., those of the patient (when possible), the family, as well as members of the health care team—it would appear that their ethical obligation is directed toward the process, rather than to any one individual who must or should be engaged through that process. Yet, this conclusion appears hasty. Do clinical ethics consultants not incur obligations by virtue of their professional role? Perhaps they have obligations to those involved in a consult, and direct obligations to one member in particular: the patient. If so, how might clinical ethics consultants ensure that the patient’s “voice” is adequately represented?
This panel will address this issue through the following question: Is it always (or ever) appropriate or advisable for the clinical ethics consultant to see the patient and, more specifically, should there be a presumption in favor of doing so? Various positions will be explored and assessed from both theoretical and empirical standpoints. For example, proponents might draw a strict boundary on moral expertise; point out that who gets to tell the patient’s story is often ethically significant; and outline a vision of the ethics consultant-patient relationship as one based on responsibility. Alternatively, opponents might counter that there is no clear mandate for always seeing patients; that, unlike the physician-patient relationship, the ethics consultant-patient relationship is not fiduciary; and that visiting the patient does not enrich ethical analysis. Throughout this discussion, the role and obligations of the ethicist-as-professional will be scrutinized and assessed critically in view of the potential of clinical ethics consultants to improve the quality of patient care.

F. Workshop - Clinical Ethics Support in Psychiatry: How to address coercion?

Hess CSM 5-101

Moderator: Guy Widdershoven

Stella Reiter-Theil, Prof. Dr., Dipl.-Psych; Guy Widdershoven, Prof., Dr.; Yolande Voskes, PhD, RN; Reidar Pedersen, PhD, MD, MA, BA

Professionals working in psychiatry encounter specific ethical problems. Coercion is a topic of both paradigmatic and controversial nature in mental health care. Cases involving (decisions about) coercion entail dilemmas. If health professionals choose to use coercion such as involuntary medication or locking the patient in a seclusion room, they have to justify the resulting limitation of the patient’s freedom of choice or movement. If they abstain from coercion, the safety of the patient or third parties may be at risk which has to be justified, too.

Although psychiatry in general and the use of coercion in particular are full of ethical problems, clinical ethics support has been found to be less prevalent in mental healthcare institutions than in general hospitals.1 One reason might be that value-laden decisions such as those around using coercion to prevent harm are often handled in a legal framework and procedure. However, in our view law does not render ethics superfluous within a clinical context. Furthermore, even in the legal context moral concerns of health care cannot be denied – quite the opposite: legal and ethical aspects and their relation need to be addressed explicitly in order to foster the moral quality of care.

In this workshop we will present and discuss experiences with three kinds of clinical ethics support in psychiatry as they are being practiced in different European groups: Moral Case Deliberation (The Netherlands), Context-Adjusted Ethics Consultation (Switzerland) and the Clinical Ethics Committee (Norway). Contributors will refer to the same case example and refer to their specific experiences embedded in their frameworks and settings relying on brief conceptual introductions.

Expected outcomes: Firstly, the presentations will provide insight into ethical aspects of using coercion in psychiatry making explicit the need for explicit ethical reflection.2 Secondly, through presenting and comparing various approaches to clinical ethics support in mental health care, the participants will learn about the respective underlying concepts and experiences. Commonalities and differences between these approaches will be explored and conclusions drawn regarding their applicability in different psychiatric contexts.

1 Hem, Pedersen, Norvoll 2014.

2 Reiter-Theil, Schürmann, Schmeck 2014.
G. The Interface of Research and Clinical Practice  Hess CSM 2B
Moderator:  Sean Philpott-Jones

1. Vaccinate or Mask: What does Choice Have to do with it?

Kyle Anstey, PhD; Jennifer Mary Bell, MPH

Many Canadian acute-care hospitals are introducing “Vaccinate-or-Mask” (V-M) policies that apply to their health care workers (HCW), including staff, physicians, students and volunteers. These policies claim to allow HCWs to choose between being vaccinated against influenza, or wearing a procedure mask during influenza season in areas where patients are present. Under some of these policies, HCWs are also required to wear additional visible identifiers of their influenza immunization status. If noncompliant, they are subject to enforcement measures up to and including dismissal.

We argue that taking the vaccine is effectively mandatory in a V-M context. HCWs are only ‘free’ to decline influenza vaccination if they are willing to be branded with a visible sign of this decision. Nor are V-M policies defensible as reasonable restrictions on HCW autonomy. First, Canadian experiences with the uptake of the H1N1 vaccine, as well as with seasonal vaccine uptake by some professional groups, demonstrates that significant rates of participation are possible with less restrictive means. Second, V-M policies are arbitrary, in that they fail to include visitors and some patients. Finally, V-M imposes a structure in which organization talk past, rather than engage in a dialogue, with their staff. It is known from the patient safety literature that failure to engage front-line staff can have measurable negative effects on staff morale and patient outcomes. Such approaches decrease trust and can have unintended negative consequences beyond V-M policies.

Furthermore, while protecting patients from hospital-acquired influenza is an important goal, it is known that influenza vaccinations are only moderately effective, and this effectiveness likely wanes throughout the vaccination season. The quality of evidence showing the impact of vaccinating staff against influenza on patient outcomes is low. Higher-quality research is required before imposing a coercive policy that is a choice in name only.

2. Surrogate Consent to Non-therapeutic Research: When substituted judgments may be inaccurate

Mats Johansson, PhD; Linus Broström, PhD

Decision-making for decisionally incapacitated individuals raises many ethical issues. One of those issues concerns what the aim of such surrogate decision making ought to be. According to one influential decision-making standard, the substituted judgment standard, a surrogate ought to make that decision which the patient would have made, if competent. Empirical findings indicate, however, that surrogates (usually loved ones) are not very good at accurately predicting what the person in question would have wanted. In this presentation, we argue that the significance of these findings differs depending on whether the surrogate is making the decision in a clinical context or in a research context. In research, we maintain, precautionary reasoning should typically make surrogates not authorize enrollment of the decisionally incapacitated individual. Since research is meant to generate knowledge rather than benefit the research subject, and many studies cannot be expected to provide a net benefit to the research subject, the possibility of surrogates being wrong about the individual’s preferences regarding research participation suggests that in all those cases it is better to err on the side of non-inclusion. Ethics support services need to pay attention to this asymmetry between clinical and research settings, and its implications for the applicability of the substituted judgment standard.

3. Calibrating Evidence Based Medicine (EBM): Clinical ethics vs. research ethics

M. Wayne Cooper, MD, PhD, MS (Bioethics)

Despite the general view otherwise, EBM is not an “all-or-none” enterprise. One must recognize and understand its presuppositions in order to calibrate its application at the time of research ethics and clinical ethics consultations. The presuppositions of EBM are: 1. There is no internal morality of medicine; 2. The theory of probability solves the problem of induction; and, 3. Mathematics represents the reality of the natural world. None of these presuppositions is self-evident or irrefutable and each can be adjudicated along a continuous spectrum, making it such that the application of EBM as a whole can likewise be adjudicated along a continuous spectrum. The spectrum of presupposition 1 extends from the principle of Beneficence to the principle of Autonomy; the spectrum of presupposition 2 extends from the Frequentist to the Bayesian approaches to probability; the spectrum of approaches to presupposition 3 extends from Platonic Realism to Mathematical Formalism. The EBM relevant to
research ethics tends towards a more rigorous application of each presupposition, while the EBM applied in clinical ethics finds space for practitioner and patient preferences.

Cases of clinical ethics and research ethics will be presented to illustrate the spectrum of each presupposition.

Recognizing the arguments for/against each of the presuppositions will aid the ethics consultant to weave the physician’s and patient’s preferences into what is taken to be more “objective” aspects of research and clinical practice.

4. Return of Results in Psychiatric Genomics Research: The burden on patient-participants’ clinicians

Gabriel Lázaro-Muñoz, PhD, JD, MBE

Large-scale genome-wide association studies (GWAS) have recently identified more than 130 genomic loci associated with schizophrenia. One of the principal challenges now is to translate these findings into clinically useful information (e.g., improved diagnosis, risk prediction, pharmacogenetics, treatment, and prevention). The translation of these findings may be particularly helpful for the approximately 30% of patients who suffer from treatment-resistant schizophrenia (TRS). Depending on the severity of their symptoms, patients who suffer from TRS may receive long-term inpatient treatment. In theory, these “extreme phenotype” TRS patients stand to gain from translational psychiatric genomics research, however, conducting genomic research (e.g., whole exome sequencing; WES) with these patients generates numerous research and clinical ethics challenges. This paper focuses on clinical ethics challenges associated with the return of genomic research results, particularly the clinical management of these results by mental health clinicians.

There is an emerging consensus that when feasible genomic researchers should return clinically useful research findings. These could include those primary findings that are related to the patient-participants’ mental health condition, but also secondary target findings that are considered medically actionable such as risk for certain types of cancer (e.g., Lynch syndrome, hereditary breast and ovarian cancer) and heart conditions (e.g., Long QT syndrome, familial hypercholesterolemia). However, as researchers discharge their ethical duty to return these findings, they may impose a number of professional and ethical duties on the mental health clinicians who care for patient-participants with TRS. Depending on the study, research results may be returned directly to clinicians or clinicians may receive these findings because patient-participants or their authorized representative bring these results to them. Once in possession of these research findings mental health clinicians must decide whether and how to act upon them. This paper has two principal aims: 1) to review the emerging ethical consensus that researchers have a duty to return certain research findings with a focus on psychiatric genomics research; 2) to examine the ethical challenges that mental health clinicians may face when managing both primary and secondary genomic research findings in a long-term inpatient care setting.

H. Ethics Education  Annenberg A11-41 (Levy Library enter from the 11th floor)

Moderator: Michael Dunn

1. Ethics Is Magic!

Carolyn Johnston, LLB, LLM, MA, PhD

Medical ethics teaching tends to focus on imparting knowledge of ethical principles and frameworks and topics such as consent and confidentiality, perhaps to the detriment of learning how to implement this knowledge in reality, under the time constraints and practicalities of modern medicine. Magic can be used to help complement theoretical teaching, develop understanding of and application to, difficult and emotional discussions. Doctors are required to develop good relationships with their patients in order to allow open and honest conversations. Magic and medicine both require the ability to form relationships in a very short period of time. Magic can provide techniques and an opportunity to practice developing relationships, allowing a good foundation for the consultation.

Patient recall following consultations is low, especially after receiving disturbing news. Emotional and psychological arousal cause attention narrowing, whereby attention is given to the central focus of the scenario at the expense of other information. Failure to retain and process information can limit the patient’s ability to fully engage in discussions and the decision making process, making it difficult for valid consent and expression of autonomy to be
fully realized. Attention narrowing is an extremely important concept in magic. The emotional response from a trick allows time to set up the next part of the trick without being spotted. Demonstrating magic and encouraging students to practice tricks is an engaging and effective way to understand this effect. Through learning what will be missed after a simple magic trick, students may develop an appreciation of just how much information patients fail to process following a far stronger emotional response after receiving difficult news. Students can also learn how to give advance warning of the event in order to reduce this impact and emotional response and allow time for attention to return before moving on to discuss other areas such as treatment plans.

Magic is a useful device in medical education to equip students with an understanding of how to approach potentially difficult and emotional consultations in order to fully utilize and implement their theoretical knowledge in practice.

2. Designing and delivering a junior doctor-led case-based ethics teaching program for medical students

Dr. Wing May Kong, Dr. Selena Knight, Dr. Anna Romito

Undergraduate ethics teaching has made huge progress in the UK in the past decade, with junior doctors and medical students reporting increasing confidence in identifying ethically challenging cases. However, they continue to report difficulties taking action when faced with difficult cases.

The first two years of training for new UK doctors is the national Foundation training program. A Foundation Doctor-led teaching programme was designed in which medical students were invited to bring cases/events from their clinical placements for small-group discussion facilitated by Foundation Doctors. Foundation Doctors were provided with training and teaching resources. Ground rules were established at the start of each session (e.g. confidentiality, mutual respect). The aim was to improve students’ confidence in identifying and working through ethically challenging cases, identify potential barriers to taking ethical action and provide them with skills useful in their future careers. Foundation Doctors were chosen as facilitators as we felt this would reduce the potential hierarchical barriers which might otherwise hinder discussion, and encourage Foundation Doctors to share and reflect on their own experiences whilst helping students develop practical, real life solutions.

The programme was run as a pilot scheme at one London teaching hospital, and has now been successfully extended to six hospitals in the North West London region. To date 16 teaching sessions have been run providing teaching to over 60 students, and it is hoped this will extend further as more Foundation Doctors have expressed interest. Feedback from medical students and Foundation Doctors has been extremely positive. Cases bought to sessions have encompassed a range of ethical, legal and professional issues, including capacity, end of life decision-making, and the role of medical students. Students have reported many of areas of learning from sessions, particularly how to apply ethical principles they often view as ‘abstract’ to ‘real life’ ethical problems.

This programme provides a valuable method for bring ethical discourse out of the classroom and into everyday clinical practice and has the potential to be extended to the training of doctors at later stages of their careers and for multi-disciplinary learning in ethics.

3. Teaching Ethics through Principle-Based Case Analysis: A blended learning seminar for medical students in Germany

Katja Kuehlmeyer, Dr. rer. biol. hum.; Georg Marckmann, MD, MPH

The principle-based case analysis provides a step-by-step guidance for the ethical discussion of clinical cases. It is based on the application of the four classical principles of biomedical ethics. We used the teaching model "blended learning" in order to train medical students in principle-based case analysis. Blended learning seminars are characterized by a combination of online material and face to face teaching.

Structure and Content of the Seminar

Online part: The students access the learning material (video, scientific publications, structure including questions to the student, an exemplary case) through an online learning platform. First, the student is asked to introduce
herself and express her expectation to the seminar. Questions are answered by the tutor within 48 hours. Then, the student is asked to familiarize himself with the material (self-directed learning). The student’s assignment is to write a principle-based case analysis of an exemplary case.

The tutor evaluates the student’s case analysis according to a model solution. The tutor only assesses whether all relevant aspects of the case are appropriately covered. Whether the student arrives at the same conclusion as the tutor is not evaluated. Then the student receives individual feedback via email.

**Face-to-face part:** In the face-to-face part, the tutor selects examples from the participants’ case analyses and presents them anonymously following the step-by-step structure. The students’ paragraphs are discussed in the small-group setting. At the end, the professor presents his own case analysis to the students and differences to the students’ assessments are discussed.

**Conclusion**

In addition to getting acquainted with self-directed learning, the main benefit of the blended learning seminar is that students are not just presented a structure for ethical analysis but learn how to use it. Through the individualized feedback, the student can improve the thoroughness of her analysis. The final face-to-face discussion allows the students to deepen their understanding of the case and to reflect the underlying reasons of their own resolution in comparison to others. The teaching concept can be used to train personnel in clinical ethics consultation.

4. Developing a Learning Framework for Clinical Ethics Education in Singapore

*Sumytra Menon, LLB (Hons) LLM*

The CENTRES (Clinical Ethics Network for Training, Research, and Support) initiative in Singapore was tasked by the Ministry of Health to create a network of hospital clinical ethics committees and develop capacity in clinical ethics consultation. Over the past few years, CENTRES has set up a network and forum to enable discussion and knowledge sharing, and conducted workshops to train clinical ethics committee members.

As a next step, CENTRES will be holding an international conference in January 2015. This conference will be attended by local and international experts, as well as local clinical ethics committee members, academics, doctors, nurses and other health professionals.

Our aim is to develop a formal learning framework for clinical ethics education, which we hope will complement the Draft Good Practice Guidelines for clinical ethics committees, developed earlier. Ultimately, we hope that clinical ethics committees across Singapore will adopt the formal learning framework. During the conference, we will formally engage with all participants and specifically seek their feedback and suggestions on how to improve the learning framework. This talk will focus on the process of developing that draft framework, how the discussions with conference participants were structured to maximize opportunities for engagement and feedback about the framework, the learning points that emerged from the process, and the refinements subsequently made to the framework post-conference.

I. Models of Clinical Ethics Consultation

**Moderator:** Peter Williams

1. The Role of Consultation Ethics in an Electronic National Registry for Advance Directives

* Nuno Moreira Fonseca

Since July 2014 Portugal has put in place a national registry for advanced life directives. It comprises living wills and healthcare proxy designations, and renders their consultation expedient to healthcare teams in case the patient becomes incapable of expressing his will.

Healthcare teams of both public and private sectors can consult the registry.

In order to register an advanced life directive, patients must put into writing their will and deposit it in their designated public primary care center. The document will be validated within ten days, if the patient’s will is clear and there are not found any medical or juridical incompatibilities.
There are currently more than 60 primary care centers throughout the country receiving advance life directives. In each center a single physician is responsible for the reviewing these documents. These physicians are not required any specific training and may not dispose of the appropriate legal or ethical support.

This poster address the benefits of creating a national ethics consulting commission to review the content of advance life directives instead of having multiple less prepared gatekeepers in this process.

2. In Defense of a Role for Moral Philosophers in Clinical Ethics Consultation

Lily Frank, PhD

Calls to embrace diversity in professional backgrounds in bioethics often include the observation that bioethicists have many roles, from clinical ethics consultants, to professors and scholars, to policy makers or advocates. Thus the kind of disciplinary expertise required to be a bioethicist varies widely with one’s role (Kopelman 2006; Iltis and Carpenter 2014). I focus on the bioethicist as clinical ethicist and defend a foundational role for the moral philosopher (hereafter philosopher), given her unique training, knowledge, and expertise in understanding moral problems. I do not suggest that team or multidisciplinary approaches are misguided. By foundational role, I mean that to constitute a clinical ethics “team” or “department” it must include a philosopher and that the expertise and skills of other team members serve to support to the philosophic endeavor. I anticipate and respond to three objections. First objection is that there are practicing clinical ethicists who are not trained as philosophers (Kopelman 2006, p. 606). Second is that clinical ethics demands inter-personal skills in which philosophers are not trained, such as mediating conflicts or empathic communication. The first objection fails since it assumes exactly what is at issue is who should play a central role in clinical ethics. The second objection relies on a problematic model of clinical ethics, the mediation model. The third objection is that philosophers are no more likely than anyone else to do the right thing or embody virtue and for this reason are not uniquely positioned to play a foundational role in clinical ethics. This is not a demand made of experts in other fields; a cardiologist who understands the risks of consuming a high-sodium diet is no less an expert if she does not adhere to that diet. This objection makes the error of taking for granted that expertise in philosophical ethics will seamlessly translate in to acting well; that to know the good is to do the good. It also seems to assume that the morality of medicine is closely tied to the morality of ordinary life, a position facing substantial challenges (See Rhodes 2000, 2003, 2004).

3. Who Needs Closure?

Camilla Scanlan, AAMLS, BSc, MBA, MHL, PhD(Cand); Associate Professor Ian Kerridge, BA, MPhil(Cantab), BMed, FRACP; Ainsley J Newson, BSc(Hons), LLB(Hons), PhD

A quest for closure in clinical ethics consultation has recently arisen as a theme in the clinical ethics literature. For some, seeking or obtaining closure is seen as a measure of success in clinical ethics consultation. Closure may also be seen as a mechanism by which to promote well-being or avoid work-related stress in ethics consultants. In our paper, after initially exploring what closure means in clinical ethics, we critique the claim that ethics consultation should focus on, or even that it should require, closure. In many ways, closure is illusory. By their very nature, clinical ethics consultations will occur in a context of significant moral disagreement, moral distress or moral disquiet. They may also arise in a context of overt conflict. Even after an ethics consultation ends, it is almost inevitable that there will remain what we term “moral residue”. This residue, with its continuing impact, may take many forms. For ethics consultants, it may mean an ever-growing psychological caseload. For patients and their families, it may mean facing continuing questions about their clinical encounter. For health professionals, it may mean ongoing reflection regarding the choices or actions taken. To aim to ‘draw a line’ under this process, we contend, fails to account for what clinical ethics can and should do. While closure may serve instrumental ends for all involved, clinical ethics should not be about finishing conversations, but continuing them, not about providing answers but about encouraging questions, and not about providing certainty, but about nurturing resilience. Techniques to provide closure may add to the armamentarium of clinical ethics services, but should not define them. To this end, we don’t need closure in clinical ethics. We do, however, need a process to foster resilience, reflection and collective learning.

4. The Social Intuitionist Model of Moral Judgment in Healthcare Ethics Consultation

Tyler J. Van Heest, MA; Joan Liaschenko, PhD, RN, FAAN

In this paper, we compare three approaches to healthcare ethics consultation (HCEC) based on research from moral psychology, or the study of human functioning in moral contexts.
First, we present Jonathan Haidt’s social intuitionist model (SIM) of moral judgment: a psychological model of moral judgment that integrates research findings from cognitive and cultural psychology, neuroscience, evolutionary theory, and primatology. The SIM holds that an individual's initial moral judgments appear suddenly and automatically in consciousness without a deliberate search for evidence or reasoned inference. Post hoc moral reasoning, or the conscious search for supporting evidence, follows this initial moral judgment. Additionally, the SIM views moral judgments as an ongoing, iterative, social process rather than one individual reasoning to a correct answer by applying a moral theories or principles.

Next, using the SIM as a framework, we discuss the three approaches to HCEC previously described in the literature: 1) the authoritarian approach, 2) the pure consensus approach, and 3) the ethics facilitation approach. We draw several conclusions. First, the pure consensus and ethics facilitation approaches emphasize interpersonal moral discussions, which help attenuate each individual's biases in moral judgments, while the authoritarian approach does not. Second, the pure consensus and ethics facilitation approaches differ in whether or not consultants are allowed to share their own moral intuitions, judgments, and reasoning in the discussion. As previously discussed in the HCEC literature, allowing consultants to share their own moral intuitions, judgments, and reasoning implies that consultants possess some sort of expertise to justify their inclusion in the moral discussion.

Finally, we speculate that HCE expertise likely does not reside in a superior ability to apply moral theories, as has traditionally been proposed. We speculate that consultants possess expertise rooted in 1) process and interpersonal facilitation skills and 2) nuanced perspectives developed through experience with morally challenging cases. Discussing HCEC in light of research in moral psychology provides new perspectives on the role of HCEC in practice and consultant education.

Wednesday, May 20th, 2015

3:30-5:00 Parallel Sessions 2

A. Panel - Quality Assessment of the Ethics Consultation Service at the Organizational Level: Accrediting ethics consultation services

Moderator: Marilyn Mitchell

Kenneth A. Berkowitz, MD, FCCP; Aviva L. Katz, MD, MA, CIP, FACs, FAAP; Kathleen E. Powderly, CNM, PhD; Jeffrey P. Spike, PhD

It is an exciting time in the development of the field of health care ethics consultation (HCEC); several major quality assessment (QA) efforts are underway. One, the ASBH Quality Attestation for Clinical Ethics Consultants project, focuses on individual ethics consultant's competency. Another, which is being coordinated through ASBH’s American Board of Program Directors, aims at developing standards for bioethics training programs. Although a consultant’s training and competency are important, the overall success of an Ethics Consultation Service depends on more than just the knowledge and skills of its consultants. Assessing the ECS at the organizational level would complement other QA efforts by assuring that in addition to consultant expertise, appropriate ECS structures/policies/processes/accountability are in place for the ECS to function properly. A well-performing ECS must be positioned appropriately in the organization, adequately supported, function professionally, and achieve outcomes consistent with its goals. ECS-level assessment would evaluate those parameters and whether the ECS functions consistently, is accessible by those who need it, is sensitive to local culture/environment, and provides collective competency for HCEC. It would assure that the ECS meets emerging HCEC standards, engages in continuous quality improvement and professional development activities, and promote organizational visibility and accountability for the ECS. ECS-level assessment would be consistent with the trend towards service-level accreditation in health care settings in addition to credentialing the involved individuals (e.g., IRBs, Home Care Programs, Rehab Programs, Surgical Specialty Services, Trauma Programs, and Laboratory Services). Panelists will consider accreditation of ECS in the context of accreditation efforts in other health care fields; explain why a high quality ECS requires more than just well-trained and competent individuals; explore how assessment at the ECS-level would complement and enhance other ongoing HCEC QA efforts; explore the benefits of ECS accreditation;
consider strategies, barriers, and resource and workload implications; examine how assessment of ECS might be prioritized with other HCEC QA efforts.

**B. Workshop - Making Ethics an Integral Part of Post Graduate Residency Training**

*Annenberg 12-62*

**Moderator:** Caroline Brall  
_Naomi Dreisinger, MD, MS, FAAP; Robert Schiller, MD; Saadia Akhtar, MD, FACEP_

Over the past decade medical school education has increasingly incorporated concepts related to ethical thought process and medical ethics into their curricula, yet upon graduation from medical school this education often ends. As residents they are taught to apply didactic knowledge acquired during medical school relevant to their specialty leaving little time for education and discussion of important ethical issues.

This session would describe 2 models for incorporating ethics education into residency education both in general and within their subspecialties.

This presentation would be a panel discussion. Three panelists will deliver a 15-minute presentation describing different approaches to postgraduate/residency education in medical ethics. We have created 2 different concepts, which aim to educate residents in a broad fashion. The first two panelists will outline the concepts listed below, and future goals will be ascertained. The final panelist will describe the importance of increased exposure to medical ethics from a GME perspective

1. Department specific lectures and monthly incorporation of ethics cases into rounding and morning report discussions. This has been in practice in the Emergency Department (ED) for the past 5 years. Each year Residents are given 2-3 one hour-long didactic lecture focusing on ethical concepts. Topics that have been covered include nonjudgmental regard and bias in patient evaluation as well as medical errors and approach to difficult conversations. Lectures are generally a combination of classroom style didactic lectures with additional use of simulation and role-play to enhance learning. Monthly case based learning occurs in the ED within the resident’s morning report. Each month 1 morning a week is dedicated to an ethics case. Residents chose a case from their recent experience in which an ethical issue arose. The resident leads the discussion with the guidance of an ED Attending.

2. Elective in medical ethics. This elective is already incorporated into Family Medicine Residency. This elective will open to any resident. The elective’s is to become familiar with how ethical dilemmas are approached in a hospital and ambulatory setting. The resident attends ethics committee meetings, joins ethics consultations, and is an integral part of the palliative care team.

**C. Panel - Experiences in Developing and Implementing Clinical Ethics Support in an Academic Hospital?**

*New York Academy of Medicine 20*

**Moderator:** Bert Molewijk  
_Suzanne Metselaar, MA; Yolande Voskes, PhD, RN; Laura Hartman, MA; Margreet Stolper, MA_

The practice of Clinical Ethics Support (CES) is growing. In the Netherlands, health care institutions use various forms of CES. Traditionally, support for health care professionals concerning ethical issues in health care institutions is provided by clinical ethics committees. Over the past decades, Moral Case Deliberation (MCD) has become more used and implemented in the field of health care. This form of CES aims to improve the moral competences of the health care professional by providing a structural group reflection on concrete cases in practice.

Facilitating and implementing CES in the context of an academic hospital comes with contextual challenges. Tensions between practical issues and theoretical aspects of particular forms of CES, like MCD, are part of the process of implementing CES. Reflection on experiences of ethicists, health care professionals and other stakeholders in practices of CES may help to improve the quality and professionalism of CES.

In this panel session we will present our experiences in developing and implementing Clinical Ethics Support (CES) in an academic hospital in the Netherlands, and reflect on these experiences. Furthermore we will present the
preliminary results of a study on a national network that aims to share and exchange best practices of CES. Four presentations will be given, each with a maximum of 8 minutes. 25 min will be used for discussion facilitated by the chair. The total session will take 60 min.

Chair: Bert Molewijk

- 3 min: Welcome and Introduction
- 8 min: Developing and implementing CES starts with educating students; implementing MCD in the undergraduate and graduate curriculum (Yolande Voskes)
- 8 min: Developing and implementing CES requires regular support (next to adhoc meetings) for healthcare professionals in their daily work at the ward (Suzanne Metselaar)
- 8 min: Developing and implementing CES requires developing a structure to embed CES, including training of facilitators MCD (Margreet Stolper)
- 8 min: A national network for sharing and exchanging experiences (good practices) in order to professionalize and improve CES (Laura Hartman).

- 25 min: discussion

D. Workshop - Evaluating Interpersonal Skills in Clinical Ethics Consultation: Development and appraisal of assessing clinical ethics skills (ACES) evaluation tool

Moderator: Nada Gligorov

Katherine Wasson, PhD, MPH; Kayhan Parsi, JD, PhD; Michael McCarthy, MTS; Viva Jo Siddal, MS; Mark Kuczewski, PhD

One of the challenges for the American Society for Bioethics and Humanities (ASBH) in its Quality Attestation (QA) process for evaluating clinical ethics consultants (CECs) is how to assess consultants’ interpersonal and communication skills. The current pilot phase of the QA process involves reviewing and scoring submitted portfolios containing 12 case write-ups, a statement of ethics consultation philosophy and letters of support for each clinical ethics consultant. These elements do not allow expert reviewers to observe the CEC “in action.” One supplementary element is an ethics simulation case evaluated by experts in the field. The simulated ethics consultation would allow the QA panel to observe how the CEC performed in real time versus retrospectively. Based on the ASBH Core Competencies and the VA Integrated Ethics Tool, we developed the Assessing Clinical Ethics Skills (ACES) tool and course to evaluate a clinical ethics consultant’s performance in a simulated ethics consultation. After discussing and agreeing on key items for inclusion in the ACES evaluation tool, four bioethicists who conduct clinical ethics consultations identified observable behaviors to be scored independently for each main item. Multiple iterations of the evaluation tool and its individual items were refined through discussion, viewing past ethics consultation videos, and reaching expert agreement on each item. We then worked to increase our inter-rater reliability in scoring individual CECs and piloted the ACES tool. Results of two iterations of the ACES tool and course will be presented and discussed along with strengths, limitations and future directions.

Attendees of the workshop will be shown video examples of how the ACES evaluation tool has been used to assess clinical ethics consultants’ performances in simulated ethics consultations. Video clips of simulated ethics consultations will be presented and, in small groups, participants will rate the CEC’s performance using the ACES tool. The small groups will report their scoring to the wider group and the workshop facilitators will address issues of inter-rater reliability and further training with the ACES tool.

E. Panel - Comparing Israeli and American Experiences: Families’ requests for continued physiologic support of patients deemed dead by neurological criteria

Moderator: Steven Birnbaum

Anne Lederman Flamm, JD; Martin Smith, STD; Jonathan Cohen, MD; Tamar Ashkenazi, PhD

Anne Lederman Flamm and Martin L. Smith are ethics consultants who recently published a manuscript detailing the experience of their hospital’s ethics consultation service with cases involving requests from families of patients determined to be dead by neurological criteria to continue physiologic support of their loved ones. In addition to caring for patients and families involved in similar cases, Jonathan Cohen and Tamar Ashkenazi have recently published data about determining death by neurological criteria (DNC) in Israel since the state enacted new
requirements related to patient wishes, the testing process, and physician training. Identifying common data and focal points within their research, panelists propose the following presentation.

Ms. Flamm and Dr. Cohen will each identify legal and ethical guidelines related to determining DNC in their respective countries, as well as policies governing DNC within their hospitals. Their shared focus will be on provisions addressing: 1) accommodation of families’ requests for continued physiologic support; and 2) the nature and timing of determinative tests. Also incorporating observations about cultural attributes impacting attitudes toward DNC within their respective environments, these panelists will describe ethical challenges for professional caregivers and hospitals when families object to administering tests for DNC and/or to withdrawing physiologic support from patients deemed dead by neurological criteria.

Dr. Smith and Dr. Ashkenazi will summarize objective and experiential data collected from their respective centers regarding patients whose families objected to DNC testing or to withdrawing interventions following determination of DNC. Their data encompass patient demographics and conditions leading to DNC; how often families raised these objections as well as their reasons; how clinicians and their hospitals responded to and interacted with families; how long physiologic support extended beyond DNC; and patient/family outcomes.

Panelists will then offer, in coordinated comments, their insights regarding advantages and disadvantages of the frameworks governing clinical management of patients and their families; perspectives on what constitute “better” and “worse” outcomes for patients, families, professional caregivers and their hospitals; and recommendations for clinical best practices aimed at yielding ethically optimal management of these hard cases.


3 Drs. Cohen and Ashkenazi will present using a remote co

**F. Panel - Research Ethics Consultation in the US: An emerging role in academic medical centers**

**Moderator:** Alexander M. Capron

*Benjamin Wilfond, MD; Marion Danis, MD; Robin N. Fiore, PhD*

This panel will begin with the description of specific US research ethics consultation programs. The panelists will discuss the types of questions that get asked, their processes for doing consults, and their relationship with clinical ethics consult services and regulatory oversight. The panel will then discuss the development in the US of the Clinical Research Ethics Collaborative, which includes 30 institutions that participate in the NIH Clinical and Translational Science Award (CTSA) program. Members share experiences and knowledge using a variety of approaches including a listserv and conference calls to get feedback on ongoing and completed consults and a case commentary series. We will also discuss a new initiative to allow members to obtain “real time” input on ongoing consults.

**G. History and Philosophy**

**Moderator:** Robert Baker

1. The 30 Year Evolution of One Hospital’s Medical Ethics Committee: Lessons learned

*William S. Andereck, MD, FACP*

The Ethics Committee at California Pacific Medical Center (CPMC) was constituted in 1985 and has now documented over 1000 clinical ethics consultations requested by clinicians seeking advice on a particular patient. This presentation chronicles the early challenges faced in the establishment of the committee and the strategies employed to keep the CPMC committee viable. It traces the committee’s progress from an initial committee of well-intentioned amateurs, to one supported by professionally trained clinical ethicists, serving multiple hospitals in a regional medical system. It also discusses the changing nature of requests for ethics consultation over time and the
type of requests generated by different types of health care professionals. Finally, it focuses on the changing nature of the response to requests for ethics consultation and how an ethics committee's accumulated experience can be used to effect organizational change. This is of significance as more hospitals are acquired by health care systems as part of a larger, integrated network. The question of systematization comes up. Should every ethics committee in a regional hospital system function in the same way? What is the future of hospital ethics committees? The presenter, who has chaired the CPMC hospital ethics committee for over 30 years and founded an ethics program in a community hospital, will discuss how the nature of the work of a hospital ethics committee is changing in the era of professional ethicists and how this new wave of professionals will lead to the ultimate demise of traditional hospital ethics committees.

2. The Dissolution of Heroic Medical Professionalism: Implications for clinical ethics consultation

Benjamin Hippen, MD, FASN

Laurence McCullough has argued that modern medical professionalism emerged from efforts by Gregory and Percival to replace transactional relationships with patients common in the 18th c. with a set of fiduciary obligations to patients in service to a social institution which seeks to warrant the public trust by explicitly forswearing mere individual and guild-self interest in favor of an institutional model designed for the benefit of patients and preservation of the integrity of the clinical practitioner. McCullough is a contemporary standard-bearer for “professional medical ethics,” which he favorably contrasts with “deprofessionalized bioethics,” predicated on an historical mistake about the allegedly oppressive role paternalism played in the median physician-patient relationships of previous generations.

In a similar vein but animated by different concerns, in 1979 Mark Siegler lamented the imperialist successes of “biomedical ethics” (BME) scholars in public policy and medical education. He warned of a pervasive anti-medicine bias, meddling in legal and administrative affairs for which BMEers had no warranted authority or responsibility, and observed with alarm the non-physician ethicists’ “…virtual dominance in the teaching of medical students.” Asserting that “clinical ethics” is redundant (since good clinical medicine is ethical medicine by definition), Siegler implored clinicians to return to teaching ethics as a matter of existential urgency: Instructing the young in the courage required of the clinician-“combatant” was too important to be left to ethicists, who, bereft of fiduciary obligations to patients, can only proffer “…the counterfeit courage of the non-combatant.”

But, with a turn of History’s wheel, hospital and clinical care has been sharply compartmentalized, physicians are becoming corporate employees at record rates, shift-work is such a pervasive arrangement that the physician today is often the physician of the day, and contemporary training programs have codified this as a cultural expectation. The evisceration of continuity in clinical care is a potent challenge to the veracity, and therefore the social prerogatives, of aspirational heroic medical professionalism. In response, CEC practitioners may increasingly find themselves solicited to fill the breach caused by clinical discontinuity in ethically challenging cases, but these are responsibilities for which CEC practitioners are currently ill-prepared to meet, and should not embrace.

3. A Concise History of Clinical Ethics Consultation in the United States

John C. Moskop, PhD

In this presentation, I will offer a concise overview of the evolution of the practice of clinical ethics consultation in health care institutions in the United States over the past 40 years. Clinical ethics consultation is closely linked with the academic field of bioethics, and so the presentation will begin by noting briefly the emergence of the new field of bioethics in the 1970s. I will identify precursors to clinical ethics consultation, including the Admissions and Policy Committee of the Seattle Artificial Kidney Center, the emergence of Institutional Review Boards for biomedical research on human subjects, and the medico-moral committees of Catholic hospitals. I will describe the early impetus for clinical ethics consultation provided by the 1976 Quinlan decision of the New Jersey Supreme Court and the Baby Doe Rule recommendation that US hospitals establish infant care review committees to examine decisions to forgo life-sustaining treatment of infants with severe illness or injury. The presentation will recognize early obstacles to clinical ethics consultation, including suspicion of the practice by clinicians and the discomfort of professional ethicists in clinical settings, and strategies developed to overcome those obstacles. It will note the growing acceptance of clinical ethics consultation following the adoption in 1991 of a Joint Commission on Accreditation of Healthcare Organization practice standard requiring that hospitals establish mechanisms to address ethical issues in patient care. I will acknowledge the publication of guides for the practice of clinical ethics consultation, including Core Competencies for Health Care Ethics Consultation in 1998 and
Improving Competencies in Clinical Ethics Consultation: An Education Guide in 2009. Finally, I will recognize the continuing debate over professionalization of the practice of clinical ethics consultation through mechanisms like certification of consultants and accreditation of ethics consultation training programs.

4. A Reply to Childress and the Physician’s Conscience
   Kyle Ferguson
A growing number of bioethicists and medical professionals are engaging in an important debate over how to reply to the physician’s conscience. The debate concerns cases in which the physician consults his or her conscience and consequently refuses to provide a professional service. How, if at all, should the medical profession accommodate the individual physician’s private, personal morality? Two extreme kinds of answer exist: radical professionalism, according to which the physician’s conscientious refusal is an intolerable, unjustifiable failure of professional duty; and radical individualism, according to which the physician’s conscience requires absolute accommodation given its ties to individual liberty and autonomy. There is a growing consensus that neither extreme will do and that the right path is in the middle ground. Professor James Childress has developed one of the more influential middle-ground accounts. In this presentation, I critically examine Childress’s account, replying that the analogy on which his argument rests (viz., citizen : state :: professional : profession) presupposes answers to difficult philosophical questions about the nature of professions, professional ethics, and the relations between professions, political societies, and the persons both comprise. I argue for a particular view of the medical profession and its ethics, and I describe how it should inform our efforts to improving quality and professionalism in clinical ethics education and consultation.

H. Conflicts in Pediatrics
   Annenberg A11-41 (Levy Library 11th floor)

Moderator: Ian R. Holzman

1. Severe Cognitive Impairment and Home Ventilation
   Linda Granowetter, MD
A 3 year old boy with Otahara syndrome was considered a candidate for a tracheostomy & home ventilation. The palliative care team was asked to help the parents decide on goals. The primary ethical issue discussed was the proper use of home ventilation for a child with severe cognitive impairment and without a chance of recovery.

Background: Otahara syndrome is a rare neurological disease that presents with intractable seizures in the neonatal period. Almost all children with this syndrome are profoundly cognitively impaired and have severe hypotonia. Most of these patients die within the first few years of life due to respiratory failure. This patient is mute, unresponsive to voice, does not have a social smile or follow with his eyes. He requires gastric tube feedings because of aspiration risk. He responds to touch and pain with facial expressions.

He is the only child of 2 modern orthodox parents. Mother and father have differing viewpoints. Father wants to “pull the plug” and does not ever want to see his child on a ventilator. Mother retains hope he will improve; she is particularly interested in a marijuana trial which she believes will improve the child’s cognitive function, and there are such trials in progress for children with intractable seizures, but she has not followed through on trying to have the child enrolled on the trial.

The child had been admitted to the hospital multiple times for respiratory problems. The pulmonary physician told the family that the child will need a tracheostomy and home ventilation. Both parents said they were opposed to tracheostomy, but the mother still wanted “everything done” Both parents were told that if he developed respiratory failure and was not intubated and placed on a ventilator he would die.

Both parents wished to speak with a rabbi to help resolve their opinions. Both parents came back after speaking with the rabbi and the mother said she was even more confused. The parents were counseled to seek further rabbinc clarification as mother made it clear this was important to her. Discussions with the family and palliative care3 team continue.

2. Conflicts in Pediatric Hospitals: What to do when a parental refusal is not life-threatening?
We conducted a review of the clinical ethics case records at our hospital (The Royal Children's Hospital, Melbourne, Australia), focusing on cases involving conflict between parents and health professionals about a child’s medical treatment. In the process of this review, we identified a set of five related cases that taught us a great deal about the ethical complexity of parental refusals of treatment.

The cases involved parental refusals of recommended treatment, where the refusal did not endanger the child’s life but rather some other aspect of the child’s well-being. These were not parents rejecting biomedicine in favor of alternative treatments. Rather, these parents were seeking a biomedical hospital-based treatment path that was known to be sup-optimal from a medical perspective. The cases included three families refusing surgery-related blood transfusions for faith-based reasons; the parents preferred treatment options that involved no blood transfusion but a riskier process of surgery or the possibility of a poorer functional outcome for the child. Another case involved refusal of a Port-a-Cath insertion in favor of distressing weekly peripheral intravenous cannulation. The fifth case involved parents seeking ongoing oral steroid use with its associated long-term growth attenuation side effects for the treatment of anemia in place of blood transfusion.

Our analysis suggests that this type of case may be relatively common (5/22 conflict cases referred to our service in the time period analyzed), yet it lacks substantial analysis in the current bioethics literature. Alongside our review of the clinical ethics records, we also conducted a literature review of 14 prominent bioethics journals to identify conflict cases. The 71 conflict cases that we identified in the journals almost universally described situations involving imminent risk to the child’s life and to provide normative guidance in relation to such life-threatening situations. We suggest that there is an urgent need for substantial normative analysis and guidance in relation to parental decisions that involve different stakes for the child, such as distress, poorer functional outcome, poorer psychosocial outcome, or increased risk of surgical complications.

3. Consulting Clinical Ethics because Parents are “Doing It Wrong”

Leah Eisenberg, JD, MA

This presentation focuses on the case of an infant born with a complex constellation of heart and airway defects who has spent all nine months of her life in the hospital. She suffered a severe global cerebral injury at six months of age, and will now require intensive medical support for the rest of her life. Her parents live 100 miles from the hospital and have visited less than a half-dozen times since her birth. They have minimal resources and five other children. When they are asked to choose among options for their daughter, they consistently choose to pursue aggressive life-sustaining measures. There is increasing distress from staff members caring for her, as they feel that the infant is suffering and that her parents don't see it. They allege that they are neglectful and do not care about their daughter.

The parents in this situation were consistently choosing options offered by their child’s physician, yet those choices were heavily questioned behind the scenes by other people caring for the patient. An ethics consult was called regarding the parent’s decisions. This talk will consider the question of whether ethics consults are ever called as a way for medical staff to deal with their frustration at parents who they feel are not choosing the “right” option offered. Is it fair for this frustration to manifest as judgment, and is it an appropriate role for the ethics consult service to mitigate it? How should and do social factors impact whether a family is given the benefit of the doubt? I will argue that it is unjust to present options then judge what parents elect to do. If the medical team cannot agree on a course of action, how can we expect parents to make a specific decision? The role of clinical ethics in both avoiding and resolving complex cases involving judging of families will be explored.

4. Can family law and dispute resolution enhance clinical ethics consultation in pediatrics?

Nikola A. Stepanov, FDRP PhD (current DJUR scholar)

The primary purpose of pediatric clinical ethics consultation services is to promote and enable morally appropriate and effective decision-making by those involved in the health care of children. Depending on age, the child too may be involved in decisions about their own care. Problems, dilemmas and conflicts arise when the beliefs of caregivers like clinicians and parents (and sometimes the child) do not align. This can result in a failure to reach a
shared, workable agreement about what is in the best interests of the child, and can lead to delays in treating a child in ways that are ethically appropriate and effective.

It is not only in the pediatric clinical setting that problems, conflicts and dilemmas involving children and their best interests occur. An analogy can be drawn to the problems, conflicts and dilemmas that arise in family law matters like where a child should live to go to school, and who should primarily make decisions for a child. In family law the role of mediators has become common place. Indeed in Australia before a separated couple can go before the courts to seeking an independent decision about parenting matters, they are required to show evidence of having genuinely attempted mediation with an accredited Family Dispute Resolution Practitioner (FDRP). These practitioners come from a range of backgrounds but share one legal responsibility- to encourage parents to act and make decisions that are in their child’s best interests.

In this paper I discuss the different frameworks used in ethics and in family law for resolving problems, dilemmas and conflicts. I then put forward an innovative new framework for consideration that is an amelioration of existing ethics decision-making frameworks and family dispute resolution frameworks.

Key words: clinical ethics consultation, mediation, family dispute resolution, best interests, innovation, consultation frameworks.

I. Clinical Ethics

Moderator: Stephen R. Latham

1. Delegation Disaster: Allowing a capable patient to delegate consent to a substitute

   Sally Bean, JD, MA; Blair Henry, MTh

Imagine a patient in his early 20’s that has had lifelong chronic health problems and relied heavily on his parents for care. While deemed capable to make his own healthcare decisions, the patient is on a high level of pain medication and is concerned that he cannot retain and understand information necessary to provide informed consent. Therefore, the patient wants both parents to act as his substitute decision-maker (SDM) for treatment decisions. The academic literature demonstrates that this case illustration is not an isolated event; indeed, there is ample qualitative and quantitative data from North America which demonstrates that many patients prefer to delegate their decisions to others or prefer to make decisions collaboratively.

In North American jurisdictions, ethics and law are well settled that persons who meet the healt care decisions capacity threshold must be permitted to make their own healthcare decisions. However, when a capable patient wishes to delegate not only access to their personal health information but also the authority to consent on their behalf, there is uncertainty in law about how to proceed. For example, in Ontario, Canada, the Health Care Consent Act indicates that a SDM for consent to treatment is invoked only when a patient is deemed incapable for a particular treatment decision. Therefore, there is no provision in law to address the delegation of informed consent to a SDM. Despite the evidence that many patients prefer to delegate their decisions, there is inherent risk in accepting consent from a delegate when treating a capable patient because if a medico-legal claim were to arise, it could be argued that the physician failed to obtain informed consent.

From a healthcare organizational policy and practice perspective, should the healthcare institution: discourage; prohibit; conditionally permit (with restrictions); or permit patients to delegate consent to treatment to a SDM? Based on a legal and ethical analysis, we contend that patients should be conditionally permitted to delegate consent to treatment to a SDM. Using Ontario as a case study, the pros and cons of allowing delegation of consent to a SDM as well as possible conditions will be explored.

2. Do Everything!” – New aspects of a never-ending story

   Kurt W Schmidt, Dr. theol.

Physicians and nurses are regularly confronted, especially in intensive care units, with demands from the next of kin to “do everything” they can for a patient. Especially following an accident or a sudden disease-related crisis, this is frequently an outburst of anxiety and fear before diagnosis and prognosis have reliably been established. In the course of further treatment it is often possible – also using ethical consultation – to instill an understanding in all those involved regarding the tragic developments of a disease. Particular tensions and conflicts can arise, however, when the condition of the patient continues to deteriorate and yet the next of kin never cease to demand
that “everything” be done. Religious arguments: “Do everything! Only God has to decide when it is time for my father to die…” can specifically create considerable tensions – between the medical team and the next of kin, between one family member and another, and between the members of a multicultural medical team.

Which method of ethical consultation is appropriate and helpful here, and which method is more likely to lead to an escalation of the situation? Is a theologian particularly suited to mediating in religious conflicts, or does a theologian run increased risk of being misunderstood and misinterpreted?

Using case examples from everyday clinical routines, various possibilities and limitations are explored. Inspiring scenes from films and literature are also presented, granting unconventional access to the “Do everything!” demand and helping those involved to look at this area of conflict with new eyes. A map of possibilities and limitations when dealing with the “Do everything” demand within the framework of an ethics consultation is thus drawn up.

3. What Is Discussed During Swedish Moral Case Deliberation Sessions?

Marit Silén, PhD, RN

Moral case deliberation (MCD) is a form of clinical ethics support where a facilitator leads a collective discussion with health care providers about a real case in their clinical practice. In the Netherlands, the method is most developed and implies using specific dialogue methods, such as the Dilemma method and Socratic dialogue (1). Swedish MCD (also called ethics rounds) are practiced in some hospitals, but unlike the Netherlands, no systematic training is offered to the facilitators and there is no consensus regarding how MCDs should be conducted. In a European research project, an evaluation instrument has been developed to capture outcomes of Moral Case Deliberation (2). In order to evaluate MCD, the content needs to be known. Therefore, as a part of the project, Swedish MCDs have been audio-recorded and studied from different research questions. Thus, the aim of this study was to describe which aspects Swedish Moral Case Deliberations contain and compare the content between sessions, workplaces and specialties.

Seventy periodic Swedish MCDs were audio recorded (each ranging from 60 to 90 minutes) at 10 workplaces in Sweden. They were analysed both qualitatively and quantitatively by the Framework method and non-parametric statistics.

Preliminary results show that besides ethical reflection of action- and relational ethics, psycho-social reflections of staff’ own situation and interpretation of patient’s psycho-social situation dominated. The MCDs also contained description of medical and nursing aspects as well as concrete results concerning action in the patient situation and organizational reasons and improvement. Further results will be presented at the conference.


4. Clinicians’ Wit & Wisdom: A Plea for Middle-brow Bioethics

William Ruddick, PhD

Gurus, parents, and teachers impart moral and practical wisdom by way of memorable maxims (“Pride goeth before a fall.”) Clinicians, too, have a store of wise, practical maxims but these are largely neglected by bioethicists for various reasons. Some are metaph"àorical, exaggerative, or archaic. Most have no obvious connection to canonical bioethical principles, nor have the generality or force of such principles.

I’ve come to think they deserve examination and respect. At the very least these clinical maxims about caring, hope, trust, and dignity, for example, enlarge the range of moral concepts and considerations we can bring to bear in moral deliberation and consultation. Moreover, even if metaphorical, these maxims often apply more readily to clinical cases than do abstract principles about harm, benefit, and autonomy. Taken to be rules of thumb rather than universal prescriptions, they are more like guideposts than guidelines: they remind and guide but do not dictate, like clinical judgments, they are backed more by experience, tradition, and intuitive judgment than by principle and theory. This is a shortcoming, only if we insist on a model set by certain universalist religions or
their secular analogues (á la Kant and Bentham). Arguably, Medicine and other professions are deeply localized, without any grounds for universal conceptions of the Good Doctor. If so, medical ethics will be “local,” but not in the sense disparaged as “relativist.”

To illustrate maxims’ utility and virtues, I’ll briefly consider the perennial 17th c. maxim: “Cure sometimes, relieve often, comfort always” whose familiar concepts are central to medical practice and whose guidance is relatively straightforward, even if occasionally needing definitional decisions. (Do five-year remissions count as cures? Do internists fulfill the obligation to “comfort always” by delegating comfort to palliative care specialists?)

A larger question I will raise but not discuss: how do physicians’ store of maxims comport with their stock of disparaging acronyms, metaphors, and other witty terms for various patients and conditions, terminal and otherwise.

**Wednesday, May 20th, 2015**

**5:15-7:30 Poster Session & Reception**  
Guggenheim Pavilion Atrium

Poster Presentations

Voting for Poster Awards

**Consultation**

1. **Linus Broström, Anders Castor**  
   Bias correcting ethics consultation – on what assumptions would it be justified?

2. **Sally E. Bliss, Robert C. Macauley, Jacob M. Dahlke, Gordon J. Meyer**  
   Measuring Quality in Healthcare Ethics Consultation

3. **Uchenna Ezeibe, Kathryn L. Moseley**  
   Pediatric Ethics Consultation Service at a Tertiary Hospital: A Retrospective Review

4. **Kathleen Detar Gennuso**  
   Pediatric Ethics Consultation Service at a Tertiary Hospital: A Retrospective Review

5. **Kenji Hattori**  
   A hermeneutic approach as a fundamental way in clinical ethics

6. **Eckhard Heesch**  
   Learning by example: The concept of dual moderation in ethics consultations in the "Evangelisches Krankenhaus Bielefeld" A measure to improve the practical education of ethics consultants

7. **Wendy S. Moon, Brenda Schiltz, Joan Henriksen Hellyer**  
   Two Decades of Pediatric Ethics Consults: A review of clinical case consultations

8. **Daniel Fun-Chang Tsai**  
   Developing Clinical Ethics: Experiences and Reflection from one Asian Country and a Cultural Perspective

9. **Shiho Urakawa**  
   The trend and the features of clinical ethics consultation in Japan

**Education**

10. **Amanda Favia**  
    Stimulation as a Strategy for Teaching Ethics in Emergency Medicine

11. **Rocio Garcia-Santibanez, Harris M. Nagler**  
    Quality Improvement Project: Improving Ethics Education during residency

12. **Marin Gillis, Diana Barrett**  
    Coma Simulation Meeting Clinical Neurology and Ethics Competencies in US Undergraduate Clerkship
13. Benjamin Tolchin, Joshua Willey, Kenneth Prager  
   A case based bioethics curriculum for neurology residents

**Clinical**

14. Christopher G Ciliberto  
   Conflicting Duties for the Obstetric Anesthesiologist Whose Patient Has a Ulysses Directive

15. Philip Crowell  
   A Clinical and Legal Case that Teaches About 'Humility': The Challenge of Advance Care Directives

16. Hazar Haidar  
   Non-Invasive Prenatal Testing: an "option" to test or a "pressure" to test?

17. Benjamín Herreros, Rebeca García, Virgilio Castilla, Rodrigo Alonso, María Manuela Barrera, Diego Real  
   Therapeutic efforts: Limitation in patients hospitalized in internal medicine at a hospital in Madrid

18. Lee See-Muah  
   Limits to Disclosure

19. Mirella MuggliChristian De Geyter, Stella Reiter-Theil  
   Shall patient wishes be fulfilled in any case?

20. Daniela Ritzenthaler  
   Enquiring into resuscitation decisions concerning intellectual disabled people in Swiss residential centres

21. Arthy Sabapathy  
   An ethics-based approach to developing member behavioral contracts in healthcare organizations

**Other Challenges**

22. Gwendolyn E. Bondi  
   Community Conversations: Bringing Voice to Advance Care Planning and Directives in Community Groups

23. Marie-Eve Bouthillier, Célyne Lalande, Sonia Gauthier  
   Ethical issues in domestic violence when women stay in or return to a violent relationship

24. Grażyna Jarząbek-Bielecka, Martyna Borowczyk, Anna Chmielarz-Czarnocińska  
   Ethical reflection on responsibility in sexuality and sexual crimes: Józef Tischner's thoughts on sex

25. Mayumi Kusunose, Kaori Muto  
   Ethical Issues in Clinical Trials: Dilemmas at a Research Hospital in Japan
Thursday, May 21st, 2015

8:00  Registration                Annenberg North Lobby

8:30  Conference Announcements    Annenberg Stern Auditorium

9:00  **Plenary Session III**     Annenberg Stern Auditorium

**Perspectives on Clinical Ethics and Consultations**

*Benjamin Wilfond, Stella Reiter-Theil, Jochen Vollmann*

Moderator: Guy Widdershoven

10:30  **Coffee break/Book-Journal-Program Display**  Annenberg West Lobby

11:00  **Plenary Session IV**     Annenberg Stern Auditorium

**Perspectives on Professionalization in Clinical Ethics**

*John Lantos, Marta Spranzi, Barbara Secker, George Agich*

Moderator: Renzo Pegoraro

12:00  "**Social Lunch**"         New York Academy of Medicine, Reading Room

"**Bring a Case to Lunch**"      New York Academy of Medicine, 20 A&B

a. Fatanehsadat Bathaei
   Ethical challenges of predictive tests (a true case)

b. Jennifer Markusic Wimberly
   Disorders of Sexual Development and Patients with Varying Levels of Disclosure

c. Tarun Dutta
   CSF biomarker study in motor neuron disease

d. Kyle Ferguson
   Assessing a Pregnant Patient's Decision to Allow Vertical Transmission of HIV

e. Sebastian von Hofacker
   "Decision-rollercoaster" or "yes but no...": A cancer patient with an instable personality disorder

f. Roya Rashidpourale
   A challenge between autonomy and beneficence: How can we decide?

g. Henry Silverman
   Limiting Life Sustaining Treatments for Newborns with Uncertain Prognosis

h. Elena Toader
   Ethical issues in case of a patient, doctor surgeon, with hepatic encephalopathy

i. Manuel Trachsel
   Palliative Care for a Patient with a Therapy-Refractory Severe Mental Disorder

j. Daima Athuman Bukini
   Comparative Analysis of Research Ethics Committees and Hospital Ethics Committees: What Fits?
Thursday, May 21st, 2015

1:30-3:00

Parallel Sessions 3

A. INVITED PANEL: Recent Developments in Clinical Ethics  Hess CSM 2 Davis Auditorium
Moderator: Amanda Favia
Felicia Cohn, Soren Holm, Michael Parker, Bert Molewijk

B. Panel – Non-Verbal Patients: Discovering capacity  Annenberg 13-01
Moderator: Grace Oei
Rebecca Brasher, LCSW; Debjani Mukherjee, PhD; Lynne Brady Wagner, MA, CCC-SLP

While the classic ethics literature often focuses on lack of capacity due to psychiatric illness or cognitive limitations, there is little direction for ethicists attempting to assess non-verbal patients. Particularly challenging are patients with aphasia due to stroke or brain injury. These individuals are often written off and assumed to lack capacity because they cannot engage in traditional mental status examinations, neuropsychological testing or structured capacity interviews. These patients are often deemed incapacitated solely because professionals lack the skills to accurately assess their understanding. This panel will start with a description of best practices to assess decisional capacity and present one hospital’s model for training clinicians to document their findings in a standardized format. The remainder of the session will be devoted to a demonstrating the technique of Supportive Communication through a case presentation and a series of video tapes.

The patient is a 47 year old gentleman who is status post middle cerebral artery stroke with subsequent hemiplegia and global aphasia. In addition to concerns regarding capacity, the case touches on questions about vulnerable parties needing protection from caregivers who may not be acting in the patient’s best interests. Although the patient in this case has no functional speech and severely impaired receptive language skills -- visual aids and a supportive conversation led by a speech pathologist, allow the ethics consultants to unearth a clear appreciation of his wishes. The patient is transformed through a series of brief therapeutic interactions from being a passive, uncommunicative individual unable to engage in basic conversation, into a fully invested and animated participant, capable of making nuanced decisions that will dramatically change the course of his future.

C. Panel - Transitioning from Student to Professional: Reflections from clinical ethicists with diverse professional trajectories  Guggenheim Pavilion 2 Hatch Auditorium
Moderator: Jacques Quintin
Lauren S. Flicker, JD, MBE; Cristie M. Cole, JD; Carrie Zoubul, JD, MA

The three panelists will discuss their first year as clinical ethics consultants at different medical centers across the United States. Two of the panelists served as full time clinical ethics consultants in their first year, one of whom manages ethics programming and the ethics consultation services at four community hospitals and the other who worked as part of a two-person ethics consultation team at a 600-bed, metropolitan tertiary care hospital. The third panelist is primarily an educator who teaches clinical ethics consultation, but also participates in her hospitals clinical ethics consultation service on a more sporadic basis. Two of the panelists have advanced academic training in medical ethics and participated in a rigorous clinical ethics fellowship prior to their current positions. The third panelist received advanced academic training in medical ethics, but did not complete a clinical ethics fellowship prior to becoming a full-time clinical ethicist—however, she did have significant past experience to build upon as she learned "on the job." All three panelists will discuss how their previous training prepared them for their current positions, and how (if at all) training might be improved. In particular, the panelists will discuss (1) transitioning from trainee to clinical ethicist, (2) the elements of clinical ethics that can and cannot be taught, and (3) lessons learned from their first year as professional bioethicists.

D. Panel - Themes of Ethics Consults  New York Academy of Medicine 20
Moderator: Kathleen E. Powderly
Wendy McHugh, RN, MS; Martha JurchaK, RN, PhD
Health care institutions have a variety of ethics consultation models. Regardless of what consultation model is used, it can be informative to compare the themes that arise in the consultation process.

This endeavor focused on two Harvard teaching hospitals (Brigham and Women's Hospital and Beth Israel Deaconess Medical Center) that have different ethics consultation models. In the first phase of the project, a list of 22 consult themes was identified. Each theme began with “There is uncertainty or conflict in relation to……”. The second phase was to review de-identified consult reports at each institution for a 12 month period. Each consult was coded using one of the identified themes from the list. The third phase of the project was to then compare the results between the two institutions. During the project it was determined that some consults could not adequately be coded into one of the identified themes. Therefore, the list was expanded to 27 themes.

There are a number of benefits to conducting this type of project. Within an individual ethics consultation service the themes can be seen as an affirmation of the ethical problems that the ethics consultants thought they were encountering frequently. Securing this data can be informative so that educational activities can be coordinated around themes. As part of the training and evaluation of ethics consultants, knowledge of and comfort with addressing these themes can be useful. The data can also be used as a helpful descriptive when informing senior administrators about the work of the ethics consultation service. When the data was compared between hospitals the frequency with which the various themes arose was interesting.

E. Workshop - A Practical Approach to Assessing the Quality of Ethics Consultations

Moderator: Autumn Fiester
Robert A. Pearlman, MD, MPH; Kenneth Berkowitz, MD, FCCP; Barbara Chanko, RN, MBA; Mary Beth Foglia, RN PhD, MA

The purpose of the Ethics Consultation Quality Tool (ECQT) is to improve ethics consultation quality and thereby support ethical practices and ethically appropriate outcomes for patients and other stakeholders. Currently, there are no agreed upon standards for what constitutes quality ethics consultation.

Ensuring ethics consultation quality (ECQ) requires a reliable and valid method of assessment, which has proven to be challenging. One method for assessing ECQ is to systematically evaluate all ethics consultation summary notes associated with a particular case (e.g., medical record notes and/or consultation service notes). After reviewing the ECQ literature we drafted an evaluation template that reflects aspects of ECQ and utilizes a holistic rubric approach that focuses on four essential elements: ethics question, consultation-specific information, ethical analysis, and conclusions and recommendations. For each element we established scoring standards. Development of the ECQ tool and scoring standards was an iterative process involving repeated reviews of ethics case consultations, discussions about inter-rater differences in assessments, and refinements as needed. The approach to assessing ECQ was tested with a diverse sample of ethics consultants (N=26) from within and outside VA and suggested refinements were incorporated. We also developed training materials that can be used reliably to rate and improve ethics consultations. A draft of the ECQT was used to help in the American Society for Bioethics and Humanities (ASBH) pilot attestation process (i.e., providing standardized guidance and a process for reviewing submitted ethics case consultations).

F. Workshop - Exploring Integrity in Medicine: A case-based approach to teaching business ethics and professionalism in medicine

Moderator: Thomas D. Harter
Joshua S. Crites, PhD; Tyler Zahrli, BA; Kelly Dineen, JD, RN; Erin Bakanas, MD, MA; Rebecca Volpe, PhD

Although often not made explicit, nearly every dimension of medical practice and research includes a significant business component. Exploring these dimensions through case discussion provides the opportunity to increase sensitivity to the ethical issues, to foster professional problem-solving skills, and to gain knowledge of relevant facts, principles, and laws. Addressing matters of medical business ethics also provides the opportunity to engage at least two of the general competencies for graduate medical education established by the Accreditation Council for Graduate Medical Education (ACGME): professionalism, which includes recognizing “the importance and priority
of patient care” and being “able to identify ethical issues in clinical situations”; and systems-based practice, which includes being “knowledgeable about the health care system, including principles of economics, public health management, quality assurance and patient safety.”

This workshop will explore issues in medical business ethics using a casebook recently developed by the Bander Center for Medical Business Ethics (Bander Center). The topics for the casebook were intentionally and rigorously identified using a Delphi panel with experts and stakeholders in clinical practice and research. In addition to serving as the bedrock for the Bander Center casebook, the Delphi panel also served to establish a consensus on what topics should be addressed in medical curriculum. The casebook includes fourteen cases that directly or indirectly address one or more of the highest ranked topics in the Delphi panel. The cases are based on real events as derived from personal narratives, published case reports and medical news reporters. Designed for interdisciplinary facilitation, the casebook includes specific logistics and facilitation recommendations.

This workshop will provide participants with the genesis and structure of the casebook, the SFNO method of case analysis, and recommendations for use in a variety of teaching settings. Two specific cases will be presented to the group and workshop presenters will engage in interdisciplinary facilitation. The first case will explore the impact of the outcomes based pay for performance (PFP) model that financial incentivizes providers relative to patient outcomes. The second case, will explore various factors that incentivize excessive screenings and treatment, including self-referrals by physicians.

G. The Interface of Research and Clinical Practice  
Hess CSM 2B
Moderator: Stephanie Alessi

1. Impact and Outcomes of Neonatal ICU Comprehensive Care Rounds  
Brian S. Carter, MD; Conor L. McMann, Dawn Wolff, MPA; Feliz A. Okah, MD, MS; John Lantos, MD

Background: A difficult ethical problem in the neonatal intensive care unit (NICU) involves the goals and propriety of treatment decisions for babies with chronic problems requiring continued intensive care and life-support technology. In such cases, differences in perceived goals and values may affect care-team and team-parent communication, impact patient care, or contribute to caregiver stress, moral distress, or impaired therapeutic relationships.

Study question: Can a multidisciplinary unit-based case conference improve decision making for these chronically ill babies?

Methods: Our Comprehensive Care Rounds process has previously been described and reported (Am J Perinatology 2012). Here we reveal actionable items identified and taken in 22 such CCR consults (19 unique patients) in the past 3 years (2011-2014), their implementation, and outcomes. With IRB approval, 22 CCR reports were retrieved and reviewed from the electronic health records to analyze: concerns prompting the CCR; their stated objectives; actionable items and recommended ‘next steps’ that were identified; and evidence recommendations were followed.

Results: Primary concerns prompting CCR were: suboptimal communication, poor prognosis, and uncertain care goals. The most common recommendation after a CCR was to redirect goals to palliation. The CCR process allowed unit-based interdisciplinary deliberation, values clarification and determination of care goals facilitated by participants (physicians, nurses, social workers, ethicists, chaplains and administrators) familiar with the NICU, its culture, patients and families. The 19 CCR patients were complex (74% had prenatal diagnoses, 95% had palliative care consults and 32% had separate ethics consults). Diagnoses spanned all major organ systems, genetic disorders, and NICU complications. Technology use was high (86% on a ventilator, 82% with a feeding tube, 27% had a tracheotomy). Eight patients died: 7 after a redirection of care goals in a CCR and discussions with families, and 1 after discharge home on assisted ventilation. The other 11 patients were discharged home and are receiving continued cure-oriented life-extending care.

Conclusions: CCR can 1) improve communication; 2) clarify prognosis and care plans; 3) sometimes lead to consensus about a change in plan for clinical care. All of these outcomes may lead to better staff morale, parental satisfaction, and quality care.

2. Ethics of Video Recording in a Prospective Trial of a New Operative Technique
Research Description:

A transabdominal plane (TAP) block is a technique used by physicians to control surgical pain. It is accomplished by injecting local anesthetic into a specific layer of the abdominal wall prior to an abdominal surgery. In the past, anesthesiologists have performed the block under ultrasound guidance before a procedure begins. Recently, the surgical literature has described a technique where surgeons can perform a TAP block under direct visualization once laparoscopic instruments have been inserted into the abdomen.

A recent IRB approved prospective study was performed to evaluate the use of this new technique. Presentations within their host institution as well as at national meetings have included video recording to demonstrate the procedure.

Question: Is it ethical to record and present de-identified procedures to colleagues in the teaching/demonstration of a new technique?

Topics for Discussion:

1. **Informed Consent**: Informed consent is a key part to any medical or surgical intervention. It is not so definite as to whether consent needs to be obtained when using recordings of de-identified information.

2. **Risk of Patient Identification**: There is discrepancy from medical associations regarding video recordings when there is no possibility of patient identification. However, it is difficult to determine risk probability.

3. **Privacy**: If the video has audio recording, the information captured is not only regarding the patient. The recordings also impact the privacy of other people in the operating room, and questions whether they must provide consent.

4. **Security**: Many of these recordings that are used for national or institutional conferences are stored on personal electronic devices. If these are considered part of the medical record, it is important to determine if they should be under the same security as patient information.

5. **Ownership of Recordings**: The video is not necessarily the property of the recording surgeon. Rather, it is more likely to belong to the host institution or the patient. In these cases, it is also important to recognize intellectual property in the event that the recorded procedure is part of a published article.

Environmental Bioethics and Clinical Ethics: Mutual advantage for research and planet

Cristina Richie, M.Div., Th.M., Ph.D. (cand)

In 2009 the United Kingdom examined the carbon expenditure of their National Health Services (NHS) and calculated that the NHS was responsible for 25% of England’s public sector emissions- over 18 million tons of carbon dioxide a year. Two years prior the United States health care sector expended an estimated 546 million tons of carbon dioxide¹ over thirty times higher than the U.K. Many ethicists believe these levels are unsustainable and environmental bioethics, in particular, has called for a reduction in CO₂ emissions of the medical industry.

Thirty years ago the field of environmental bioethics emerged as a response to pollution, carbon emissions and human health. Initiatives like Practice Greenhealth, the Healthy Hospitals Initiatives and the NHS *Carbon Reduction Strategy* have played a major role in advocating for sustainable hospitals. Furthermore, the NHS has addressed sustainability in clinical research.

The National Institutes for Health Research (NIHR) is the branch of the NHS that supports research- case studies, clinical trials, study design, data collection, and trial monitoring. The NIHR *Carbon Reduction Guidelines* "developed by researchers for researchers... highlights areas where sensible research design can reduce waste without adversely impacting the validity and reliability of research."² Efficiency in study design, eliminating unnecessary site visits and rapid publication are suggested.

Given the urgency of climate change and the widespread move towards sustainability, this presentation will introduce environmental bioethics as a topic of concern to clinical ethicists and explain the impact that it will likely have in the future of clinical work. Using the NIHR *Carbon Reduction Guidelines* as a springboard, I will discuss conservationist strategies for institutions and individuals and also highlight possible areas of concern such as
privacy as health records are converted to electronic records to save paper. The fusion of environmental bioethics and clinical ethics is inevitable. Empowering clinicians to direct the future of environmental clinical ethics can result in a mutual advantage for research and the planet.


4. Communicating Risk and Benefit at the Bedside: The case for stem cell counselors

Christopher Thomas Scott, MLA, PhD

In little more than a decade, stem cell science has moved rapidly from discovery to testing in the clinic. Hundreds of early phase stem cell clinical trials are estimated to be underway, some for serious and debilitating conditions such as end-stage heart disease, immune-deficiency, autism, and spinal cord injury. This robust translational push equates to thousands of patients enrolled in stem cell trials and many more thousands of prospective participants inquiring about whether they are eligible for new studies. Many, if not most, of these patients will learn about stem cell trials through their personal physicians or through specialist referrals. Because stem cell research is a frontier science and patient populations for some trials will be especially vulnerable, there is a need for professionally trained clinical staff to objectively explain the risks and benefits of stem cell transplants to prospective participants and their families, and to counsel those patients enrolled in trials. A case study of a patient enrolled in the world's first trial using cells derived from human embryos will be used to describe the unique ethical dilemmas presented in an acute treatment setting for spinal cord injury (1). Then, an argument will be made for the creation of a new clinical discipline—stem cell counselors—designed to address these and other major ethical challenges facing personal physicians and physician-scientists and staff who aim to treat patients seeking stem cell therapies. These include communicating specialized information in charged and controversial social contexts, guarding against medical tourism, and enabling personal autonomy and informed consent. Using the genetic counseling paradigm as a starting point, a model for a stem cell counseling discipline will be proposed, and a training curriculum will be described (2). Finally, the benefits of a stem cell counseling core to clinical researchers, ethics professionals, and institutions will be outlined. These include advantages for IRBs, stem cell oversight committees (SCROs), clinical ethics consultation services, patient advocacy organizations, and trials study staff.


H. Evaluating Consultation

New York Academy of Medicine, 440

Moderator: Benjamin Hippen

1. ‘Just a Collection of Recollections’: Evaluating how we evaluate our consultations

Virginia L. Bartlett, PhD; Mark J. Bliton, PhD; Stuart G. Finder, PhD

The past half-decade has seen increased attention directed toward how best to evaluate clinical ethics consultations, with increasing focus on evaluation by external evaluators (Hastings Center Report, ASBH Quality Attestation Project). The same cannot be said about how we, as clinicians, make sense of and learn from our own experiences within the midst of any one consultation – how we evaluate, for instance, the request for, unfolding of, and conclusion of any specific ethics consultation.

This absence of sustained attention to the issue of ethics consultants’ experience highlights a crucial question: is it possible to give an accurate account of clinical ethics consultants’ experience as experienced by ethics consultants? How this question is answered has implications for the kinds of cases we choose to share with others – and the ways in which we choose to share them. Before the challenge of submitting one’s accounts or case reports for review and evaluation from others (at one’s local institution or in the broader field), there is thus an underlying challenge of understanding and evaluating our own accounts.
To highlight this crucial— and often deeply challenging— dimension of actual clinical ethics practice, we will share three accounts of an actual clinical ethics consultation, each told in the voice of the ethics consultant but each exhibiting a different perspective. Presented in an interwoven, interactive format and illustrated by a multi-media power-point presentation, the three perspectives presented - prototypical clinically descriptive (and presumably neutral) account; didactically reflective and self-evidentiary account often seen in journal presentations; highly self-critical reflective account emphasizing uncertainties inherent to clinical ethics practice— reflect different manners for responding to the ways actual clinical involvement in ethics consultation practice accentuates and refocus the question of how to understand and evaluate our own work, as well as that of our colleagues.

As our tri-partite presentation of a single ethics consultation shows, how we understand, frame, and relay our experiences of our work will influence how we learn from one consultation to the next, as well as influence how others— institutionally or in the broader field— understand what we do as clinical ethics consultants.

2. Could a Clinical Ethics Consultation Be Profitable?

Clemence Desire, PhD Student; Cesar Meuris, Philosophy PhD student and bioeticist; Martin Cauchie, Bioeticist student and anthropologist

Following the ICCEC 2014 workshop on philosophical underpinnings of ethics consultation, we would like to propose a reflection on the financial compensation of this practice.

The issue of whether clinical ethicists should be paid depends on the status of bioethics consultations. The competences, the nature of the services and the role of clinical ethics in the medical decision process lead to the issue of the professionalization of the ethics consultant and the determination of a possible legal status for experts in clinical ethics. In this context, we tackle up front, in a for-profit environment, the issue of a possible remuneration for clinical ethics consultants and whether it is in contradiction with a moral healthcare service usually conceived as a social, medical and philosophical responsibility.

In this context, we examine the question of the impact of remuneration on clinical ethics consultation. What would the effect of being paid for a clinical ethics consultant be? Does money taint consulting advice, ruining independence? Considering money as a social contribution to professionalism, is it non-ethical to argue that an ethical consultation could be profitable? We propose questioning the dominating idea that the actors working in the area should not be financially remunerated, at the cost of perverting their neutral interest in the field. We wonder if this policy would not generate the exact opposite effect than the one desired: it could create absenteeism, compromise investments, and reinforce the idea that ethics is a secondary matter— although it should occupy a more central space in medicine.

In this line, we advocated for a more pragmatic way to consider the ethics activity. Who works in the ethics area, for which reasons, and in which socio-political context? Moreover, who pays the ethics consultant? Why could we not finance people and departments to invent standards and methods at a local scale and experiment ethics in the health system? We argue that the issue of the remuneration of clinical ethics consultation must be embedded within a larger thinking on what should be financially compensated or not in the health system of a modern democracy.

3. Evaluating Outcomes of Clinical Ethics Consultation (CEC): An empirical-ethical analysis

Jan Schildmann, MA; Sebastian Wascher, MA; Dr. Marjolein Gysels, Prof. Dr. med. Claudia Bausewein; Prof. Dr. med. Dr. phil. Jochen Vollmann

Evaluating outcomes of clinical ethics consultation (CEC) has been advocated widely in the literature. However, there is a scarcity of data assessing the impact of CEC in daily clinical practice. In addition, those evaluation studies which have been conducted in recent years have been criticised from different disciplinary perspectives. While parts of the criticism is directed to normative premises underlying some of the chosen outcome measurements there is also criticism regarding the methodological robustness of the empirical research instruments which have been used to evaluate outcomes of CEC.

The starting point for this paper is the conception of evaluation of CEC as a case of "empirical-ethics research". By "empirical-ethics research" we refer to methodologies with the shared characteristic of combining methods from (socio-)empirical science and normative ethics. In a first step we will present a selection of outcome criteria which
have been used in CEC evaluation research and conduct an analysis of associated empirical and normative challenges. One example criterion which we will explore in more depth is “satisfaction” of CEC participants. Here we will discuss empirical challenges such as an appropriate measurement of satisfaction within the context of CEC and possible confounders. In addition we will assess from a normative perspectives in how far satisfaction of CEC participants is an ethically justifiable goal of CEC. In a second step we will outline quality criteria for CEC evaluation research which are based on a recently published quality framework for empirical-ethics research and which will be adapted to the area of CEC evaluation research. In the concluding part we will explore implications of the application of the suggested quality criteria for the development and use of outcome criteria in CEC evaluation. In this context we will discuss in how far the definition of appropriate outcome criteria for CEC evaluation needs to be informed by contextual factors such as the clinical setting or cultural or country specific aspects.

4. Qualitative Evaluation of an Outpatient Ethics Consultation

Sandra Thiersch, MA, BA

Background:

Due to the increasing technological progress of medicine, doctors and patients are increasingly confronted with ethical issues (e.g., decisions on the end of life). Over the last 20 years, ethic committees were founded in German clinical institutions to assist doctors, nurses, and patients as well as their relatives in dealing with these issues [1]. The implementation of clinical ethics committees has made progress [2]. However, there are hardly any consultation services for the outpatient area [3, 4]. To fill this gap, 21 persons established an outpatient ethics consultation in Bavaria in 2012. After 2 years of work, they decided to evaluate their offer.

Materials and Methods:

There are two aims of the study:

1) Creating an evaluation concept

2) Evaluating and improving the consultation service

The approach of the Responsive Evaluation of Robert Stake [5] and the Coding Manual of Johnny Saldana [6] were used to evaluate the consultation service. There are two steps of the evaluation:

1) Implementation of a qualitative interview study (3 expert interviews, 19 interviews with the members of the consultation service and 10 interviews with persons who took advantage of the consultation service)

2) Implementation of a questionnaire survey among family doctors (November 2014)

By using this mixed methods approach, we want to answer the following questions:

→ How were the implementation and organisation of the outpatient ethics consultation?

→ What are the responsibilities of the outpatient ethics consultation?

→ What should be improved?

Results:

In September 2014, we have started to evaluate our results:

→ By implementing an outpatient ethics consultation, sponsors are very important for supporting public relations and for paying ethics consultants

→ 9 out of 10 persons who took advantage of the consultation service perceived the offer as useful and helpful

→ In addition to the ethical consultations, an aftercare for relatives, nurses, and family doctors is useful sometimes

Conclusion:
The Responsive Evaluation proved to be suitable for getting a first overview. The aim should be to develop a unified approach for evaluation to support the clinical and outpatient ethics consultation by doing their work.

References:


I. Issues in Ethics Consultation

Moderator: Nada Gligorov

1. Is a Hospital Ethics Committee Useful in Improving Healthcare: An experience from Turkey

M. Murat Civaner, MD, PhD; Mustafa Gullulu, MD; Hasan Dogruyol, MD; Tahsin Yakut, MD; Merih Yurtkuran, MD; Ali Aydinlar, MD; Kasim Oztuk, PhD; Ferda Kahveci, MD; Ridyan Ali, MD; Dilek Durak, MD; Berrin Ozcan, MD; Simsek Cankur, MD; C. Mine Yilmaz; Irfan Kiristroglu, MD

Since Clinical Ethics Consultation (CEC) is a relatively new concept and not a legal requirement for healthcare institutions, Hospital Ethics Committees (HEC) are sporadic in Turkey. Considering that it might provide useful guidance in ethical dilemmas both for clinicians and patients, we have decided to establish a HEC in our university hospital in Bursa, accredited by Joint Commission International. In the first phase, in order to determine the actual needs of clinicians, a quantitative study was conducted among 220 clinicians. After explaining its nature and functions, 79.8% of the participants said that they face cases in their daily practice where they would apply to a CEC service. “Knowing the rights and legal obligations on a certain case” (66.4%), “witnessing / being accused of malpractice” (64.1%), “dilemmas derived from cost-effectivity policies” (59.1%), “determining the limits of duty to care” (51.4%), and “ethical problems related to end-of-life care” (45.1%) were the most cited situations which they stated that they would use CEC for. Then the HEC was established in 2012 with 11 members including the Dean of the School of Medicine as the head, the Chief of the Hospital, the head departments of surgical, internal, and basic sciences, and a member from School of Law who is an expert on civil law.

After a three-year period, the applications brought to HEC’s agenda were evaluated in a retrospective study. A general overview of the applicants, cases, decisions, and their implementation is provided, and the nature of decision-making, as well as the barriers and challenges are examined, comparing to the experiences in the literature. Contrary to the results of the initial study, clinicians used the HEC for different reasons than they had stated before, usually covering the problems derived from organization of healthcare, violence towards healthcare workers, and the claims about abusing the services for personal interests. The possible reasons of this phenomenon is discussed in this presentation, and suggestions such as improving hospital policies and procedures in order to prevent conflicts derived from power relations, and developing educational initiatives to create awareness were made.

2. What is the role of compromise in clinical ethics?

Carolyn Plunkett, MA
A normal expectation of a society in which people are free to choose their moral convictions and act accordingly is that we will encounter differences on ethical, political, and social issues. Resolving those differences and the disagreements that ensue often demands compromise. Compromise occurs when disagreeing parties each “give a little” to the other in order to reach an agreeable solution. When compromise occurs, the solution is suboptimal from every individual’s perspective, yet best in practice. Consider one paradigmatic example. A wants to plant arugula in the garden she shares with B, but B wants to plant tomatoes. They agree to plant half of the garden with arugula, and half with tomatoes. From A’s and B’s perspective, the solution falls short of ideal, yet it is the best in practice given their commitment to sharing the garden.

There are interesting philosophical issues raised by compromises, perhaps most notably how to justify compromising on supposedly unbending moral standards. My question, though, is whether conflicts that arise between doctors and patients (and their families) or among members of healthcare teams are like the garden case. In some ways, the analogy is clear. When a doctor believes surgery is the best way to remedy an embolism in her patient’s leg, yet the patient wants only to return home and seek no intervention, a medical regimen such as daily heparin, which should slowly dissolve the embolism, is somewhere “in the middle.” But is it a compromise? The cases are disanalogous, too. On the one hand, A and B are equal stakeholders in their shared garden. The doctor and her patient, arguably, are not equal stakeholders in the patient’s care.

I think the answer to the question raised has implications for how we view the goals of clinical ethics. Is it to empower patients to be stewards of their own care? Is it to educate patients? Or is it resolve conflict between equal parties? Thinking about the role – and limits – of compromise in clinical ethics can help us adjudicate between models of clinical ethics consultation and practices.

3. The Circle of Care: Questions for ethicists about information access and control

The Circle of Care (CoC) refers to an imaginary zone within which a healthcare team provides direct or indirect care to particular patients. An exploration of Canadian federal and provincial regulations reveals, however, that despite its frequent invocation the term is never precisely defined. Ontario’s Information and Privacy Commissioner states only that “it is a term commonly used to describe the ability of certain health information custodians to assume an individual’s implied consent to collect, use or disclose personal health information for the purpose of providing health care”. Expressly excluded from the CoC are those engaged in “research, fundraising, marketing”. Moreover, implied consent cannot be assumed when the health information of one patient might assist with “the provision of healthcare to another individual or group”.

Privacy legislation, however, has little to say about the interactions between patients and members of healthcare teams - like Practicing Healthcare Ethicists (PHEs) and Chaplains - who support patients, staff, physicians and families in ways that are often indirect and ill-understood. If PHEs are part of the CoC, it is not obvious that they can rely on the notion of implied consent as most other team members do. PHEs often operate as consultants and, even if they are full-time members of the healthcare staff, it is not self-evident that their involvement is warranted or welcome in all patient cases. Worse yet, many patients are still unaware of what we do.

Healthcare professions have regulatory bodies that delineate conditions for accessing and sharing health information. With the professionalization of PHEs becoming a more pressing and achievable aim, the positioning of ethicists in relation to the CoC raises intriguing questions. Two that give us particular pause are: Who should be included within the so-called circle of care, and (of those within the CoC), with whom may personal health information be shared?

4. Neutrality and Impartiality in CEC: The ethics consultants’ complex stance

The ASBH facilitation model for clinical ethics consultation does not explicitly state that the consultants should adopt a ‘neutral’ stance towards the decision stakeholders. However, as Adams and Wilslade (2011) have convincingly shown, it indirectly fosters neutrality and impartiality as opposed to advocacy as an appropriate model of CEC. However, this stance remains elusive and is characterized negatively by what it is not rather than positively by what it means. In this paper I would like to explore this issue by looking at the philosophical sources of both
neutrality and impartiality. Indeed, these two terms, which are often considered as synonymous are used in two different contexts: the first is used in the political context and refers to appropriate actions. The second is used in the moral context and describes an ideal attitude. Neutrality means the refusal of favoring one vision of the good over another: in a liberal, as opposed to communitarian, political system, public policies should be neutral with respect to the values pursued by individuals and/or communities. Neutrality thus fosters restraint and minimal intervention in the affairs of those who are the object of our decisions. Impartiality on the contrary, refers to the fact that it is not legitimate for a moral agent to privilege one’s own relations from the moral point of view: family, friendship, love, personal or cultural affinities should not justify a differential behavior in terms of beneficence or attention. Impartiality thus fosters an attitude of objectivity and abstraction from one’s own deeply held concerns.

In the second part of the paper, I would like to discuss these two terms in relation to the consultants’ role. By drawing on a few consultation cases, I’ll show that neutrality does not result from a position of systematic restraint but rather by a double and symmetric involvement with both patients/proxies and HCT members. Impartiality, for its part, is not the starting point of the consultation. Indeed consultants are emotionally involved in the situation and tend to have strong immediate feeling as to which party should be morally privileged. However, during the case conference the consultants’ spontaneous position is held up against dispassionate team members who redress the moral leanings of the consultants and allow the consultation to achieve an impartial result.
A. INVITED PANEL: Perspectives on Medical Ethics from Today’s Clinicians and Their Clinician Parents  
Hess CSM 2 Davis Auditorium  
Moderator: Michael Parker  
Barron Lerner, Daniel A. Moros, Lisa Hirschhorn

B. Panel - Enhancing Inter-professional Conversation in the ICU through an Ethics Early Action Protocol  
Hess CSM 2B  
Moderator: Arthur Kopelman  
Katherine Brown-Saltzman, MA, RN; Carol Pavlish, PhD, RN, FAAN; Joan Henriksen Hellyer, PhD, RN; Ellen Robinson, PhD, RN

Communication that ethical issues are brewing is often shut down due to differences in perception, poor communication, or a hierarchical power differential. A tradition of reticence clearly calls for innovative tools that create opportunity for interdisciplinary dialogue on ethical concerns. What if the process of early recognition, prior to the escalation of conflict, could be neutralized in a way that favors good assessment and communication? An innovative evidence based protocol, constructed from nursing and physician insights, was developed and refined into an interprofessional Ethics Early Action Protocol (EEAP). The protocol incorporates early risk factors and significant ethical considerations promoting nurses and physicians to engage in dialogue. Included in the procedure are a scoring mechanism and an ethics action plan that encourages engagement and follow-through. The effectiveness of this procedure was tested for six months at six ICU's at three sites - UCLA, Mayo, and MGH and was incorporated as both a quality improvement project and research approved by the IRB's. Physicians and nurses received a 15-minute online training orienting them to the EEAP. The goal was to evaluate four areas: identification of high-risk ethical situations early in ICU stay, promotion of teamwork and family satisfaction, mitigation of providers' moral stress, and enhancement of health care providers’ ethics self-efficacy. At one site the protocol was placed within the EMR where easy access and integration may establish future standardization. The results of this investigation provides valuable information on whether an interdisciplinary Ethics Early Action Protocol helps health care teams identify, collaborate, and intervene in ethically-difficult situations.

C. Panel - Value Development in Clinical Ethics: Must clinical ethicists be ethical?  
Annenberg 5-210 A&B  
Moderator: Kelly Armstrong  
Thomas D. Harter, PhD; Mark P. Aulisio, PhD; Courtenay R. Bruce, JD, MA

In the Core Competencies for Healthcare Ethics Consultation (2011), the American Society for Bioethics and Humanities (ASBH) connects the quality of healthcare ethics consultations (HCEC) to a consultant’s development of certain values. Several specific values are listed: tolerance, patience, compassion, honesty, forthrightness, self-awareness, moral courage, prudence, humility, leadership, and integrity. This connection is echoed in ASBH’s Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants, where it is stated that HCEC consultants are expected to act with professional integrity, which is partly defined as the cultivation of these values.

This presentation will discuss the implications of this expectation in both HCEC training and practice. Three clinical ethics experts who practice in different regions and different types of health systems will address three specific issues. Our first presenter will discuss whether a HCEC consultant’s role should be to model “virtuous” behavior in both training and practice. This presenter will make the case that modeling “virtuous” behavior should not be considered part of the HCEC consultant’s role. Contrary to this view, our second presenter will explore whether, and to what degree, the expectation to develop the above mentioned values can be practically evaluated as part of HCEC training programs and as part of the quality assessment of consultations to assess the development and
cultivation of these values by HCEC trainees and individual consultants. Lastly, our third presenter will discuss the bounds of ASBH's expectation for HCEC consultants and trainees to cultivate the above mentioned values. This presenter will focus on two questions: 1) how should the field of HCEC respond to consultant's who demonstrate these values in HCEC, but do not demonstrate these values in either their personal lives or in other areas of the profession such as collegiality toward peers, and 2) how should the field of HCEC address trainees who fail to develop one of more of these values?

**D. Ethical Dilemmas**

**Annenberg 13-01**

**Moderator: Sumytra Menon**

1. Uncertainty, Controversy, Dilemma: Fundamental ethical questions in clinical ethics

   *Jan Schürmann, MA; Stella Reiter-Theil, Prof. Dr., Dipl.-Psych.*

**Background**

CEC is not only liable to standards of efficacy and practicability, but also of ethical justification. It has been argued however, that due to its consensus and practice orientation CEC falls short of profound ethical justification. How does CEC reflect fundamental ethical questions (FEQs) arising in its own practice?

**Conceptual framework**

FEQs can be defined by their form and content. Several *forms* of ethical questioning are suggested on the basis of a literature analysis. Six types of FEQs were formulated accordingly: 1) What are the procedures of ethical reflection? 2) How to articulate and agree on a normative framework? 3) How to understand basic normative concepts? 4) Role of ethical regulations or guidelines? 5) Handling conflict between ethical considerations and law? 6) Can the outcome be generalized, i.e. used in other cases? The *content* of FEQs can be defined by any kind of moral problem occurring in the clinical setting, e.g. treatment limitation.

**Approach**

70 documented CECs – 30 somatic, 30 psychiatric, and 10 pediatric cases – of our service were analyzed according to standards of qualitative research. The aims of the study were a) descriptive, i.e. to find out whether and how FEQs are raised and handled in CEC, b) explorative, i.e. to identify unexpected FEQs, c) conceptual, i.e. to adapt the definition of FEQ accordingly.

**Results**

Preliminary results show that more than half of all examined CECs raised FEQs of type 1-6. Each type could be verified in one or more instances. Prevailing examples: collision between patients’ and third parties’ interests (child/maternal, forensic patient/public); treating patients with uncertain/oscillating decisional competence; questioning a surrogate’s legitimacy.

The range of handling FEQs in CEC differed significantly: just mentioned, explicitly discussed, marked for further investigation/action, examined in reanalysis, addressed in forthcoming ethical policies.

Unexpected FEQs were found, e.g.: How to manage prognostic uncertainties responsibly? How to handle lacking information in emergency?

In light of a detailed analysis the typology as well as suggestions for the reflection of FEQs will be put to discussion.

**Conclusion**

In CEC FEQs can and often do arise. CEC should develop strategies to identify and handle FEQs systematically.
2. Healer or Dealer? The case of dispensing doctors in Singapore

Theodora Kwok, MBioeth; BSc

Due the immense influence the pharmaceutical industry has in shaping our healthcare landscape, there needs to be vigilance of the wide array of conflict-of-interests (COIs) situations in medicine; lest we create more in our bid to improve the system. In this paper, I will highlight the potential COIs situations that can arise when doctors are allowed to dispense and prescribe medications. Although relatively uncommon in countries like Australia or the United States of America, it is not one prohibited by law, only rarely seen in common practice. However, in countries like Singapore, Thailand, Hong Kong and China, and until less than 15 years ago; South Korea, it is common for a doctor to fulfill the dual role of doctor and pharmacist in a practice. This might give rise to the perceived or potential COI when considering the financial incentives doctors may receive when they earn from the sales of prescribed medication. How then would this, if ever, affect their prescribing practices? In this paper, I will examine the healthcare obligations doctors have to their patients, and show how in fulfilling this dualism of roles, the obligations doctors have for patients may be unduly influenced. I shall be focusing on the social, and medical issues that arise from this system in the Singapore context. The expected outcome is a paper that better understands how dualism of roles and COIs in medicine influence its practice, and inform future policy developments that can confer better protections on the quality of care provided to patients.

3. Do Patients Want to Know about Surgeon Experience?

Jennifer Markusic Wimberly, MD

Regarding the use of mesh in the repair of pelvic organ prolapse, the Federal Drug Administration (FDA) has issued two public health notifications, in 2008 and 2011, to both surgeons and patients alike for the purpose of disclosing and understanding the risks of mesh implantation as part of the informed consent process. A third notification was issued by the FDA on March 27, 2013, this time as part of the informed consent process for the use of mesh sling in the repair of stress urinary incontinence (SUI). In this document, it is suggested to a patient to ask the surgeon before the decision to have SUI surgery to disclose what “type of specialized training he/she received with a particular product and/or procedure.” Another recommendation is for the patient to question the surgeon on “how often he/she has performed this surgery with this particular product.”

The five basic tenets of informed consent include disclosure, capacity, voluntariness, comprehension and consent[1]. Nowhere is surgeon experience involved in the informed consent process, yet it is now part of an official recommendation issued by the FDA regarding synthetic material surgery.

After receiving IRB approval, a survey was administered by neutral third parties to patients in 2 separate outpatient settings. The survey had three components: the REALM-SF (to assess literacy), STAI-X2 (to assess anxiety), and a specifically designed Observer Questionnaire (OQ) with yes/no answers. The OQ included Q1: Should the consent form include the number of times a surgeon has performed this type of “new” surgery?, Q2: Should a consent form include since when the surgeon has started to perform this “new” surgery?. Descriptive statistics were used.

Three quarters of queried women would like to know more about their surgeon’s expertise with a new type of procedure before consenting to it. Age and race were statistically significant factors for patients wanting to know the number of times a surgeon had performed a “new” surgery but were not significant factors for wanting to know since when the surgeon began to perform the “new” surgery.

4. Ethics Consultation in Life-Threatening Anorexia Nervosa

Stella Reiter-Theil, Prof. Dr., Dipl. Psych.; Dr. Dagmar Meyer, Master of Advanced Studies in Applied Ethics; Prof. Dr. Alain Di Gallo

Background – question

Anorexia Nervosa (A.N.) is a possibly life-threatening illness among young, mostly female patients frequently enduring years or decades. Their parents and therapists are often confronted with severe conflict between respecting the patient’s wishes (not to eat/be fed) and the obligation of nonmaleficence and beneficence (to prevent serious harm or even death by starvation).

(How) Can EC help health care professionals in charge of A.N. patient treatment?

Methods

Literature study.

One in-depth ethical case study on the basis of detailed EC documentation.

Comparative discussion of (three) CE cases of A.N.

Results

Ethics Consultation (EC) about the appropriate management of A.N. has been reported very rarely in the literature.1 Guidelines are in use for the treatment of A.N.,2 but they hardly advise therapists how to address ethical challenges. This corresponds with the backdrop of Psychiatry in implementing Ethics Support documented in a literature review.3

1 Ethik Med 2010; Camb Q Healthc Ethics 2012
2 e.g. Aust N Z J Psychiatry 2004; Am J Psychiatry 2006
3 Psychiat Praxis 2014
A young woman suffering from severe A.N. since 6 years underwent a series of treatment efforts (standardized, strict weight criteria, in both out- and inpatient settings) with repetitive failures and “malcompliance”. EC was requested by the therapist leading to an adjustment of the therapeutic philosophy:
- reducing pressure by respecting the existential dimension of the patient’s ambivalence towards weight gain; prioritizing dealing with the patient’s aspirations;
- i.e. respecting the patient in her non-adherence and (possibly unrealistic) plans;
- involving the patient in actively setting the treatment goals; advance care planning for acute emergency (risk of physical deterioration through further weight-loss).

Also in two other cases, the respective A.N. therapists supported more self-determination and involvement of their patients in setting their own treatment goals after EC, even in situations where (physical) deterioration or death was imminent.

Discussion

The treatment of A.N. patients raises specific ethical issues: treatment limitation, coercion, advance directives, palliative treatment goals, and patient decisional capacity – driving established treatment philosophies to their limits. Therapists evaluated the EC outcomes as helpful although the consultations seemed to contradict traditional concepts of A.N. treatment that are informed by “rescue ethics” and paternalism, especially when the patient is in a critical state of health.

E. Workshop - Utility of an Online Electronic Ethics Consultation Platform Annenberg 12-62
Moderator: Nada Gligorov

Lauren B. Smith, MD; Andrew Shuman, MD; Yael Shinar, MDiv

Our ethics consultation service utilizes a web-based, encrypted and password-protected electronic platform as part of a collaborative multidisciplinary ethics consultation model (The Physician Executive. 2011;37:62-64). Using this system, ethics committee and consultation service members receive real-time updates concerning active consults, and have the opportunity to provide immediate feedback to the on-call ethics consultants performing the consult. This system avails the on-call consultants of the expertise, input and comments of the entire ethics committee in an electronic format. In this way, difficult topics can be explored, and additional opinions probed, without the need to assemble the entire committee on short notice. In addition, this is a valuable and powerful teaching tool, as trainees (medical students with specific interests in medical ethics, and others) share access to this electronic resource. This feature allows trainees to learn about the consultation practice and the myriad of opinions one case may generate, as one of the goals of this program is to train the ethics consultants of the future. It also creates a valuable cache for clinical research and quality improvement. This presentation will summarize the logistics, structure and experience with this electronic resource, using a selection of our most interesting and difficult cases which specifically benefited from real-time online feedback. Topics will include allocation of scarce resources, reproductive justice, discontinuation of medical devices, research ethics, and futility. We believe that application of similar technology and consultative models may be of interest to ethics consultation services at other institutions.

F. Ethical Support Services Annenberg 1201

Michael Dunn, PhD

Over the past fifteen years, bioethics has embraced the Internet as a revolutionary means to disseminate educational materials. PDFs, slide sets, and webinars have become indispensable tools in bioethics and clinical ethics teaching. Yet, to capture the power of the web, bioethics and clinical ethics educational initiatives can more fully embrace non-linear design principles to support reflective ethical development and practice in professional health care settings. In this paper, I describe the process by which an international, interdisciplinary team convened in Singapore to use a web-based framework to think about content, design, pedagogy and the needs and expectations of health care professionals, in order to develop and produce an innovative, open-access web-based clinical ethics casebook. I conclude with a number of key lessons distilled from our experiences that could be of value for other efforts that seek to support a wide range of professional development activities in bioethics and clinical ethics education across different practice and geographical settings.
2. Clinical Ethics Support Services in Switzerland

PD Dr Rouven Porz, lic. theol., dipl. biol. Sibylle Ackermann; lic. iur. Michelle Salathe

Goal: The aim of our presentation is to provide an overview of the growing structures of ethics support services in Switzerland, and to put this growth in a critical and scientific perspective from the viewpoint of the SAMS.

Background: The Swiss Academy of Medical Sciences (SAMS) was founded in 1943 by the five Swiss medical faculties, the two veterinary medical faculties and the Swiss Medical Association (Foederatio Medicorum Helvetica – FMH). The current mission of this independent foundation is (among others): clarification of ethical questions in connection with medical developments and their effects on society and comprehensive reflection on the future of medicine. Further, from an international perspective, it is important to know that ethics support services are not mandatory in Switzerland.

Methods: A quantitative survey was sent to all Swiss healthcare institutions (except outpatient care institutions) in summer 2014. The question items relate to status, structure and methods of the clinical ethics support services in the respective institution. After similar surveys were conducted in 2002 and 2008, this is the third survey of this kind. The structure of the survey has been further developed - based on the results of 2002 and 2008.

Results and Discussion:
The analysis of the returned surveys (response rate approximately 75%) is currently taking place (November 2014). We expect from the results a better substantive overview of the procedures, methods and attitudes in the respective institutions in terms of their clinical ethics support services as well as the institutional and content-related challenges with which they are confronted. We also expect an overview of the variety of structures that have evolved in the field of clinical ethics in Switzerland. We discuss these results with respect to our developed national "recommendations in the field of clinical ethics" (published in 2012, by the SAMS).

3. Telemedical Ethics Consultation: Improving quality and justice in health care

Ralf J. Jox, MD, PhD

After decades of pioneering, implementing and expanding Clinical Ethics Consultation (CEC), the focus has recently moved towards quality improvement. Studies in many countries have found that the quality of CEC services, the standards of training programs and the competence of professionals vary considerably. Moreover, there is regional and institutional variance: while most metropolitan regions and acute care hospitals can rely on ethics support structures, many rural regions, long-term care facilities, and ambulatory health care services have an unmet need for CEC.

While the implementation of high-quality CEC services across all regions and health care institutions would be optimal, this is unlikely to happen soon due to financial, logistical and personal restrictions. In analogy to comparable problems of health care delivery I recommend using information and communication technology (ICT) to overcome these barriers ("telemedical ethics consultation").

Telemedicine is defined by the World Health Organization as the use of ICT to improve patient outcomes by increasing access to care and medical information. This includes access to ethics consultation that facilitates responsible treatment decisions. Telemedical consultation has proven effective in improving treatment outcome in stroke and many other situations.

Currently, ethics consultants do telephone consultations, but rarely use the full range of telemedicine options. Anecdotal reports, however, have suggested an additional benefit of exactly this. Telemedical CEC is conceivable in all three domains of CEC: (1) Ethics committees could improve the guideline development by inviting distant experts to join their sessions audiovisually; (2) Educational activities could benefit from e-Learning instruments; (3) The greatest benefit can be expected for case consultation: critically ill or highly contagious patients may be better integrated into case discussions, patient relatives living far away could participate in the discussions, general practitioners could be involved in a time-saving manner, and the moderators could benefit from live peer review by experts.

Theoretically, the concept makes sense. We now need pilot projects to evaluate the feasibility, acceptability, and effects of telemedical CEC.

Daniel Davis, PhD

More so than ever before, hospitalized patients tend to be very sick individuals with complex medical, psychosocial, and spiritual needs as well as needs that arise from the challenges of making treatment decisions and planning for transitions, back home or to a rehabilitation or skilled nursing facility. The focus of this presentation is a collaborative initiative that seeks to optimize the professional response to these complex needs by four (usually) hospital-based services—palliative care, spiritual care, care management, and clinical ethics consultation. The hypothesis driving this initiative is that a more intentionally collaborative approach to the triage of these complex needs by these services will yield care that is more patient- and family-centered and more responsive to both the totality and complexity of these needs.

This approach is under design and development at the Geisinger Health System in Danville, PA. The first step in its development is an educational program for individuals within each service—a program that clearly delineates the roles and functions of individuals within each service and highlights the types of patient problems and needs that may be beyond the scope of one service and yet fully within the scope of another. This program thus seeks to equip individuals within each service with a knowledge of the problems and challenges that might be appropriately addressed by individuals in another service. For example, in the course of tending to the spiritual needs of patients, chaplains frequently encounter other issues or problems that are appropriately managed, for example, by clinicians in the palliative care service or that might be an appropriate focus for either informal ethics advice or formal ethics consultation. Based on this first step, the second step is to train individuals within each service on the “why,” “how”, and “when” of appropriate triage of an encountered or identified problem to another service. The goal of this paper presentation is to present and gain participant feedback on the potential benefits of, as well as the real or potential barriers to the ultimate effectiveness of this collaborative initiative.

G. End of Life

New York Academy of Medicine, 20 A&B

Moderator: Michael Nair-Collins

1. End-of-Life Discussions and Burdens for Families of Patients with Terminal Conditions

Dragana Ignjatovic Ristic, MD, PhD; Zlatan Metiljevic, MD; Tomislav Stojiljkovic, MD; David M. Steinhorn, MD

We present a case demonstrating divergent attitudes to end-of-life (EOL) care in Serbia today compared with approaches in Western countries. It highlights an urgent area for the development of bioethics in Serbia.

Background: An 8- yo previously healthy Serbian girl developed a pontine glioma. Her family actively advocated for her to receive maximal therapies including a course of Avastin following conventional palliative radiation and pharmacologic therapy. Her family sought advice regarding treatment from experts in the USA. Because of the expected fatal nature of the tumor, the family was discouraged from traveling to other countries for attempts at therapy. An American pediatric palliative care expert, who was lecturing in Serbia, was asked to evaluate the girl in the hospital regarding other approaches to EOL symptom management. Evaluation demonstrated a markedly Cushingoid pre-adolescent girl with impaired expressive ability and some evidence of awareness to her surroundings. At the request of the family, the case management was discussed with the mother, the ICU physician, and a Serbian ethicist. The discussion included options for symptom management, expectations for the clinical trajectory, and plans for care when airway control was lost due to tumor progression. At this point, it became clear that Serbian medical standards mandated intubation and mechanical ventilation in spite of the medical acknowledgement that death would occur nonetheless. While the family recognized that artificially supporting her life would not benefit her, they were bound by the Serbian medical standards. The American consultant suggested that it would create additional burden, discomfort, and suffering to provide artificial life support and encouraged the medical team to allow death to occur without intubation, providing suitable medications for comfort.

Outcome: The child was intubated and died in the adult ICU (where parent visitation hours are severely restricted) receiving mechanical ventilation.

Conclusion: Using this case as a backdrop, we will discuss contemporary Serbian bioethical considerations in EOL decision-making, highlight their contradictions to current Western bioethical standards, and suggest areas of
importance for the inclusion of Western bioethical principles in Serbia. The role of bioethical consultation in Serbia will be discussed and contrasted to Western standards.

2. Chronic, Deteriorating with No Effective Treatment: Palliative care and mental illness

Eleanor Milligan, PhD, Grad Dip Ed, BA(Hons1) BSc; Jenny Jones, PhD, BA(Hons 1); Harry McConnell, MD, FRCPC; Ben Sankey

Like physical health disorders, mental health disorders can be chronic and life limiting illnesses. In many cases, mental illness can be resistant to treatment to the point where ongoing intervention would be futile. Futility, chronicity and deterioration that is likely to end in death are the key features of referral to palliative care in other areas of health care. Yet patients living with a life-limiting and chronic mental health condition are rarely recognized as being in a palliative phase of care.

In this presentation we will discuss the challenges experienced in caring for Jane**, a young woman in her early twenties living with borderline personality disorder and a history of persistent and extreme self-harm. Over the past 8 years Jane has damaged her abdomen to the point where multiple surgeons agree that further surgery would not be in Jane's best interests and may in fact cause further harm. We will lead discussion on the consequences of ongoing futile medical intervention, and consider the alternative pathways available if a palliative approach was taken. For this small group of patients we pose the questions: 1. Does the failure to recognise the severity and inevitability of death for such patients deny them access to more appropriate palliative care at end of life? 2. Are certain illness trajectories deemed more suitable for transition to palliative care? 3. Is it possible that, in acknowledging certain instances of mental illness as life limiting and ultimately untreatable, patient dignity may be enhanced? 4. By enabling access to more appropriate care may the moral burden of enforced futile interventions on staff be reduced?

* Presenting Authors

** A pseudonym

3. The Clinical Ethicist as a Facilitator in the End-of-Life Decision-Making Scheme

Maya Peled-Raz, LLB, MPH, PhD

In 2006 the Israeli Dying Patient Act came into effect. According to this act, physicians are obligated to identify patients, who may expect a statistically prognosis of six months (despite receiving the best care available), and once such a patient has been identified – to proceed according to a set scheme – designed to enable and promote the dying patient's end-of-life decision making.

Empirical data shows, however, that despite the act's eight years standing, Israeli medical professionals are still hesitant (at best) and reluctant (at worst) in facilitating such a decision-making process amongst their patients.

In April 2013, a unique process was initiated by Bnei-Zion Medical Center's ethical counseling service, with the support of the center's management, seeking to evaluate the different barriers hindering the implementation of the law's end-of-life decision making scheme, and to outline an ethical approach to the management to end of life decision making – feasibly applicable at Bnei-Zion medical center.

Due to the complexity of the issue, and with the realization that the thinking process itself may as well be viewed as a starting point for the implementation process, all of the following partners were invited to take an active part in the process: heads of all the relevant wards, representatives of the hospital's management, nursing management, social work management, representatives from the medical records department and experts in the field of gerontology and psychiatry.

In multiple 3 hour sessions, moderated and facilitated by the center's clinical ethicist, the following issues were explored, leading to practical resolutions:

3) Identification of emotional and practical obstacles to the implementation of the legal outline in the medical center, and in the different wards.
4) Identification of correlating arrangements, which may better work in the different wards, bypassing different obstacles.
5) Structuring a scheme for the support of the dying patient’s decision-making process, tailored to different wards’ characteristics and capabilities—while recognizing and accepting this unique scheme’s divergence from the wording of the law.
6) Identification and creation of effective tools for the implementation and facilitation of the new tailored scheme.

4. Consultations to Assess the Dutch Euthanasia Law before Ending Life

Gerrit K. Kimsma, MD, MPH

The focus of my presentation shall be at a kind of bedside consultation that is unfamiliar outside of countries where physician-assisted dying (PAD) is not practiced, since it is illegal.

One of the legal conditions for physicians to proceed with PAD is the duty to ask for a collegial consultation at the bedside of a patient who has requested help in dying. The theory, the format of this type of consultation, its institutionalization into a professional organisation and its effect in and on the practice has been subject to research and shows interesting aspects. Especially with respect to shifts in acceptable PAD.

This collegial consultation has become more complex with respect to the nature of the cases and the consultation responses since the introduction of a legal Life Ending Clinic in the medical field, an institution consisting of ambulatory teams of physicians and nurses, outside of a doctor-patient treatment relationship. I shall focus on these increased complexities and give examples.

H. Ethics Education

Annenberg 10-70 (Levy Library enter from the 11th floor)

Moderator: Naomi Dreisinger

1. Making Expert Clinical Ethics Reasoning Visible: An approach to teaching clinical ethics

Clare Delany, PhD

Like expert practitioners in healthcare professions, an ‘expert’ clinical ethicist’s reasoning and critical thinking are often tacit and invisible to others. Explicit clinical ethics knowledge domains include moral philosophy and biomedical ethical principles. More tacit processes of ethical reasoning include discerning a moral issue within a clinical situation; exercising moral judgment in a specific clinical scenario; influencing others in moral decision making and developing moral authority or respect from others about their views and advice.¹ ²

In clinical education settings, research has focused on specifying key differences in the clinical reasoning processes employed by experts and novices.³ Making the thinking processes of expert practitioners more visible has informed clinical reasoning teaching strategies and the development of pedagogies for teaching clinical reasoning.⁴

This same empirical research is lacking in the domain of clinical ethics expertise.¹ Clinical ethicists’ expertise in posing questions, seeking information, mediating and summarizing ethical options has not been empirically examined for the purposes of ethics education.

In this presentation, the ethical reasoning of clinical ethics experts from a paediatric clinical setting will be examined, via a process of ‘making their thinking visible.’⁵ Their responses to a series of questions about their ethical reasoning and critical thinking will be presented. Analysis of these examples of the thinking behind ethicists’ ‘visible communication’ will be used to inform a pedagogic framework for teaching clinical ethics.

¹ Archard D. 2011. Why moral philosophers are not and should not be moral experts. Bioethics, 25:(3), 119-127
⁴ Delany C. and Golding, C. 2014. Teaching clinical reasoning by making thinking visible: an action research project with
allied health clinical educators. BMC Medical Education, 14:(1), 20.


2. Improving Student Competency in Clinical Moral Reasoning

Paul Cummins, PhD; Katherine Mendis

Ethics faculty at the Icahn School of Medicine at Mount Sinai (ISMMS) recently implemented two interventions designed to reinforce our ethics curriculum for medical students. Previous research had validated our institution’s model for assessing third year medical students’ competency in medical ethics, and our general curricular approach. Confident in our assessment model, we sought to improve student performance.

We designed and implemented a written ethics project with faculty feedback, as well as a standardized glossary of bioethical terms. To measure the impact of the written ethics project we compared students’ scores on their comprehensive ethics assessment in 2011, prior to the curricular additions, to the 2013 scores of students who only received the written ethics assignment supplement. To measure the impact of the glossary, we distributed it to half of the students sitting for the ethics assessment in 2013, and compared their scores with those of their classmates who had sat for the exam previously, without receiving the glossary. We conducted ANOVA and post-hoc analyses to compare mean scores on questions and aggregate scores. Chi-square tests were used to compare the proportion of students scoring at each assessment level.

The 2013 students who only received the written ethics project scored 12.5% higher than the 2011 students, and they displayed significant improvement in justifying a resolution of a clinical ethical dilemma. The 2013 students who received the glossary were significantly better at recognizing which principles and concepts of biomedical ethics were relevant to a clinical case and explaining how they created a conflict. Therefore we recommend written ethics projects and distribution of glossaries as effective ways to enhance medical student competency in clinical moral reasoning.

3. Experience of the Italian Master in Clinical Ethics Consultation

Renzo Pegoraro, MD STL

This work aims to present an assessment of the strengths and weaknesses of the Master in Clinical Ethics Consultation whose two editions were realized in 2012-2015, organized in collaboration between Catholic University in Rome, University of Varese, University of Napoli, Fondazione Lanza, ULSS 7 of Veneto Region.

The Master intends to prepare for ethics consultation, using the individual consultant model or performing consultation as part of an Ethics Committee.

The goal of this 2 years program of education and training in healthcare ethics consultation is to offer knowledge and practical skills to manage ethics consultation in hospitals and other healthcare facilities, for moral doubts or conflicts at the bedside, for organizational and HTA issues, to collaborate in preparing ethical guidelines. The course program is structured according to the standards of the American Society for Bioethics and Humanities (ASBH) contained in the report “Core Competences for Health Care Ethics Consultation” an organized in:

- Area of core knowledge (moral reasoning, ethical theory, common bioethical issues and concepts);
- Area of ethical assessment and analysis skills;
- Area of process, evaluative and interpersonal skills (vocational).

This Master is addressed to those who have a Masters Degree, or Bachelor’s Degree, in the area of healthcare, psychology, law, philosophy and theology, and the science of education.

The Programme is scheduled in 6 intensive weeks and 4 week-ends distributed in the places of the Institutions partners.

The first two editions of the Master were attended by 30 people: 16 doctors, 7 philosophers, 2 lawyers, 3 nurses, 1 biologist, 1 pharmacist coming from various parts of Italy. Appreciated were the quality of the lessons, the opportunity to learn different methodologies of ethics analyzes and different organizational experiences of consulting. Critical points: the different backgrounds of the participants, the need for greater interaction between the participants, the practical training experiences at the bedside to participate in counseling.
4. Utilizing a Clinical Simulation Lab to Train Ethics Consultants

*Carolyn Santora, MS, RN NEA-BC, CSHA, CPHQ; Carla Keirns, MD, PhD, MSc, FACP; Kelly McGovern, MA; Colby Rowe, MS, NRP*

**Background:** The Institutional Ethics Committee (IEC) at Stony Brook University Hospital has been in existence since 1989. As with many traditional ethics committees it has a tripartite mission: consult service, policy review and education. Recently the committee substantially increased our membership. We sought to develop effective training for our new members, and to ensure continued knowledge and skills in our senior membership. Adult learning theory supports training adult learners using practical methods directly relevant to their everyday work, and quality improvement focuses on observation, application, and feedback to improve performance. One of our new members is the director of our medical school's Clinical Simulation Center. We therefore sought to use the simulation center for training, evaluation, and quality improvement in the critical skills areas of ethics consultation.

**Process:** A planning committee of interested ethics committee members was formed. The members represented expertise in the areas of ethics education, ethics consultation, and education through simulation. Ethics scenarios were chosen that represent common ethical dilemmas that consultants face. Scripts were written with checklists for the standardized patients and family members. Standardized patients (SP's), actors commonly utilized for clinical simulation education, were hired and trained in three different ethical scenarios.

**Outcome:** On November 11, 2014 Twenty IEC members rotated in three teams through each of the scenarios, actively interacted with the actors, and prepared mock consultation notes. Each scenario interaction was followed by a team session to discuss the case and create the consult note. Three expert proctors watched the interactions and team sessions via video and audio links. All were recorded for later review and feedback. A debriefing followed which included both the SP’s and the ethics committee participants. The expert observers led the debriefing session.

**Conclusion:** The simulation exercise provided an excellent learning milieu and was extremely well received by all participants.

The unique learning process was a wonderful example of collaboration between hospital, practice, and School of Medicine resources resulting in a dynamic and effective learning process. Data will be presented from the course evaluation survey.

I. Ethics Consultation

**Moderator:** Christian Hick

1. Reasons for Requesting Ethics Consultation: Learning from requestors’ retrospective reports

*Stuart G. Finder, PhD; Virginia L. Bartlett, PhD*

Deeply enmeshed with the question of how best to evaluate ethics consultation is how those with whom ethics consultants regularly clinically interact understand what ethics consultation is and does. Such questions underlie much work on quality improvement, outcomes assessments, and other efforts pertinent to capturing ethics consultants’ contributions to patient care. This paper adds to that discussion by exploring implications from data collected as part of follow-up surveys of nurses, physicians, social workers, and other healthcare team members who interacted with ethics consultants in 218 clinical ethics consultations during two 6-month periods.

Data came from two sources. The first was a follow-up instrument which included (a) multiple choice questions outlining kinds of activities in which ethics consultants engaged and their possible helpfulness, (b) fill-in-the-blank questions asking why consultation was requested and what was most important about that involvement, and (c) Likert scale assessment of effectiveness. The second was the “Case Opening” form used by ethics consultants, which included verbatim reasons for request completed at the time of requests.

Data analysis highlighted multiple challenges for evaluating, and practicing, ethics consultation. To illustrate, this paper focuses on data from 71 healthcare providers who requested ethics consultation. Comparing (a) reasons for requesting ethics consultation transcribed at the time of request (on Case Opening forms), (b) requestors’ retrospective statements about why ethics consultation was requested (from their follow-up questionnaires), and
Specifically, we maintain our data demonstrates how retrospective surveys may often, if not always, be confounded by significant memory issues (among others matters), thereby raising serious question of the legitimacy and validity of relying upon the recollections of others to best represent how ethics consultation contributes to actual patient care. Self-reports by ethics consultants are, however, similarly suspect. We suggest the real culprit is that moral issues prompting ethics consultation continue to unfold over time. We thus end by briefly addressing the implications of the above for articulating a practical sense of responsibility for clinical ethics consultants.

2. Decision-Making for the Unbefriended Patient: A model approach

Joan Henriksen Hellyer, RN, PhD; Kathy Meyerle, BS Pharm, JD; Brent Moos, LICSW

Patients who lack both decisional capacity and appropriate surrogates are some of healthcare’s most vulnerable. Grounded in the narrative of a challenging case, this presentation proposes a model approach for befriending patients that relies on a subjective patient-centered best interest standard. This approach is being utilized in one major academic medical center and the presentation will share the challenges and learnings from this experience.

In general, the approach involves a process facilitated by the ethics consult service. When a patient appears to be unbefriended, the ethics consult service collaborates with social services to perform a comprehensive search for an appropriate surrogate. If no willing or available surrogate is found, the standard step is to appeal to adult protective services at the county level. If the county refuses to provide a guardian, the ethics consult service convenes a small panel of people who are not directly part of the care team. This “befriending team” includes a physician, a member of the ethics committee, and a non-clinical person (perhaps a person who shares a common cultural heritage.) The befriending team interacts with the clinical team as a surrogate would, participating in care conferences, deliberating about goals of care, and consenting to or refusing interventions.

The role of the ethics consult service is not to determine the ethically “correct” path, but to shepherd the process. The ethics consult service works with the clinical team to identify any information about the patient regarding values and preferences with the goal of knowing what creates meaning and purpose in the patient’s life, as well as what constitutes an acceptable quality of life. The service then shares the information with the befriending team and coordinates meetings and deliberations.

Ideally, the befriending process would never be needed. Making decisions for patients who cannot is not what healthcare institutions are entrusted by society to do. However, instead of abandoning individual providers to shoulder the burden of such decision-making, it is more appropriate to recognize the necessity when it arises, and have a standard and transparent process in place. A befriending team allows for thoughtful, consistent deliberation in a proactive manner that can honor the patient and keep his interests central.

3. Physician Attitudes toward Unsolicited Clinical Ethics Consultation for Unrepresented Patients

Carrie S. Zoubul, JD, MA; Barrie J. Huberman, PhD

Many hospitalized patients require surrogate decision-making to direct their medical care, either because they are too acutely ill or chronically impaired to participate in decisions. However, some patients do not have anyone available to make decisions for them. This group of patients is commonly referred to as “unrepresented.” Unrepresented patients are inherently vulnerable, and often at risk in other ways as well—for example, due to homelessness, psychiatric illness, substance abuse, or social isolation. While the number of unrepresented patients in hospitals is not entirely clear, it is generally understood to be significant.

Common medical decision-making mechanisms for unrepresented patients include legally authorized choices made by treating physicians and reliance on court-appointed guardians. The clinical ethics literature describes significant shortcomings inherent in each approach. In our experience as ethicists at a major urban teaching hospital, clinical ethics consultation (CEC) is often requested for process and decision support in the care of unrepresented patients. However, the respondent model generally results in inconsistent involvement and/or delayed ethics input when the consult comes late in an admission. Our experience suggests the need for a process driven, ethically sound approach to decision-making for the unrepresented, spanning routine medical care and treatment, to end-of-life decisions. We anticipate that proactive, triggered (unsolicited) CEC will improve the quality of medical decision-
making for the unrepresented as well as decrease moral burden among clinicians associated with high stakes decision-making where patient preferences and values are unknown.

Before we champion the notion of implementing a triggered CEC in these cases, we believe it is essential to assess the point of view of the treating physicians as important partner stakeholders. As such, we aim to evaluate physician opinion by means of survey, and will include both attending physicians and house staff in order to determine their points of view regarding regular ethics involvement with unrepresented patients. The results of this survey study will be reported and discussed with an eye toward addressing barriers and magnifying strengths in order to inform best practices in clinical ethics consultation.

4. Moral Distress in Clinical Ethics Consulting

Jessica P. Miller, PhD

Moral distress is a psychological disequilibrium that occurs when a health care professional is not able to provide the care that s/he believes is best for a patient. Coined in 1984 to describe institutional barriers to ethical action by nurses, the causes of moral distress have been broadened to include both internal and external constraints. External constraints include lack of administrative support, policies that conflict with patient care, and inadequate staffing. Internal constraints include self-doubt and perceived powerlessness. The nursing literature is replete with data which indicates that moral distress is a significant cause of nurse burnout, and can cause physical, emotional, and existential problems with negative behavioral and institutional effects. Today moral distress is considered a significant phenomenon in a range of health care occupations.

Ethics consultation is frequently identified as a source of assistance for clinicians facing moral distress. Ethics consultants can help clinicians identify moral distress, understand its source, and suggest strategies for addressing it. An ethics consultation with a treating team can help sensitize clinicians to the distress experienced by their colleagues, promote a shared sense of moral responsibility, and restore equilibrium.

Clinical ethicists are often involved in the most challenging and intractable patient care situations. They can frequently be involved in cases characterized by significant team division and/or breakdowns in communication and trust between clinicians and patients and patients’ families. Moreover, clinical ethicists are often working alone or in small departments. Often consultation services are understaffed or underprepared for the work they are asked to do. They can be perceived as outsiders by some members of the clinical team, especially if they lack a clinical background, and sometimes do not garner the higher level administrative support that would make them more effective in their roles. For all of these reasons clinical ethicists are at risk for moral distress.

This presentation explores the ways in which the clinical ethics consulting can generate moral distress. It includes examples from the presenter’s own ethics consulting experience. It lists reasons why moral distress among clinical ethicists has been overlooked by researchers.
A. Workshop - Designing Simulation-Based Clinical Ethics Education Using Mannequin, Web-Based, and Standardized Patient Modalities

Moderator: Steven Birnbaum

Marianne L. Burda, MD, PhD, MA; Kathryn E. Wilt, PhD, RN

Simulation is a highly effective method for teaching health care skills, such as physical exam, procedural skills, and communication skills. Simulation is utilized in the education of many health care students, residents, physicians, and health care staff to learn new skills and processes and improve existing skills. Simulation provides a safe environment in which participants can make and learn from mistakes without harming patients. Simulation education encompasses many different modalities, including standardized patients, low and high technology mannequins, web-based virtual patients and other computer-based simulations, and simple and complex task trainers. Simulation is one method of teaching skills in clinical ethics that is primarily used with medical students, but less frequently utilized in the clinical ethics education of other health care personnel. The main modality of simulation used for teaching ethics is standardized patient-based, providing learners an opportunity to practice navigating difficult ethical issues with patients, surrogates, family members, and other health care professionals. The use of standardized patients to teach ethics has grown and is now utilized for the ethics education of other health care students and personnel, including teaching ethics case consultation skills and professionalism. But as this session will illustrate, other simulation modalities are also very effective to teach clinical ethics, professionalism, and clinical ethics case consultation.

This session will focus on how to incorporate all modalities of simulation into ethics, professionalism, and ethics case consultation education, from development to implementation of the simulation session. The panel presentation will start with a comprehensive overview of the various simulation modalities. The panelists will next show how to choose the appropriate simulation modality for a particular group of learners and ethics education topic. The panelists will also discuss the different components of a simulation scenario and go through the steps involved in developing and implementing the aspects of a successful ethics simulation session from conception to completion. The panelists will illustrate the above process by drawing on clinical ethics simulation education sessions they successfully conducted with various health care personnel, for example, a mannequin-based disaster evacuation scenario, a web-based virtual patient end-of-life planning scenario, and standardized patient-based decision-making scenarios.

B. Panel - Facing the Clinical Challenges of Young Adult Cases through the Lens of Pediatric Palliative Care

Moderator: Hala Al Alem

Ali Hesch, LCSW; Joanne Hojsak, MD; Kathy Hoffstadter-Thal, CPNP, MSCR

The Mount Sinai Kravis Children’s Hospital has a dedicated Pediatric Palliative Care Program that offers interdisciplinary care to improve the quality of life for children who face serious, chronic, and life-threatening conditions. The team focuses on comfort and relief of symptoms while addressing the physical, psychosocial, and spiritual needs of the child and family. This session will discuss the multi-faceted role of pediatric palliative care and highlight challenges faced when working with young adult patients aged 19-21 and their families. Specifically, our panel will address the ethical issues we faced with each patient, similarities and differences amongst the cases, and how these dilemmas were resolved or not.

C. Panel - Worse than Futile: Medically Non-beneficial Treatment in the Setting of Complicated Grief

Moderator: Jacqueline Chin

Annette Mendola, PhD; Vicki Cannington, MSN, APRN; Lynnette Osterlund, MD; Caroline Vogel, MS, MDiv
In cases of medical futility, treatment often persists at the request of the family. In many situations, it is justifiable to continue such treatment for a short time to allow them to come to terms with their impending loss. Denial is a normal part of grieving, and allowing families some time to absorb bad news is only fair, gracious, and kind. However, prolonged nonbeneficial treatment can result in needless suffering for the patient, moral distress for staff, and poor allocation of health care resources. Additionally, continued nonbeneficial treatment becomes counter-productive for the very families for which it is intended to help by causing protracted denial, complicated grief, and family tensions. Allowing nonbeneficial treatment of a patient, therefore, requires genuine and careful attention to the family’s grief rather than being a default setting for the path of least resistance.

Treatments that cannot benefit the patient and are likely to further complicate grief in families should not be offered. If a requested treatment will not benefit the patient, the physician should investigate whether providing some such treatment is likely to ease the grieving process, or, alternatively, to exacerbate it. Other members of the health care team — nursing, social work, ethics, pastoral care, etc. — can be called on to help. Such situations call for carefully crafted interdisciplinary care to address the multidimensional needs of the patient and members of the family. Offering treatment that cannot achieve medically attainable goals is not only an abnegation of responsibility to offer only effective forms of care, but also an abnegation of the responsibility to address the possibility of complicated grief. Loss is a spiritual condition to be borne, not a medical problem to be solved.

D. Panel - Striving for Excellence in Ethics: Getting Serious about Ethics Quality Standards in Catholic Healthcare

Annenberg 10-70 (Levy Library enter from 11th floor)

Moderator: Lauren S. Flicker
Mark Repenshek, PhD; Ron Hamel, PhD, John Paul Slosar, PhD

This session examines the use of The Catholic Health Association’s Striving for Excellence in Ethics resource and assessment tool designed to assist Catholic healthcare organizations to evaluate the breadth and quality of their ethics services, identify potential areas of improvement and measure progress.

Since Summer 2011, several health systems and facilities have utilized the resource, providing an opportunity to share real-world experiences and insights with ethics committees that are committed to achieving excellence in their programs. The panel will include three perspectives related to the introduction of the Striving for Excellence in Ethics resource to help create a more standardized and measurable approach for healthcare ethics programs. In this way, such measurement can help determine process improvement in clinical ethics consultation. Professional dialogue on these three approaches may begin to move the conversation to what may be viewed as auspicious for continuous quality improvement in clinical ethics consultation.

Context/Problem:

While there is growing evidence of relative agreement on the importance of practice standards for healthcare ethics programs in general and clinical ethics consultation in particular, there is also evidence of a wide degree of variance as to what constitutes specific measures of quality and standardization of practice.

Session Overview:

Association Focus:

1. The impetus for this work centered on a concern for the quality of ethics consultation and healthcare ethics committees in general across Catholic healthcare. Based off of work already developed both by ASBH and the VA, an advisory group was developed within Catholic healthcare for the purpose of creating a document examining the breadth of ethics-related services. This portion of the session will provide a descriptive of the resource’s birth as well as lessons-learned in its implementation from the Association to the Catholic healthcare institutions.

System Focus:

2. The second point of view, that of a system office for a large integrated healthcare delivery system, is concerned with measuring how local ethics mechanisms at each hospital align with shared expectations, practices, and processes nationally. Using the Catholic Health Association’s Striving for Excellence in Ethics
for healthcare ethics programs, an emphasis is placed on using quality improvement methodology to identify the impact of ethics mechanisms on clinical and organizational systems.

Hospital Focus:

3. The third point of view, which is that of a local system with an academic penetration in one metropolitan region in the Midwest, is concerned with measuring processes and outcomes related to clinical ethics consultation. Using such measures, this organization is motivated to identify and track the ways in which clinical ethics practice and process can be the catalyst for positive organizational change. Using a specific example, this perspective will discuss how our ethics committee is seamlessly integrated with the medical staff peer review structure to address systemic quality improvements. Through the integration of common cause analysis, ethics has elevated the peer review process beyond morbidity and mortality, shifting care from what can be done to what ought be done. This portion will also address our outcomes metrics in reduced readmission rates and cost.

E. Panel - Systemizing and Improving Ethics Consultation Services Within Recently-Formed Hospital Systems

Moderator: Harris Nagler

Martin L Smith, STD; Margot M. Eves, JD, MA; Cristie M. Cole, JD

In the United States, mergers and acquisitions of hospitals and healthcare systems have become commonplace. These mergers create a cascade of challenges and opportunities that impact institutional cultures; leadership and administrative structures; organizational policies, procedures, and protocols; and clinical practices of physicians, nurses, and allied health professionals.

During the past 15 years, our long-existing (90+ years), tertiary academic healthcare center and hospital (1200 beds) acquired eight community hospitals (one with a religious affiliation) within a 35 mile radius of the academic center. These acquisitions created a complex organizational environment of multiple hospital cultures, leadership changes, consolidation of policies and procedures, and evolving clinical practices. Within this context, we were charged with utilizing, enhancing, and systematizing existing clinical ethics programs, including the hospitals’ ethics consultation services.

This panel presentation will begin with a description of the challenges and opportunities that the hospital acquisitions created for the clinical ethics programs at the academic center and the community hospitals. We will then describe the multiple resources, tools, and strategies we have developed and operationalized to systematize the ethics consultation services we oversee and to implement quality improvement mechanisms. We will also explain how we have respected and integrated variations in hospital resources and cultures.

More specifically, this panel presentation will explain, 1) the over-arching staffing model we adopted, i.e., having trained clinical ethicists train and advise multiple volunteer ethics committees and consult teams; and 2) our successful use of a Clinical Ethics Advisory Committee to create standardized tools for all of our ethics consultation services (e.g., consultation checklist, medical record documentation template).

The session will include time for discussion with and questions from session attendees.

F. Ethics of Bioethics

Moderator: Robert Baker

1. Institutional Responses to Health Care Providers’ Rights of Conscience Claims

David Alfandre, MD; Barbara Chanko, RN, MBA; Cynthia Geppert, MD, MA, PhD, MPH, MSBE, DPS; Kenneth Berkowitz, MD, FCCP

There is a dearth of formal guidance for systematically responding to health care providers requests to decline to participate in a treatment or procedure based on a right of conscience (ROC). Responding to this gap, our office developed ROC guidance for ethics consultants to use in formulating a response to a ROC claim. This guidance was
intended to promote a consistent approach to ROC requests in our large integrated health care system. This paper will review our guidance including the specific steps to take when responding to a ROC claim.

In our approach the decision maker first differentiates a claim based on moral and/or religious grounds from one based on clinical/professional standards. Claims based on clinical and/or professional standards are clinical decisions that should be assessed for validity by clinical subject matter experts, not as ROC claims. For moral and/or religion-based ROC claims, we specifically suggest that the decision maker should not judge the moral validity of the claim as there are no clear standards for how to assess subjective personal beliefs in a generalizable and fair way. Rather, the decision maker should assess if accommodating the claim would result in ethically unacceptable consequences. The assessment uses a consequence-based method to provide transparent, generalizable, and ethically justifiable reasons for decisions about ROC claims. Specifically, the ROC claim should be accommodated unless honoring the claim results in outcomes that unfairly affect the patient’s health, place unwarranted burdens on the patient or organization, or would lead to discrimination or an illegal practice. We will also describe how to address providers who refuse to provide clinical information to facilitate transfer of the patient’s care, and/or decline to provide care for the patient if their ROC claim cannot be accommodated. Finally, we will briefly review other controversies in the ROC literature, including staff complicity in morally objectionable procedures or treatments, and the ethical risks of providers managing ROC claims without the benefit of formal ethics consultation or standard processes.

2. What Types of Requests Are Outside the Scope of Clinical Ethics Consultation?

Armand H. Matheny Antommaria, MD, PhD

One of the initial stages in clinical ethics consultation is screening; consultants must determine whether or not a request is an appropriate basis for a consultation. If it is not, the consultants may refer the requestor to another entity within the organization.

This session will review a number of consultation requests in order to evaluate potential criteria to differentiate appropriate and inappropriate requests.

- A grandmother objected to her grandson’s wait in the emergency department and complained that he waited longer than patients who are members of minority groups. While racism is morally wrong, it appeared that this individual misunderstood triage and was referred to the customer complaint line.
- A citizen complained about a faculty member’s support for rescinding a municipal ban on certain breeds of dogs. The faculty member had lobbied the city council using institutional letterhead contrary to medical center policy and the citizen was referred to the Vice President for Governmental Relations.
- One division director objected that another division director was requiring patients to choose between receiving treatment in one division or the other in conflict with the institution’s commitment to family-centered care. The consultants mediated an agreement between the directors to jointly review cases in which patients were receiving services from both divisions and to develop either a transfer or a coordination plan.

The cases referred cannot be distinguished from those accepted based on whether or not they contain ethical issues; they all have ethical components. For example, the second case involves the issue of academic freedom. They also cannot be distinguished based on whether they involve individual patients or general policies. While the third case was presented as a general issue, the directors could have identified individual cases if it had been important to do so. A potentially relevant distinction is whether another entity within the organization has authority over the issue. In the second case, the consultation service does not have the authority to discipline faculty members and in the third it was not clear who had joint responsibility over both divisions. Consultants need to be able to articulate which issues are outside their scope.

3. Strategies for Hospital Ethics Committees to Address Concerns Surrounding Law

Anya Prince, JD, MPP; Arlene Davis, JD, RN; Jean Cadijan, PhD

Clinicians regularly make statements of law during their medical practice, from declarations regarding privacy rights to discussions of acceptable authorized decision makers. While such attestations can be appropriate, clinician deployment of law raises two potential complications. First, the clinician may cite the law inaccurately. Second, the clinician may have an underlying motive for using the law. Since the law is often seen as the definitive source of proscription or requirement, clinicians can use the law as a tool to either definitively prevent a certain course of action or to bolster their own position. Both these complications raise concerns for ethics consultation members.

Requests for ethics consultation or standard processes.
This paper seeks to help committee members to better understand the potential underlying motivations for the deployment of law in the medical setting. By citing a legal precedent that ostensibly disallows a clinician from taking a certain course of action, the clinician can often effectively stop further conversation about options. While the law may indeed prevent certain actions in some situations, the deployment of law can be used as a tool to prevent even the discussion of options—a result that can greatly inhibit the process of an ethics consult. This paper will explore approaches for both correcting misconceptions of the law and managing situations where deployment of the law is undermining the effective communication of options between the patient, family members, and the medical team. Particular focus will be paid regarding the roles of attorney versus non-attorney members of the ethics team. Specifically, do consult members with a law degree have any additional professional responsibilities to correct inaccuracies of the law or to ensure informed discussion of legal options? Should non-attorney members of the consult team be required to have a base-line understanding of certain common legal rules? The deployment of the law in the clinical setting has implications for both a patient’s medical care and for any ethical concerns that arise during the care. Hospital ethics committees should have strategies for how to effectively address the use of law within medical care.

4. The Limits of Professional Bioethics: How to take comfort in the ethics consultant code of ethics

Abraham P. Schwab, PhD, MA

From the beginning I have been skeptical of the value of a code of ethics within the field of bioethics. This skepticism rested on two understandings of the Code of Ethics, one of which is easily dispatched. First, I believed that the Code of Ethics would be aimed at bioethicists more generally. The Code of Ethics limited its domain to Health Care Ethics Consultants, and so despite my concerns about such a Code, this particular Code sidesteps these concerns. I believed, second, that the Code of Ethics must be understood as part of a movement to professionalize bioethicists (or some subset of bioethicists). This belief arose from Robert Baker’s repeated conflation of ‘having a code of ethics’ with ‘professionalization’. This conflation is echoed in ASBH’s Code of Ethics for Health Care Ethics Consultants. Given this repeated conflation, I’m led to wonder: How would a Code of Ethics be part of the professionalization of Health Care Ethics Consultants?

On traditional conceptions of “profession,” the Code could not be part of a professionalization process because Health Care Ethics Consultants would not qualify as professionals. But, importantly, these traditional notions of a profession should be rejected because they beg the question about what it means to be a profession. By using existing professions to determine the criteria for what counts as profession, they eliminate the possibility of establishing meaningful evaluation of what counts as a profession. More recent conceptions of ‘profession’ (for example, Michael Davis’ conception (2008)) move away from question-begging determinations of profession by shifting from an externally applied criteria of a profession to internally endorsed commitments for a profession. Using these conceptions, the Code of Ethics can serve as part of the professionalization process, but it does so at great cost. Subjective determinations of a profession, while appealing on many levels, turn the category of ‘profession’ into a set so diverse and undefined that it limits the value of what it might mean to be called a ‘profession.’

G. Autonomy

Moderator: Loretta Kopelman

1. Autonomy, Sexuality, and Intellectual Disability

Andria Bianchi, MA

Autonomy is a critical component to living a life that is appropriately self-directed. Furthermore, respect for autonomy grounds many ethical judgments about why people should be allowed to make decisions for themselves. Unfortunately, many philosophical conceptions of autonomy present challenges for people with intellectual disability, such that they may not be viewed as autonomous (Davy, 2014, p. 6). Consequently, they may not be able to practice activities that they desire to pursue, such as sex.

In my paper, I explore the ethical issues of sexual autonomy and intellectual disability. I commence by introducing influential accounts of autonomy and demonstrate how they fail to encompass people with intellectual disability. Next, I discuss philosopher Laura Davy’s approach to autonomy, which accommodates people with intellectual disability.
Although Davy’s approach effectively describes how people with intellectual disability can be autonomous, the complexity of sexual autonomy is not addressed. Upon recognizing this gap in Davy’s approach, I seek to explore the relationship between sexual autonomy and intellectual disability by analyzing one of the most problematic complexities that contributes to its challenge of being addressed. This complexity is in regard to societal perceptions, especially those of healthcare professionals. For example, a 2011 article from *The International Journal of Mental Health Nursing* quotes a nurse in stating:

> When you talk about sexuality, a large number of staff tend to be very uncomfortable with the idea; they believe that our patients should be asexual, they don’t have a right to sexuality, and they feel very uncomfortable that these people should have a sexual life. . . . It is as if people with a mental illness have no right to sexuality” (Quinn, Happell, & Browne, 2011, p. 25).

As demonstrated in this quotation, unsupportive perceptions of sex and intellectual disability are still prevalent in today’s society. This is problematic given that sexuality is generally accepted as a fundamental part of one’s well-being (Quinn & Browne, 2009, p.195). However, if people with intellectual disability should be viewed as sexually autonomous, then how can we influence a change in perception to assist with this required support?

2. Justice and Respect for Autonomy: Jehovah’s Witnesses and organ transplants

*Paul J. Cummins, PhD; Federico Nicoli, MA*

The clinical challenge of organ transplant to Jehovah’s Witness patients who refuse blood transfusion is widely appreciated, but recent studies indicate patient blood management protocols can make transplant surgery comparatively as safe as in patients who accept blood transfusion (Jassar, Ford, et al.-2013, Vaislic, Dalibon, et al.-2012, Konstantinidis, Allen, et al.-2013). There is evidence that patients who refuse blood transfusions face a more complex perioperative, intraoperative, and postoperative course (Jabbour, Gagandeep, et al.-2005a, Jabbour, Gagandeep, et al.-2005b, Magner, Ouellette, et al.-2006). Organ transplant patients, like Jehovah’s Witnesses, who refuse blood transfusion raise a distinct clinical ethical dilemma involving justice: should transplant surgeons list patients for transplant when, for religious reasons, the patient refuses some treatments that optimize transplant success? A Jehovah’s Witness patient and transplant team may disagree about whether it is appropriate to list the patient for transplant, and clinical ethicists will need to respond to such situations. Clinical ethicists will not find much guidance on this issue in the bioethics literature. This issue is not widely researched, and a preliminary search returns only two papers that directly contemplate this issue; both conclude that patients must consent to life-saving transfusions to be organ transplant candidates (Boggi, Vistoli, et al.-2004, Bramstedt-2006). Bramstedt-2006 supports this conclusion by comparing this policy to behavior contracts for alcoholics needing liver transplant. Our paper rejects this rationale and aims to develop guidance for clinical ethicists who encounter this dilemma by examining (1) data on patient outcomes for both transfusion accepters and deniers and (2) Italian and US hospital polices and protocols for organ transplant patients who refuse blood transfusion. In addition, by comparing Italian and US practices, the paper will consider what lessons can be drawn about the place of religious values that conflict with bioethical values in clinical ethics consultation. In conclusion, our paper will challenge the extant guidance on cases in which organ transplant patients refuse blood transfusion for religious reasons, provide guidance rooted in empirical data and a comparison of international policies, and begin to eliminate the gap in the literature.

3. The Perfect Storm: Patient mistrust and physician misuse of autonomy

*Casey Jo Humbyrd, MD; Mary Catherine Beach, MD, MPH*

The principles of respect for autonomy and beneficence conflict when a competent patient makes a decision that is inconsistent with their best interests. In such situations, physicians generally defer to the principle of autonomy or “self-rule,” and support the “bad” decision. Yet, respect for autonomy has become the over-ruling principle of medical ethics to such an extent that it trumps all other considerations, including beneficence. By applying ethical principles in a “stacked deck” manner, physicians misuse autonomy to avoid responsibility. While patients have a right to make a decision against their best interests, the principle of beneficence likewise dictates that physicians have a responsibility to guide the patient in the decision-making process.

We theorize that a physician’s willingness to accept a patient’s decision in conflict to their best interest is inversely proportional to their personal attachment to a patient. With difficult patients, physicians may use autonomy to extricate themselves, allowing the patient to pursue an unwise course. We posit that a physician’s responsibility to involve themselves in a patient’s decision increases when a difficult patient is refusing medically advised treatment.
A physician’s lack of attachment may make them less likely to contest a refusal of treatment, yet the refusal may not truly be autonomous as it could be a response to the failures of the medical system to fully engage and care for a challenging patient.

Instead of seeing one’s role strictly as a presenter of risks and benefits, we believe that physicians have a responsibility to strive for relationships that foster trust such that patients can make autonomous decisions in the first place. When trust is lacking, patients are not able to acquire the complex medical knowledge they need to make good decisions because they lack (in their view) a trustworthy source. Ironically, it is just those patients who are then allowed, without much protest, to make decisions that are not in their best interests. With all patients, and especially ‘difficult’ ones, it is the relationship between patient and physician that creates conditions that allow for autonomous decision-making, and physicians bear some responsibility for making that happen.

4. Temporizing After Spinal Cord Injury: Decision-making at the fringes of autonomy

Joshua S. Crites, PhD; Rebecca Volpe, PhD

This paper will explore what it means to respect a patient’s autonomy after a debilitating traumatic injury, with special attention to the topics of temporizing and the appreciation component of decision-making capacity (DMC). We will ground this discussion in a clinical case: Mr. C is an otherwise healthy 20 year old male who suffered a high spinal cord injury after diving into shallow water. In the days following admission, he and his family indicated a desire to pursue aggressive treatment. As a prognosis of permanent tetraplegia became more definitive, Mr. C and his family determined that Mr. C would not find a life with permanent significant disability worth living. Although Mr. C’s DMC was difficult to evaluate, psychiatry believed that he understood the relevant information and could reason about treatment options in a logical way. Psychiatry was less sure of Mr. C’s ability to appreciate the relevant information, and worried that he had not had sufficient time to consider the full implications of his decisions. The primary care team consulted ethics with the following question: "Is it ethically appropriate to place a moratorium on decision-making (ie, temporize) in order to give Mr. C more time to fully appreciate what withholding/withdrawing life support would mean."

The two primary ethics consultants (JSC and RLV) who responded to this case agree that healthcare providers have an obligation to honor Mr. C’s authentic wishes. However they disagree about whether the expressions by Mr. C and his family represent Mr. C’s authentic wishes. One consultant (RLV) is concerned about the inherent subjectivity of appreciation evaluations and argues that Mr. C is as well positioned as any other hospitalized patient to represent authentically his wishes. Furthermore, she (RLV) is not at all sure how long one must temporize in order to bring about the significant changes in thinking that her colleague (JSC) believes are necessary for Mr. C to demonstrate appreciation.

The second ethics consult (JSC) argues that it is unclear whether any patient in the acute period following traumatic injury can have adequate appreciation of how decisions integrate with current and future values. As a result, DMC is questionable (perhaps even impossible) and healthcare providers should postpone involving Mr. C in major medical decisions until he has had some time to come to terms with what his life might be like in the future.

H. Evaluating Clinical Ethics

Moderator: Lily Frank

1. A Qualitative Study on Clinical Ethics Consultation in Four Romanian Medical Centers

Horatiu Crisan, PhD

As a consequence of the Law Regarding Reform in the Healthcare Field, issued in 2006, ethics councils were eventually constituted and institutionalized in Romanian medical institutions. Since then, a few problems concerning their functioning have already occurred. Among these critical issues, the nomination of their members, the criteria for becoming a member and the nature of the decisions they make are salient. Their allegedly circumstantial character, together with the fact that, often, the reason of their deliberation is not consultative, but rather justificatory for medical interventions which have already been undertaken constitute sufficient motives for the need for their improvement.

As, until now, in Romania, no qualitative study, aiming at evaluating the level and standards which actually guide the consultations provided by the ethical councils from hospitals has been conducted, our paper will present the
results of a qualitative research regarding the functioning of ethical councils from four medical centers in Cluj-Napoca, probably the most representative town in Romania regarding healthcare services and medical education. The qualitative study using interviews has been conducted in the following specialties: infectious diseases, surgery, intensive care and pediatrics.

Within this paper, we will first focus on the perspectives of the management teams of the medical institutions concerning the need and the role of ethics councils in solving the ethical problems which occur in medical practice. Secondly, we will try to critically analyze the way in which members of the councils perceive their role within these ethics services. Using qualitative methods, we have determined types of cases discussed by Romanian ethical councils, the procedures followed in the process of decision making and the arguments used for justifying the decisions.

The main purpose of this paper is to assess an optimal model for clinical ethics consultation in the Romanian medical framework and to offer, based on the views of those involved and taking into account the reasons for their shortcomings, a guideline for improving clinical ethics consultations and services up to a level desired by physicians, patients and families.

2. Achieving Rigor in Clinical Ethics Consultation May Include Following a Checklist

   Lisa M. Rasmussen, PhD

Even those committed to the worth of clinical ethics consultation can find themselves wondering whether a consultation they have conducted was excellent, middling, or worse. So much more, then, will critics of the field want an answer to the same question. This presentation will explore what it means to be rigorous in a clinical ethics consultation.

In the first part of the presentation, I will argue that having high standards for a discrete clinical ethics consultation is not the same as having other standards, such as a code of ethics, or standards for accreditation. For example, although standards of training, as measured by success in an accredited training program, may contribute significantly to one's ability to conduct a rigorous consultation, one is not a proxy for the other.

Second, I will argue that the nature of cases should inform the shape our account of rigor should take. Cases: are highly contextual and granular; are subject to multiple competing considerations (e.g., physical, financial, moral, spiritual, psychological); include a plurality of stakeholders; and involve multiple disciplines and their methods. Consequently, I argue, rigor cannot be achieved by adherence to a single overarching theory or method of clinical ethics consultation.

Instead, I propose that rigor in clinical ethics consultation may look more like adherence to something like the aviation checklist popularized in Atul Gawande's *The Checklist Manifesto*. In Gawande's account, a checklist is a means of ensuring, in complex situations, that what is important is not overlooked. The checklist in aviation is a living document; it is revised whenever a problem manifests that can be addressed by adding an item to the checklist. A checklist in clinical ethics consultation would not be chronological or situational, like other checklists might be. Instead, it could function as a repository of important features of cases that we know have posed challenges in the past, to prompt consultants to consider them in new cases. I conclude by offering a sample checklist and articulating what else might be needed for an account of rigor in clinical ethics consultation.

3. Setting Standards in Bioethics

   Mark Sheehan, PhD

In order to make progress on the idea of standards in bioethics we must first have an account of the nature of the field. But questions about the nature of bioethics tend to revolve around the relationship between philosophy and the social sciences. These questions tend to focus on the potential mismatch between theoretical moral philosophy and the empirical details of practical contexts. They can involve deep methodological differences particularly when it comes to questions of practical moral authority. These methodological differences make the problem of standards more acute.

In the first part of this paper, I present an account of bioethics which does justice to its interdisciplinarity and the tension between theoretical moral philosophy and empirical details. In the second part of the paper, I explore the consequences of this account for the possibility of setting standards in the field in spite of the fact that those
working in it are from very diverse disciplines. I argue that the form that these standards must take will make reference to the relationship between the various disciplines and their relationship to primary questions in bioethics, rather than by drawing directly on standards with in each of those disciplines.

4. The Effectiveness of Ethics Consults: A quality improvement project

Olubukunola M. Tawose, JD, MA

Clinical ethics has most recently been focusing on creating a professional standard and a process of certification for those who provide clinical ethics consultations, but there has not been a focus on the effectiveness of ethics consultation recommendations. For many clinical ethicists, a large portion of their work is focused on providing ethically nuanced clinical recommendations through the consults they provide. The effectiveness of these consults can affect whether an ethics consultation service is viewed as being useful and supportive to the patients, families and the staff of the institution it serves. As Davies and Hudson reported in their 1999 study of physicians views on ethics consultation, some physicians still believe that ethics consultation is not an effective means to solving ethical dilemmas. In some institutions where ethics consultation is performed, this view may still be held by care providers and patients. Improving the effectiveness of ethics consultation may help to change this perception.

At times, effectively conducting consults can be difficult for a variety of reasons and even after a recommendation is provided, there may be other barriers that detrimentally shape the effectiveness of these consults. By developing a framework to evaluate and follow-up on over 300 consults over a 20 month period, we were able to identify some of the barriers that changed the effectiveness of ethics consults. Data also showed an empirical correlation between improving ethics consultation effectiveness and improving outcomes measures such as length of stay and discharge setting.

This presentation will promote dialogue and improve the quality of ethics consultation by encouraging changes to the performance of ethics consultation. In an attempt to foster quality improvement of this aspect of ethics consultation, this presentation will do the following: 1. Introduce a method of follow-up and the evaluation of the effectiveness of ethics consults. 2. Discuss the factors that should be considered when developing a follow-up and evaluation system for consults. 3. Identify the barriers that may arise during follow-up and the assessment of ethics consultation effectiveness. 4. Provide practical considerations for ethics consultation services that aim to ensure a quality standard for an ethics consultation service.

I. Models for Clinical Ethics Consultation

New York Academy of Medicine, 440

Moderator: Nada Gligorov

1. Adapted METAP Methodology for Clinical Ethics Consultation: IVF for a 65 year-old woman

Silviya Aleksandrova-Yankulovska, MD, PhD, MAS; Alkan Emin, MD

Introduction: Assisted reproductive technologies develop fast recently encountering more and more ethical dilemmas. Formal clinical ethics consultation services do not exist in Bulgaria and medical professionals rely on their own when solving ethical dilemmas in their practice. Providing that there is a lack of trained ethicists in the country and clinicians are generally resistant to outside influence in the decision-making process, METAP methodology which offers tools for ethical case analysis by the health professionals at place could be highly beneficial.

Objective: This report aims at presenting the application of adapted METAP methodology for clinical ethics consultation to a case of IVF requested by 65-years old woman.

Methodology: Adapted METAP methodology and accompanying materials were presented to the leader of the team of the reproductive center "Radost"-Varna who had passed courses of bioethics and business ethics thus being appropriately prepared for the application of the methodology. The leader of the team organized ethical case discussions at place. Original self-administered questionnaire was developed to receive feedback from participants in the ethical meetings.

Results and discussion: 65-year old woman after successful IVF, performed in 2010, requested new procedure with donor’s ova. In patient’s view the sibling would provide support to the already born child in case of mother’s death. Ethical case discussion was focused on medical good for the patient, beneficence for the already born child,
and current legislation which forbids transfer of embryos created with donor’s ova in postmenopausal women. Besides the patient and the physician in the discussion were involved the head midwife and two embryologists. The discussion resulted in refusal of second IVF procedure even though the patient was persistent in her wish. Re-assessment was not planned. The meeting was generally assessed as useful although the participants could not judge the usefulness of the adapted information brochure.

**Conclusion:** METAP methodology helped mainly in clarification of legal framework and ethical dimensions of the case. Improved communication in the team was also reported. Further revision of the information brochure is necessary.

2. **Different Models of Ethics Case Consultation: An expert survey and experimental study**

*Ralf J. Jox, MD, PhD; Julia Heiland*

**Background and aims:** A major activity of clinical ethics consultation (CEC) is moderating ethical discussions among health care professionals, patients, family members or surrogates on difficult treatment decisions. Most ethics consultants who moderate these discussions use protocols such as the 4-Boxes Model or the Nijmegen Model. We wanted to know how CEC experts see and use such models and which ones they use. In addition, we aimed to study the effect of heterogeneous models on the process and outcome of case discussions.

**Methods:** We conducted a self-administered questionnaire survey among participants of the International Conference on Clinical Ethics Consultation 2014 in Paris, asking about the use of protocols for case consultations. In addition, we conducted a social experimental study to investigate the effect of models: we asked three experiences ethics consultants to moderate one case discussion each, using the same standardized real case and standardized role actors for each of the three discussions. Two moderators used the same model (principle-oriented ethics consultation) and the third used a different one (Basel Guideline). Discussions were videotaped, transcribed, and evaluated using content analysis.

**Results:** All ethics consultants participating in the survey reported using models for case consultation, mostly the 4-Boxes Model, CASES, the Nijmegen model, and Moral Case Deliberation. Half of them have the models in mind as a structure for moderation, 39% use printed versions during the discussion. Two thirds experience the use of a model as very helpful, primarily for structuring the discussion, ensuring that no relevant factor is missed, and promoting an ethically sound analysis. In the experimental setting, the process and outcome of the discussions varied with each moderator, but even more with the different models. In particular, the differences concerned the core of ethics case consultation, the ethical evaluation of norms and obligations relevant in the case.

**Discussion:** Models for ethics case consultations are widely used and appreciated, but their heterogeneity is problematic because they have divergent effects on the outcome of discussion. We need to establish quality criteria for case discussion models to ensure that treatment decisions for patients are not unfairly biased by varying CEC standards.

3. **Competencies Required for Clinical Ethics Consultation as Coaching**

*Nicholas J. Kockler, PhD, MS; John F. Tuohey, PhD; Kevin M. Dirksen, MDiv, MSc*

A function of a clinical ethics consultation is to guide clinicians in how to think about and through the challenging issues of a case. Standard approaches to clinical ethics consultation in the United States emphasize advisement or conflict mediation. In contrast, our approach has been to focus on seeing the consult as an opportunity for coaching. This coaching serves as a principal teachable moment for what we hold to be the fundamental goal of ethics education for health professionals: to assist the clinician in transforming technical skill and knowledge into caring therapeutic relationships. An additional, complementary function is to guide patients and family members, with respect to their values and context, in thinking through controversial, non-obvious, or problematic decisions. This approach to ethics consultation calls into question whether the core competencies for health care ethics consultation as promulgated by the American Society for Bioethics and Humanities are adequate and whether alternative competencies for ethicists are warranted. Using a case study as our reference, this paper will describe our underlying philosophy of clinical ethics consultation; such a consultation offers the opportunity for coaching that leads to dynamic professional development and enhances the therapeutic alliance in practical wisdom to find moral freedom and integrity.
4. Getting the Most out of Little: Micro moral deliberation on the inter-professional healthcare floor

J.J (Jos) Kole, PhD

Although moral case deliberation (MCD) in multidisciplinary settings is quite common in Dutch healthcare, there is hardly paid any attention to every day clinical interprofessional communication and its ethical impact. It still seems as if clinical ethics focuses one-sidedly on the larger medical ethical issues and dilemmas and that moral deliberation, likewise, concentrates on such cases in clearly arranged group discussions that, in most cases, take at least one to one-and-a-half hour. The claim of this paper is that much is to be won in clinical ethics with more attention paid to day to day interprofessional communication on the working floor. Given that such small scale communication often takes only minutes of time, it may be termed ‘micro moral deliberation’.

This paper therefore investigates how everyday interprofessional moral communication may be stimulated and improved by applying general conversation and interviewing methods to moral communication. Is it possible to train healthcare professionals to give each other critical moral feedback in a constructive way, irrespective of the asymmetrical power relations that are still present in healthcare? Can healthcare professionals of whatever kind improve each other’s moral acts and attitudes by applying motivational interviewing techniques?

The paper explores a new field of research at the crossing of (inter)professional ethics and moral deliberation on the one hand and communication and conversation methods and techniques at the other. It’s ultimate aim is to find new moral educational strategies that can be implemented in clinics and in curricula of diverse healthcare professionals like nurses and M.D.’s.
Thursday, May 21st, 2015

6:30-8:30  Awards Reception  Museum of the City of New York

About ICCEC 2016  Nneka O. Mokwunye

About the Hans Joachim Schwager Award for Clinical Ethics  Stella Reiter-Theil

Awards for Best Poster  Karen Davis

Award for Best Abstract  George Agich

The John Conley Foundation Award to Dr. Mark Siegler
in recognition of his outstanding contributions to the professionalization of clinical ethics consultation and to clinical ethics education  Monika Conley
Parents from Afghanistan living in the US want their daughter who is fourteen to be married in Afghanistan. She has told her mother that she has already had sexual relations and her mother wants her to have a hymenoplasty “or there will be an honor killing.” Their daughter, who was born and raised in the US, does not want to be married, have a hymenoplasty or leave the US. She tells this to her doctor. What should her doctor do to help her?

Globally one in nine girls is forced to marry each year and 14.2 million forced marriages occurred in 2010. It is a growing problem in the US. In addition to forced marriages being a civil rights violation, they are a leading cause of death among 15-19 year old, including from domestic violence and complications relating to pregnancy and child birth. The problem for health care providers and ethics committees is that almost no legal protection exists for such minors in the US, in contrast to the UK. Strategies are discussed to help stop forced marriages.

2. Pregnancy in the OR: A case analysis of conflict of risk

Joan Liaschenko, PhD, RN; Mary Faith Marshall, PhD

Balancing the potential for harm against the potential for good is the mainstay of clinical ethics. Most commonly, the harm and benefit in question refers to a proposed intervention being considered for the patient. It is less common that the harm and benefit reflect a conflict in the distribution of risk between the patient and the clinician. In this paper, the authors present a case in which there is such a conflict between the patient and the clinician in the exposure to risk and the harms that can result. The case involves a young mother who is in the OR about to undergo surgery to donate a kidney to her eight year old daughter. The clinical ethics consultant was called to the OR when the woman was found to be pregnant with gestation estimated at approximately two weeks. Maternal-fetal medicine was consulted and informed the woman that surgery at this stage tends to be “all or nothing,” that is, either the woman miscarries or she does not. If she does not, the fetus is expected to make it to term. There was nothing said about the potential for any adverse effects secondary to the anesthesia. Both the woman and her partner wanted to assume the risk to the pregnancy and for any potential consequences to the fetus and child and more forward with the surgery. The anesthesiologist did not. The authors argue that such a conflict has significant moral relevance. The paper explores the range of risks affecting both the woman and the anesthesiologist and raises several questions: What is the range of risks each faces? What are the harms associated with the risks? On what basis should decisions be made about whose assessment of risk should prevail? What role should position statements by professional organizations play? What role should risk management assume in such a situation? The authors argue that the competent, pregnant woman should be the last arbiter of the meaning of various risks to her life and that her voice should prevail in the moral conversation.

3. Teaching Non-Authoritarian Clinical Ethics: Using a positions-inventory in CEC education

Autumn Fiester, PhD

While there is universal agreement that values-imposition by CECs is serious violation of national consultation standards, there have been no concrete suggestions for either diagnosis or prevention of the problem. The national bioethics organization and various task forces have all issued warnings and cautions about this, but the problem is too insidious to be ameliorated by mere directives. Students training to be CECs need a concrete method for identifying their personal values, locating them within the set of defensible American viewpoints, and defending those opposing positions. To achieve this, I argue that the essential first step in non-authoritarian consultation is learning to identify one’s own personal values and normative commitments against the backdrop of justifiable, but contrasting, beliefs commonly found in American values pluralism. Locating one’s own values among
a set of possible other legitimate beliefs works to dethrone the moral commitments that one might subliminally take to be objective, absolute, or universal. Employing an instrument I term the “Bioethical Positions Inventory,” CEC trainees perform a normative self-diagnostic that brings their implicit value commitments into sharp relief. The second critical step in preventing authoritarian CEC is the subsequent exercise of producing a reasonable, sound defense for each of the opposing positions to the trainee’s own. I argue that this two-step exercise of identifying one’s own values and then defending the antithetical values held by others protects CECs from value-hegemony.

4. Anticipate and Communicate: Using the Bioethics Commission’s clinician and patient primers to facilitate ethical engagement of incidental and secondary findings

Elizabeth Pike, JD, LLM

A 16 year old comes into the hospital after suffering a concussion. An MRI brain scan shows no trauma from the head injury, but reveals a mass in the patient’s brain. The discovery of this unexpected mass—an incidental finding—could lead to a variety of outcomes. If the mass is the early stage of an otherwise undetected brain tumor, the discovery could lead to lifesaving treatment. If the mass is benign, pursuing additional diagnostic tests exposes the patient to unnecessary risks of serious physical harm. Watchful waiting creates anxiety in the patient as well as the clinician, who is generally trained to intervene. What, then, is a clinician expected to do to ethically manage this incidental finding?

In December 2013, the Presidential Commission for the Study of Bioethical Issues (Bioethics Commission) released its report Anticipate and Communicate: Ethical Management of Incidental and Secondary Findings in the Clinical, Research, and Direct-to-Consumer Contexts. The report articulates that clinicians should anticipate and communicate: They should assess the types of findings that can arise from particular tests and the implications of these findings and communicate this information to patients through consultative conversations.

Building on the work done in that report, the Bioethics Commission subsequently released primers for clinicians and patients to help clinicians implement the Bioethics Commission’s recommendations. In this presentation, Bioethics Commission staff lead Elizabeth Pike will review the Bioethics Commission’s recommendations for ethically managing the incidental and secondary findings that arise in the clinic. Pike will also demonstrate how to use the clinician and patient primers and illustrate how these primers can enhance clinical consultation.

The demonstration will: 1) answer frequently asked questions about incidental and secondary findings, when they are likely to arise, and how clinicians should plan for their ethical management; 2) describe arguments in favor of returning—and not returning—such findings; 3) describe how basic ethical principles apply; 4) explain relevant considerations for developing an ethical plan for managing incidental and secondary findings; and 5) demonstrate how clinicians and patients can use the primer’s “list of considerations” to manage the findings that do arise.

B. Panel - The Formation of Clinical Ethics Consultants: The role of the mentor-mentee relationship

Moderator: Ralf J. Jox

Daniel Davis, PhD; Joseph A Raho, PhD; James A. Hynds, LLB, MTh, PhD

In the September-October 2013 issue of The Hastings Center Report, a presidential task force of the American Society for Bioethics and Humanities (ASBH) unveiled a proposed “two-step model” for quality attestation in clinical ethics consultation. An in-depth portfolio, documenting and explicating a candidate’s experience and an oral examination constitute the two essential steps toward this end. After years of debate, this is a very welcome development toward the goal of consistently high quality in clinical ethics consultation, but we wish to focus attention on a crucial but inadequately thematized aspect of the pedagogical process that ideally informs and shapes the experience documented in the portfolio—the mentor/mentee relationship. Drawing on an Aristotelian concept of moral formation, as well as on their respective personal and professional experiences, the members of this panel will:
1. Explore the role of the ideal mentor in elucidating his/her theoretical and practical reasoning in response to the specific challenges of ethics consultation as well as in reflectively modeling the affective behaviors essential to facilitating an ethically principled resolution to conflicts;
2. Identify the pedagogical obligations that mentors have toward their mentees and toward practice of consultation itself;
3. Identify the reciprocal obligations that mentees have toward their mentors and to their future profession;
4. Describe “the mutuality of acknowledged value” that distinguishes successful mentor-mentee relationships; and
5. Propose a set of practical guidelines for establishing and nurturing successful mentor-mentee relationships in the practice of clinical ethics consultation.

The panel will be comprised of clinical ethics consultants at various stages of their respective careers. The panel organizer, Dr. Dan Davis, will introduce the theme of the panel and offer introductory reflections on the experience of being mentored and of mentoring. The next presenter, Dr. Joe Raho, will describe salient aspects of the experience of being mentored, both during his doctoral work at the University of Pisa in Italy and, currently, during his fellowship in clinical ethics at UCLA. Dr. James Hynds will then offer additional reflections on the mentoring process. Dr. Davis will then bring the panel to closure with a set of proposed practical guidelines for mentoring relationships in clinical ethics consultation.


C. Panel with Video - Introducing Ethics Consultation to a Family: Assessing a model

Annenberg 11-41 (Levy Library enter from 11th floor)

Moderator: Steven Birnbaum

Martha Jurchak, RN, PhD; Wendy McHugh, RN, MS

Among the many ways Ethics Consultation distinguishes itself from other forms of clinical consultation is by the involvement of the patient and/or family members. But how does one introduce the ethics consultation model to family members? Often the idea of ethics consultation stirs worries of wrongdoing or censure, and few have had experience with ethics consultation. We have developed an educational tool and interactive discussion format to address this question. In this presentation, we use a video recording of three different “takes” of an ethics consultant introducing him or herself and describing the ethics consultation model to family members of a patient on whom the staff has requested an ethics. Each “take” is followed by a discussion with the audience about what worked or didn’t work in the interaction. The video also allows for an assessment of the ethics consultant’s ability to convey information, establish initial rapport, and begin to form the ethics consultation intervention. This “observability” of the important initial phase of ethics consultation work is unique because much of the consultation process is difficult to witness and this format allows for consultants—both veterans and those new to the field—-to analyze and assess expectations, skills, and process by which a critical component of ethics consultation---the involvement of family members—is initiated.

D. Panel - A Model for Real Time Ethics Consultation: Streamlining processes in a time of constrained resources

New York Academy of Medicine, 20 A

Moderator: Jacqueline Chin

Harris M. Nagler, MD, FACS; Terry Altilio, LCSW, ACSW; Naomi Dreisinger, MD; Nathan Goldstein, MD; Deborah Korzenik, Esq; Robert Schiller, MD; Janet Stein, MD

Mount Sinai Beth Israel presents a novel approach to addressing ethical dilemmas in patient care. Since our full time ethicist position was eliminated, we created an innovative ethics consultation model. Instead of relying on one trained ethicist or a full Ethics Committee review for each ethics consultation, we have created a more nimble subcommittee approach, which involves, on a rotating basis, interested members of the Ethics Committee who have developed an expertise in responding to the range of medical-ethical issues that routinely arise in a hospital setting.
Our Ethics Consultation policy sets forth the process for obtaining Ethics Committee review.

A dyad consisting of a Coordinator (non-physician, n=9) and a Consultant (physician, n=7) who are members of the Ethics Committee engage in the following process: review of the medical record, discussions with relevant parties which may include clinicians, the patient, proxy, surrogate, family or close friends. The Consultant and Coordinator work together to identify decision makers, analyze the ethical issue(s), and facilitate communication. If consensus is reached, the resolution or recommendation is documented in the medical record. Since November 2007, there has been an average of one consultation a week regarding: 1. Futility, 2. Capacity, 3. Refusal of treatment, or 4. Confidentiality.

If an expanded discussion and consultation is necessary, a Subcommittee is convened, consisting of a minimum of 4-5 participants: the Coordinator, Consultant and two other members of the Ethics Committee. The Subcommittee investigates and makes a recommendation which is, as with any consultation, documented in the medical record.

Consultants and Coordinators represent varied medical specialties and disciplines and perform their duties in accordance with the core ethical responsibilities of the American Society for Bioethics and Humanities. This model of a committed and varied self-sustaining group which provides rapid and available consultative support when ethical issues arise contributes to a sense of shared responsibility for this essential aspect of quality patient care. We are currently planning initiatives to promote consistency of advice and outcome, including: 1. Retrospective review of consultations, 2. A standardized template, 3. The development of a required core curriculum for all individuals providing consultations.

E. Workshop - Beyond Conflict: A simulated ethics consult involving drug abuse during pregnancy

Moderator: Marion Danis

Constance Perry, PhD; Kathleen E. Powderly, CNM, PhD; Kevin Powell, MD, PhD, FAAP; Katherine A. Taylor, JD, PhD

This interdisciplinary panel discusses the issue of "maternal-fetal conflict.” This controversial topic was a “Hot Topic” for clinical ethics in the late eighties and nineties when there were a number of procedures forced on pregnant women against their will out of concern for the well-being of the fetus. Court rulings on the tragic case of Angela Carder (forced C-section) and Ferguson v. City of Charleston (hospital reporting results of nonvoluntary drug tests of pregnant women to the police) both confirmed a woman’s right to privacy. Furthermore, there were several studies which indicated that in most cases, the forced treatment in that era had no positive impact on the health of the resulting infant. Since then, fetal medicine has advanced in both diagnostic accuracy and therapeutic options. Opiate abuse during pregnancy has risen 3-10 fold. In 2014, Tennessee passed the first state law explicitly allowing the prosecution of a pregnant woman for harm to her fetus due to use of narcotics. And other states continue to prosecute women for fetal deaths allegedly caused by drug use, or by suicide attempts, or refusal of a cesarean section. It will likely be an issue faced by any ethics committee and/or consultation service that includes coverage for obstetrics and neonatology.

The panel will present and discuss this issue in an interactive format, by simulating an ethics committee meeting. At first the “committee” will present and discuss a particular case. Then the committee will consider the possibility of a hospital policy to help clinicians work through future cases. Finally the committee will consider implications for public education and community outreach. The audience will be invited to serve as outside members of the committee. In this way the audience becomes involved in the simulation discussion. This provides a constructive and proactive format with which to discuss this contentious and emotionally charged issue.

F. Pediatrics Issues

Moderator: Yen-Yuan Chen

1. Ethical Bargaining and Parental Exclusion: A clinical case analysis

Elizabeth Victor, PhD, MSM; Laura Guidry-Grimes, MA
Although in clinical ethics there has been significant attention to when physicians should follow through with a parent’s wishes, there has been much less discussion of the obligation to solicit viewpoints and decisions from all caregivers who have equal moral and legal standing in relation to a pediatric patient. How should healthcare professionals and clinical ethicists respond when one caregiver dominates decision-making? We present a case that highlights how these problems played out in an ethical bargain. Ethical bargaining occurs when the parties involved choose not to pursue the morally preferable option for the sake of coming to a resolution. In the case, a child had a condition that would require ultrasounds and blood tests every three months to check for tumors. The father proposed a bargain: he would follow up on the child’s tests on the condition that the physician would shield the mother from all decision-making and information related to the child’s diagnosis. The father justified her exclusion on the presumption that she would despair and become “a bad mother.” The medical team worried the father would not return with his child if they did not agree to his terms, and they acquiesced. We argue that there is an obligation to notice and acknowledge power asymmetries in the family unit. While there are moral and practical limits to how and when physicians should intervene in family dynamics, we discuss the steps that the medical team should have taken in this case to avoid undermining the parental authority of the mother. In our recommendations, we examine the role of clinical ethicists and ethics committees in preventing ethically impermissible bargaining, mitigating the potential effects of implicit bias (e.g., in privileging male caregivers over female caregivers), and documenting damaging family dynamics. These ethicists are well-placed to track and respond to caregivers’ conflicts, silences, and barriers to autonomy.

2. A Working Group on Clinical Ethics in Pediatric Oncology - A Nordic platform for ethics support

**Background:** Ethical problems in pediatric oncology have traditionally been handled at an individual level, and are often considered challenging. A joint working group on ethics, consisting of pediatric oncology nurses and physicians, was constituted during the biannual joint meeting of the Nordic Society of Pediatric Oncology and Hematology (NOPHO) and the Nordic Society for Pediatric Oncology Nurses (NOBOS) in 2008.

**Purpose:** The intention of the working group is to be a Nordic competence group addressing ethical questions and offering ethics support within pediatric oncology. The purpose of this presentation is to present the development, activities, achievements and goals of the NOPHO/NOBOS Working Group on Ethics (WGE) 2008-2014.

**Methods:** The WGE has 16 members (9 nurses and 7 physicians) with at least two representatives from each of the Nordic countries. The group meets yearly at two 1-day-meetings and one 3-day-workshop. Meetings are focusing on education, work and organization of ethics support. Members are educated through international courses and conferences in clinical ethics, and are trained facilitators in moral case deliberation.

**Results:** All WGE members participate in, or have initiated, formalized clinical ethics projects at their pediatric departments, hospitals, regions or countries. Member activities in clinical ethics support include: facilitating deliberation on ethically difficult cases in the care team, teaching ethics to nursing and medical staff/students, supervising research projects and serving as members of national, regional or local clinical ethics committees/societies. Ethics research and quality assurance including evaluations of moral case deliberations in pediatric oncology are being planned.

**Conclusions:** WGE represents the first joint working group of NOPHO and NOBOS. It has proved beneficial to combine pediatric oncology nurses and physicians from different countries for this work. Through collaboration and education we have created a common Nordic platform for developing clinically applied ethics. Importantly, the WGE has inspired and enabled all members to initiate or engage actively in projects locally, regionally and nationally, thus increasing the focus on clinical ethics in the care of children with cancer at many levels.

3. Failure to Thrive as a Sign of Neglect in Medically Complex Children

**Failure to Thrive (FTT) and neglect are both prevalent among children. In 2012, 3.4 million referrals were made to state child protective service agencies for maltreatment, involving 6.3 million children in the U.S. Of the substantiated referrals, neglect was the most prevalent form of maltreatment involving over three-fourths of cases and nearly seventy percent of fatality cases. One of the potential contributing etiologies for FTT can be neglect. Similar to FTT, the identification of neglect is hampered by its differing definitions as well as the difficulties inherent**
when subjective value judgments need to be applied. Adding to the difficulty of identifying neglect as a contributor in FTT is the increasing prevalence of medical complexity and technology dependence among children. These unique patients require extra scrutiny as research has shown that they are at increased risk for abuse and neglect. An ethical analysis of a clinical case will address issues of how clinicians approach child maltreatment, how state agencies intervene, and how effective and appropriate this paradigm of practice is for children with medical complexity whose interest may significantly differ from that of otherwise healthy children.

L.P. is a 10 year old male with 3p.25 chromosomal deletion resulting in multiple medical problems including persistent, severe FTT, whose parents were suspected of medical neglect. His case will be presented and analyzed with the common ethical frameworks utilized in assessing fitness of surrogate decisions makers of children, including; best interest standard, satisficing parentalism, and the harm principle. Features common to this type of scenario will be discussed; the biases and subjective value judgments of health care providers and social services factoring into these scenarios and the role clinical and prognostic uncertainty can play in the assessment of neglect in children with medical complexity. Discussion of this case will help others involved in caring for children with medical complexity where possible neglect and FTT coexist, enabling them to analyze these cases through ethical constructs.

4. Ethics Beyond the Ethics Committee in a Pediatric Canadian Hospital

Randi Zlotnik Shaul, JD, LLM, PhD; Becky Greenberg, RN, PhD; Jonathan Hellman, MBBCh, FRCPC

The 1980s saw the creation of hospital ethics committees (HECs) that were focused on clinical ethics case consultation. The activities of ethics committees today go beyond consultation and include engagement in education and policy development. In many institutions the HEC has even been supplemented or supplanted by specially trained bioethicists within Bioethics Departments.

Formal bioethics services at The Hospital for Sick Children, Canada, have been in existence for almost 30 years. While services began with an ethics committee, the multi-faceted needs of a highly renowned clinical and research institution resulted in the establishment of a Bioethics Department with two full-time bioethicists. This increased flexibility in terms of availability, scope of issues and the nature of the services provided, so that multiple points of integration and traction beyond case-based clinical consultations and the work of an ethics committee can be accommodated. Services currently provided include clinical, organizational and research ethics consultations, ethics education across professions and specialty areas, policy development, monthly Bioethics Grand Rounds, an annual Bioethics week, externally funded research grants, scholarship, mentorship and internal, local, national and international committee work and collaborations in paediatric bioethics.

The Department engages in regular benchmarking and innovative learning from institutions engaged in similar activities around the world. The Bioethics department also undertook a formal needs assessment whereby 352 surveys were completed, primarily by clinical staff focused on the range of services provided and staff’s perceived needs going forward.

This presentation will discuss (1) the mission, vision and infrastructure of a highly integrated Canadian Paediatric Bioethics Department within a major clinical and research institution (2) the wide range of services provided by the Department (3) efforts being pursued based on the results of international benchmarking scans and learning, and (4) initiatives arising from the results of the needs assessment. The multi-faceted needs of complex health care institutions require ethics services well beyond clinical case-based consultations. Addressing the needs of patients, clinical staff and an organization’s administration, is supported by the provision of a wide range of ethics capacity-building services and engagement with all hospital staff and patients around relevant issues through collaborative scholarship and research.

G. Quality Improvement in Ethics Consultation

New York Academy of Medicine, 20 B

Moderator: Nada Gligorov

1. How to Support the Supporters? Support measures for an ethics consultation service

Tanja Löbbing, Margret Pfafflin, Klaus Kobert
The “Ev. Krankenhaus Bielefeld” (EvKB) offers several formats of ethical support such as clinical ethics consultations on demand. Ethics consultation rounds in the EvKB include besides the two consultants parts of the treatment team, the patient, his/her legal representative and/or the relatives of the patient. Since 2006 about 350 deliberations have been realized by the 12 members of the ethics consultation service team, in recent years about 50 ethics consultations every year.

The consultants face difficult questions in complex situations during their ethics consultations. They cope with these demanding challenges in a stepwise procedure.

Firstly, the moderator and the co-moderator discuss the process, possibly occurred difficulties and the ethical reasoning in the aftermath of the consultation.

Secondly, a specific case is reflected and reviewed among all consultants. These meetings, called “intervisions”, are performed regularly in six weeks intervals for two hours. Within these sessions, the ethics consultants have the possibility to discuss difficult situations and exchange their ideas collegially.

Thirdly, a supervision led by a psychologist focused on interpersonal conflicts and how to handle them. Psychodrama was used to develop solutions and coping strategies.

Fourthly, in 2014 the ethics consultation service engaged a professor of philosophy from the University of Bielefeld in order to get profound philosophical support. The idea was to create a model in which the experiences of the practical field meet the theoretical philosophical arguments. The philosophical coaching now runs three times per year.

Fifthly, a two-day workshop for ethicists and interested clinicians is organized annually. Experts are invited to specific topics, e.g. tripping hazards in ethics consultation. The workshops aim to strengthen the cooperation between the members of the service and to deal with hot ethical topics (e.g. characteristics of ethics consultation in psychiatric settings).

The goals of the approaches are to provide professional support for the consultants and to increase the quality of clinical ethics consultation. The process of development, the content and our experience with these methods will be presented and consequences for clinical ethics consultation will be discussed.

2. Using Ethics Consultation Data for Quality Improvement

Barbara Chanko, RN, MBA; Kenneth Berkowitz, MD, FCCP; David Alfandre, MD

Assuring the quality and consistency of health care ethics consultation (HCEC) is a recognized challenge. Central to our organization’s efforts to improve the quality of HCEC is the use of ECWeb, a secure, Web-based software program designed to standardize ethics consultation practices and to provide an electronic method of documenting/storing/retrieving HCEC data. Since the nationwide roll-out of ECWeb in our system in 2008, our 140 HCEC services have created more than 13,500 HCEC records.

The presentation will use ECWeb data to illustrate how aggregating, tracking, trending, and reporting on HCEC characteristics, processes, and evaluations can inform quality improvement at the level of the individual, ethics consultation service, facility and/or systems. We will present three types of HCEC aggregated data summaries (i.e., reports):

- The utilization report includes variables such as the: number/type of consultation; urgency of request; requester’s role; patient location/setting; type of assistance requested; consultation model used; ethics topics addressed, etc.

- The process report includes variables such as whether there was documentation of: a face-to-face patient visit; notification of the attending; a health record review; decision making capacity; the patients’ preferences and interests; medical facts; relevant ethics knowledge; formal meeting(s) held; identification of the ethically appropriate decision maker; identification of a surrogate (if appropriate); recommendations, etc.

- The evaluation report includes the participant’s (e.g., consult requester) perception of service quality such as: timeliness; ease of access; overall helpfulness; and overall satisfaction. The report also includes perception of the consultants’ skills in: clarifying the ethics concern; providing practical information/resources; making the
requester feel at ease; respecting the requester’s opinions; explaining things well; clarifying decisions that had to be made and who should make them; describing possible options; clearing up any disagreements, etc.

Our ECWeb system will be briefly described. The advantages of using standardized consultation processes and documentation systems will be highlighted. The association between HCEC data trends and promoting ongoing quality improvement efforts/initiatives will be discussed. Efforts underway to improve the existing ECWeb system and to modify it for use by partners outside of our system will be explained.

3. A Quality Approach to Excellence in Community Ethics: A case study from Canada

Christopher E De Bono, PhD, M.Div; Jennifer Foster, BA, MBA, PMP; Frank Wagner, BA, MA, MHsc

How does a Canadian, provincially mandated and publically funded, home care case management center achieve quality excellence in community ethics?

For more than 10 years, the “Toronto Central Community Care access Centre” (CCAC) has been a pioneer in the development of its community home care ethics program. From its origins, the program aimed to help staff recognize an ethical issue when they face it, know where to get help to manage it, and be equipped with the tools, resources and education they need to work through the ethical issues they face in the community.

Great things were achieved including international recognition of the CCAC’s innovative ethical deliberation framework, called IDEA. But the program experienced a series of adverse effects as well: there was a duplication of services by ethics of risk and legal issues; difficulty meeting ever growing external and internal demands for ethics consults and education; and consequently, an increasing concern related to sustainability and potential burn out for the ethicists.

A formal program evaluation in 2013 recommended that the ethics program would benefit from a quality improvement approach. It was believed that this process would better structure the aims, objectives, and measures of success for the department. It would also offer an informed way to restructure the ethics service and clarify the professional identity of the ethicist.

This workshop will tell the story of this ethics quality improvement initiative at our CCAC. This includes an analysis of the application of QI methodology, stakeholder engagement, as well as the challenges and improvement opportunities for changing the structure of an existing community ethics service.

Participants will glean lessons learned as to how QI supports ethics capacity building. Participants will be able to apply these lessons, as appropriate, to their community organizations and the broader service community.

4. A Bioethics Consultation Skills Checklist: Learning and feedback tool

Hannah I. Lipman, MD, MS; Lauren Flicker, JD, MBe; Patrick Herron, DBE

The number of bioethics consultant training programs is growing, but there is not yet consensus about optimal learner assessment methods. Providing effective consultations involves facilitating meetings with various stakeholders and mediating conflict. Tools are needed to standardize the evaluation of consultant communication and mediation skills. The authors present the Bioethics Consultation Skills Checklist, a 19-item tool to standardize learner self-assessment and faculty evaluation, as well as provide a framework to provide learners with specific and actionable formative feedback.

The Einstein Cardozo Bioethics Consultation Skills Course is a 4-day intensive focusing on practical skills needed to perform quality bioethics consultations. Utilizing interactive lectures, small group discussion, case analysis, guided exercises, multimedia, and simulated consultations, the course addresses topics including ethics analysis, role conflict, charting and communication skills. The primary experiential learning activity is the simulated consultation. Participants role-play all stakeholders in the consultations, which present common issues, such as interpretation of advance directives, conflict about goals of care, and patient refusals. Participants develop a better understanding of the perspectives, values, and concerns of the various stakeholders. In the role of consultant, learners demonstrate specific communication and mediation skills in order to bring the patient’s voice into the room, clarify values, explain bioethics concepts, mediate conflict, and bring the stakeholders to consensus around an ethically
supportable plan. Simulated consultations are video recorded and available online to review for teaching purposes and formative feedback.

The Bioethics Consultation Skills checklist includes 19 behaviorally anchored skills the consultant should demonstrate. Items are grouped into 5 domains: information gathering (e.g. allows participants to tell their story, elicits participants’ values), communication skills (e.g. gestures/body language), relationship skills (e.g. acknowledges feelings, discomfort, cues), bioethics facilitation skills (e.g. explores how values apply to medical decisions, bringing participants to consensus around an ethically justifiable plan) and bioethics knowledge. The tool provides a shared framework to facilitate self-assessment by learners and provision of specific and actionable feedback by faculty. The authors will present the Bioethics Consultation Skills Checklist, rationale for items’ inclusion, qualitative feedback from faculty about its usefulness, and a quantitative assessment of inter-rater reliability.

H. Capacity and Consent

Moderator: Stefan Bernard Baumrin

1. The Boundaries of Clinical Ethics: Are nonconsensual pelvic exams inside or outside?

Phoebe Friesen, BA, BA, MA

When a conflict arises between patient autonomy and the need to train medical students, does a clinical ethicist have a duty to bring such an issue to light? In this paper, I consider the practice of medical students performing pelvic exams on anaesthetized women who have not been consented. I argue that this custom is unethical, in that it violates both trust and autonomy, and that clinical ethicists hold a unique epistemic position from which to raise awareness and concern with regards to this practice. I begin by outlining the importance of maintaining trust and respecting autonomy in a physician-patient relationship and how the process of informed consent works to preserve these goals. I then acknowledge that the consent process is inevitably selective, in that all potentially relevant information can never be covered in full. Drawing on the work of Roger Higgs on truth telling, I offer guidelines to determine what should be included in the consent process, which I describe as everything except that which has the potential to cause significant harm or that which is trivial. I distinguish between two types of consent: consent for therapeutic purposes and consent for training purposes, and argue that when therapeutic and training practices come apart, consent should be obtained separately for each. Following the guidelines introduced above, I consider whether a pelvic exam performed on an anaesthetized woman for training purposes ethically requires consent. I argue that consent is required because the practice is non-trivial, and I offer several reasons in support of this claim. I then consider three objections to my view, the Physician Neutrality Objection, the Implied Consent Objection, and the Practical Objection. After responding to each of these, I return to the importance of the role of clinical ethicists in responding to this practice. I offer evidence that many medical students are uncomfortable when they first encounter this custom, and yet their concern diminishes throughout their time in medical school. This suggests that the practice has become normalized within the culture of medicine, and a voice from outside is required to examine the harms involved.


The Role of Capacity Assessment in Clinical Ethics

Jeffrey P. Spike, PhD

Presenter teaches capacity assessment in medical schools and residency programs in the US. Experience shows that capacity is on the problem list of most ethics consults. So where one places the locus of expertise will make a big difference in many cases. The presenter will show how, given the definition of capacity and the method of its assessment, it is as much an ethical concept as a cognitive or psychiatric concept. A few cases will be presented that show the mistake of thinking that one ought to always get a ‘psych consult’ to assess capacity, especially if they use a MMSE. While it is only natural to hope to find an expert to deal with the difficult and controversial aspects of an ethics case, this can sometimes lead to ethical failures. Ethicists need to “own” at least an independent ability to assess a case themselves, including the patient’s capacity. Included will be some useful handouts on capacity assessment.

Philosophical Dimensions of Patient Regret

Katherine Mendis

Medical professionals frequently express concern that patients may regret receiving specific medical treatments (often, but not always, elective surgeries). This concern gives rise to ethical questions and dilemmas that extend from the clinical to the political. Physicians may hesitate to perform tubal ligations or vasectomies on patients who are below a certain age or do not have children; the consent process for these surgeries often involves assessing or asking the patient to assess the likelihood that they will one day regret the procedure. The possibility of patient regret and the necessity of preventing and/or minimizing it have influenced gatekeeping measures for the surgical treatment of Gender Identity Disorder, and may play a similar role in legitimizing surgical treatment for Body Integrity Identity Disorder. And the extent to which significant numbers of patients regret elective abortions is, in some contexts, assumed to be relevant to abortion law and policy.

This presentation introduces a philosophical analysis of regret, drawn from developments in decision theory and various conceptions of autonomy. A more thorough understanding of the psychological and moral dimensions of regret will enable clinicians to properly conceptualize its importance in clinical ethical dilemmas. Preliminary recommendations for how regret ought to be considered in the consent process will be offered.

Ethical Consensus Building

Kumiko Yoshitake, PhD

Shared decision making is a decision making method for the issues in clinical settings. The stakeholders like patients and their families, doctors and nurses collaborate together for satisfactory decisions and for the prevention of medical disputes. The method of shared narratives is also an important idea for understanding the medical decision making process.

Shared decision making and the shared narratives, however, do not answer the question what kind of communication skills are necessary and what kind of factors medical staff should understand to develop skills needed at meetings for ethical issues.

“Ethical Consensus Building” is the process of decision making in which medical parties like patients and their families, doctors and nurses, not only share the reasons of their opinions, but also aim at collaborative decision making made by the collaboration of stakeholders for the prevention, avoidance and resolution of ethical disputes in clinical settings.

Ethical consensus building contains, as essential factor, the processes of identifying and analyzing stakeholders’ interests through their facilitation skills in meetings. The consensus builder decides who are stakeholders and analyzes the interests and the histories of the reasons behind stakeholders’ opinions. The analysis makes it possible for the stakeholders to forecast the risks of medical disputes, based on the understanding of the reasons of opinions traced from the past to the present, and to share forecasting risks by each party.

The purpose of this study is to consider the meaning and structure of “ethical consensus building” in clinical settings.
The method contains 1) identification of the characteristics of communication skills of stakeholder analysis, 2) consideration of what kind of factors are essential in the discussions for ethical issues, 3) specification of the essential contents of the ethical education for medical staff.

The finding is the notion of shared reason and the notion of history of reason. These notions help us to understand deeply the meaning and values of stakeholders’ opinions not only from different directions but also from the viewpoint of time flow. Such an understanding is the gateway to discovering any lurking dispute risks.


LLAnb Annenberg 10-68

Moderator: Robert Baker

Anita Tarzian, PhD, RN; Lucia D. Wocial, PhD, RN; Courtenay R. Bruce, JD, MA

The Board of the American Society for Bioethics and Humanities (ASBH) recently approved and disseminated the final version of the "Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants" (2014). By setting out core ethical responsibilities of individuals performing healthcare ethics consultation (HCEC), the Code makes a major step towards professionalization. In essence, the Code uses an aspirational tone to proclaim a profession’s commitment to those served by patient-focused consultative activities, and it allows healthcare ethics (HCE) consultants to maximize their ability to fulfill their professional obligations.

On behalf of ASBH and the Clinical Ethics Consultation Affairs (CECA) Standing Committee, these panelists (consisting of the past and current Chairs of CECA, as well as a CECA member) will describe key considerations and strategies for developing and implementing the Code. Specifically,

Panelist #1 will discuss the evolution of the Code’s development (e.g., outlining precursor documents and describing the process of Code development), as well as discussing implications for the field of HCEC and bioethics.

Panelist #2 will discuss the key elements of it (i.e., a preface professing the commitment to shared values and 7 responsibility statements enumerating how these commitments are to be respected). Panelist #2 will also provide take-home points for what the Code does and what it does not do.

Panelist #3 will identify opportunities and strategies for using the Code. Panelist #3 will use multiple-choice and issue-spotting questions from a resource guide that CECA developed for self-learning and teaching.

Our goal is to cultivate familiarity with the Code by using different didactic and interactive teaching methods. This panel presentation is designed to teach students, trainees, and new and seasoned HCE consultants about the Code, allowing them to engage in self-awareness and self-assessment to reflect on their own individual practices.
Friday, May 22nd, 2015

10:30  *Coffee break/ Book-Journal-Program Display*  
Annenberg, N&W Lobby

11:00  **Plenary Session V**  
*Educating Clinical Ethicists for the Profession*  
**Mark Siegler, Rosamond Rhodes, David Magnus, Guy Widdershoven**  
**Moderator: Arthur Derse, MD, JD**

12:30-1:00  **Conference Planning & Farewell**  
Annenberg Stern Auditorium

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