FROM THE FIELD

From Call to Consult: A Strategy for Responding to an Ethics Request

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Introduction

Catholic health care organizations (CHCOs) have a longstanding commitment to mission and ethics that far exceeds the regulatory requirements for ethics in hospitals. Although CHCOs devote considerable resources to promoting their commitments to mission and ethics, not everyone doing ethics consultation has had substantial training in ethics or years of experience. In some systems, employees who are not full-time ethicists generously serve as a rotating contact person for ethics. In our experience, many of these employees have reservations when they receive an ethics consultation, because they do not feel equipped to respond when the phone rings. Although education and practice are the best ways to address this discomfort, there are some basic skills that ethics representatives can gain to assist them in ethics consultation. The aim of this article is to provide a simple strategy for responding to ethics consults.

A significant amount of scholarship on ethics consultation already exists. The most authoritative professional guidelines on ethics consultation are the American Society for Bioethics and Humanities' *Core Competencies for Healthcare Ethics Consultation*. This document sets standards for the necessary competencies of an ethicist and ethics committee, and the importance of triaging consults. The authors note three general approaches to ethics consultation: the authoritarian approach, the facilitation approach, and the pure consensus approach. They argue that the most appropriate method for ethics consultation is the facilitation model. In this model, the ethicist should "identify and analyze the nature of the value uncertainty" and facilitate the "building of a principled ethical resolution."[1] The guidelines state that

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ethics consultants can help determine the range of ethically appropriate options, but should not influence the patient or family's decision.[2]

Other authors have also attempted to identify a set of roles for ethicists. For example, Self and Skeel suggest that the ethicist could be a "consultant in difficult cases, educator of health care providers, counselor for health care providers and... patient advocate."[3] Similarly, Glover et al. define the roles of an ethicist as teacher, consultant, and decision-maker.[4] La Puma and Schiedermayer claim the ethicist might be a "professional colleague, negotiator, patient and physician advocate, case manager, [or] educator."[5] In broader terms, Agich argues that ethicists should be "consulting, teaching, watching, and witnessing."[6]

Though these authors and the *Core Competencies* describe many of the functions of the ethicist[7], they are not sufficient for two reasons. First, on a practical level, the *Core Competencies* include skills for assessing and analyzing a case[8]; however, the procedural skills are abstract, and difficult to refer to in the moment of a consultation. In addition, they are still one level above the immediate experience of the person performing an ethics consultation. They still involve a small degree of abstraction by describing the professional identity of the ethicist. When the phone rings and an ethics response is required, the procedural skills outlined are not immediately actionable.

Second, the *Core Competencies* and other descriptions of the roles of ethicists do not account for the unique setting of a CHCO. Ethics in CHCOs does not exist to simply fulfill a Joint Commission requirement. Ethicists promote the broader mission of CHCOs, which incorporates certain values such as the life and dignity of the human person, the call to family and community, a preference for the poor, a promotion of the common good, the rights of workers, and financial and environmental stewardship. Given these values and the commitment to honoring the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs),[9] the roles of the ethicist in a Catholic institution sometimes exceed those outlined in professional guidelines on ethics consultation. For example, organizational commitments and the ERDs may require ethics to go beyond teaching, facilitating discussion, and identifying options. In certain situations, these commitments may justify an approach similar to the "authoritarian" approach described in the *Core Competencies*.[10]

In what follows, we propose five active functions that the ethicist or the on-call ethics representative[11] may be asked fulfill in a case consultation. In our proposition, we account for the two factors that wenoted as lacking in previous literature: First, our perspective is not abstract. Instead, it provides action-based tasks that can help define actions in the context of a call. Second, we loosely presume the context of the CHCO and the ERDs. Our proposition does not provide the content

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for ethical decisions, and in this sense it is simply a procedural strategy for the person who takes ethics call. Yet, this strategy presumes the nature of the moral content and organizational context that is distinct to ethics in CHCOs.

What Does a Caller Want from Ethics? Beginning the Case Consult

Various health care facilities place different levels of responsibility on the person who receives an ethics call. In some cases, the person may be responsible for resolving the situation. In other cases, the person may triage and delegate tasks pertaining to the situation. Regardless, one question is procedurally foundational for responding to the ethics request: What does the caller want from ethics? In this article, we propose five responses to this question: an explanation, a recommendation, a decision, a verification, or assistance through mediation.

The classifications we propose are both over-generalizations and fail to describe every case. Sometimes, after identifying what ethics is being asked to provide, it may be evident that ethics cannot provide a resolution. Perhaps the issue is better addressed by risk management or a social worker. In other cases, it may appear the caller is asking for one thing, but once the ethics consult unfolds it may become evident that the appropriate function of ethics was something other than what the caller asked. Sometimes the person may be clear about what help they need. In many instances, however, the on-call ethics representative must identify the implicit request being made of ethics. In any case, the first place to begin a consult is in identifying what the caller believes ethics should or could contribute: What does the caller want from ethics?

1. **Explanation**. Some inquiries that ethics receives may simply be a request for information about a practice, policy, or directive. The caller is looking for an explanation of information related to a case or possible course of action. Knowledge that the organization or facility has a position on the topic in question or wider media attention to the controversial nature of the topic in question may precipitate this kind of call. Examples may be inquiries about the meaning of one or more Directives, whether or not emergency contraception is morally acceptable and when, or the content of the hospital's policy on the treatment of ectopic pregnancies. In these scenarios, the caller may or may not have a particular case in mind. Her primary task is to gather information that will be used to guide decision-making.

2. **Recommendation**. In other instances, the caller will be looking for a recommendation about the content of a decision or a procedural recommendation about how to address an issue. In the former case, the caller has identified moral distress or tension between goods and seeks guidance on what action should be taken. For example, clinicians may be uncertain as to how to proceed when a patient is incapacitated, how and if the treatment will benefit the patient, and to what degree it may be a burden and to whom. With this type of ethics request,

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the caller often has genuine uncertainty about how to proceed. The task of recommending often leads the ethics representative to gather others from the committee and discuss and discern the case. The resulting communication is a recommendation, not a binding decision. Subsequently, when ethics assumes the task of making a recommendation, it ideally leads to mutual decision-making processes among all involved.

3. **Decision**. In some cases, the caller may ask ethics to make a decision or provide an authoritative and definitive response regarding a case or question. The *Core Competencies* acknowledge that the ethics consultant functions as a decision maker when only one ethical course of action exists.[12] In these instances, the ethics consultant makes a decision only because all other options are already excluded, often by legal boundaries. In Catholic health care settings, the action of deciding is more common and pertains to more issues than is the case in the non-Catholic setting. The act of deciding is distinct to CHCOs regarding issues with respect to which there is binding Church teaching, a definitive norm or practice, or clearly stated value defined by the organization and its commitment to the ERDs.

For example, a caller may consult ethics to ask whether or not induction of labor is prohibited or permissible for a certain patient. Because of the nature of the hospital's commitment to the ERDs, the caller implicitly or explicitly acknowledges and affirms that the question is a matter of expert interpretation of ethical commitments. If ethics discerns that an action is morally permissible, in many cases a provider and patient can still choose not to take that course of action. In contrast, when ethics discerns that an action is morally prohibited, that decision is binding for those who consulted ethics. Phrasing such as "Are we allowed to…" or "Does this procedure qualify as indirect or direct?" may signify that ethics is being asked for a clear decision or definitive response. For these specific cases where ethics is called to make a decision, ethics has responsibility for ensuring the interpretation and application of moral teachings.

Occasionally, the caller may convey that she is looking for a decision, when in fact the topic under question is not such that a clear decision can be given by ethics. In the case where an apparent request for a decision seems inappropriate, ethics can offer a recommendation and help the caller and others involved in the situation to discern the most morally appropriate course of action together.

4. **Verification**. A fourth possible role for the on call ethics representative is to provide a verification or affirmation, what we might call the "ethics blessing." For this task, the caller generally already has a sense of what she or he intends to do. Because of pressure, anxiety, uncertainty, or caution, the person has decided that someone needs to double-check the decision. Consequently, the person calls ethics for a verification of that which they already intend to do. Key phrases for this task may include, "I just want to run this by you," "That's okay, right?" or, "Does that sound acceptable from an ethics

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perspective?" In many instances, fear of legal ramifications or threat of legal retaliation may precipitate this kind of ethics call. In some cases – probably most cases – ethics can discuss the clinician's intuition about a decision and help him feel comfortable with his plan of action and even add insight to that plan. Nevertheless, when people call ethics looking for verification of their intuitions, the on-call ethics representative must remember that the person may well be wrong; it may be appropriate to challenge the caregiver's perspective and to involve the ethics committee or staff more broadly.

5. **Mediation**. Finally, ethics also fills the more contemporary ethics task of mediation. In many instances, ethics is consulted with a request to help mediate a difficult situation. Typically, the task of mediation pursues the practical end of consensus. Although this task may be outside of a narrow vision of ethics, it is a task that has largely come to fall on ethics. Many people call ethics simply because the situation is tense, explosive, or difficult and ethics can serve as a neutral party that effectively assists in the resolution of seemingly impassable disagreements. Keys for recognizing that mediation may be the task requested from ethics include chaotic descriptions of conflict between people or a general acknowledgement of disagreement and a request for help.

Conclusion

Of course, the functions asked of a person representing ethics exceed the five tasks we have proposed here (to explain, recommend, decide, verify, or mediate.) The caller rarely states the tasks explicitly. In most instances, the on-call ethics representative has to identify the task requested of her. Although a person who consults ethics may appear to be asking for one kind of response, closer inquiry into the situation may reveal that the ethics representative needs to respond in another way. Sometimes the representative will need to fulfill several functions at once. Sometimes ethics will not be able to provide a response to the request, which can be better answered by another department.

The proposition of this article is neither that the five roles we identify will be clearly differentiated nor that every case will fall into one part of our classification scheme. Instead, we propose these five functions as ways of thinking through what is being asked and if/how ethics can appropriately respond. The abundance of information that comes with a new case can be overwhelming for those answering an ethics call, especially if they are new to the practice. By beginning with the simple question 'What does this caller want from ethics?' and considering the five responses we have suggested, the discomfort of being the contact for ethics may become more manageable.

[1] American Society for Bioethics and Humanities, "Core Competencies for Healthcare Ethics Consultation " (2011), 7.
[2] Ibid., 7-9.
[3] Donnie J Self and Joy D Skeel, "Potential Roles of the Medical Ethicist in the Clinical Setting," *Theoretical Medicine* 7(1986): 33.
[4] JJ. Glover, DT. Ozar, and DC. Thomasma, "Teaching Ethics on Rounds: The Ethicist as

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Teacher, Consultant, and Decision-Maker," *Theoretical Medicine* 7(1986).
[5] John La Puma and David Schiedermayer, "Ethics Consultation: Skills, Roles, and Training," *Annals of Internal Medicine* 114(1991).
[6] George Agich, "Clinical Ethics: A Role Theoretical Look," *Soc. Sci. Med.* 30, no. 4 (1990): 389.
[7] American Society for Bioethics and Humanities, "Core Competencies for Healthcare Ethics Consultation " 7-9.
[8] See ibid., 10-18.
[9] USCCB, *Ethical and Religious Directives for Catholic Health Care Services* 5ed. (Washington, DC: USCCB, 2009).
[10] See American Society for Bioethics and Humanities, "Core Competencies for Healthcare Ethics Consultation " 6.
[11] We use the term "ethics on call representative" in this article; however, the claims also could apply to an individual who serves as the primary ethicist for a facility or organization.
[12] American Society for Bioethics and Humanities, "Core Competencies for Healthcare Ethics Consultation " 8.

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