Answers and Questions About Ethics Consultations

Bernard Lo, MD

ETHICS CONSULTATIONS ARE TOUTED FOR RESOLVING ETHICAL DILEMMAS, and most hospitals use them to meet the Joint Commission for the Accreditation of Healthcare Organizations’ requirement for a process to resolve conflicts in patient care. Little rigorous evidence is available, however, about the outcomes of ethics consultations. In this issue of THE JOURNAL, Schneiderman and colleagues report a multisite randomized controlled trial to evaluate ethics consultations. The intervention, which builds on a previous single-center randomized trial, involved ethics consultation in the intensive care unit (ICU) for conflicts and value disagreements either among the health care team or between the team and patients or surrogates. The comparison group received standard care, in which 25% of those patients chose ethics consultation. Schneiderman et al found that patients in the intervention group who died spent 3 fewer days in the hospital, 1.4 fewer days in the ICU, and 1.7 fewer days receiving mechanical ventilation than nonsurvivors in the control group. Almost 90% of surrogates and physicians agreed or strongly agreed that the ethics consultation was helpful. The authors concluded that ethics consultations reduced nonbeneficial care without increasing mortality.

The study has many methodological strengths, and overall it raises the standard for evaluating ethics consultations. Randomization by site, or cluster randomization, removed many potential sources of bias. Both process and outcome end points were assessed. Analysis by intention to treat led to a conservative estimate of the true effect of the intervention.

However, several methodological concerns should be considered. An important limitation was that the intervention was not standardized. Each institution followed its own procedures, which were characterized as consistent with general guidelines for ethics consultations. Clearly, what is done in an ethics consultation depends on the particular patient and the person doing the consultation. But because a consultation is not standardized like a drug, it is important to have more detail about what was actually done. Without such information, other institutions cannot judge whether the consultations in this study are similar to those at their own, or how they would replicate the intervention.

In addition, the intervention group had a slightly higher mortality rate (62.7% vs 57.8%). Although this difference was not statistically significant, it may nonetheless be clinically and ethically meaningful. In a randomized trial, differences in outcomes that are not explained by differences in baseline characteristics or other concomitant interventions are ascribed to the study intervention. In contrast to clinical trials of drugs, it is not clear whether a higher mortality rate in this study would be good or bad. The authors argue that their findings show that ethics consultations do not “simply provide a subterfuge for ‘pulling the plug.’” But this claim requires judgments about the ethical content of the consultations. Recommendations of ethics consultations should be within the “boundaries of morally acceptable solutions.” In some circumstances, an ethics consultation appropriately would lead to forgoing life-sustaining interventions. For example, the consultation might clarify that the patient would not have wanted the interventions or might correct the common misconception that withdrawing life support is synonymous with killing the patient. Conversely, it would be wrong for an ethics consultation to recommend limiting life-sustaining interventions based on inappropriate claims about futility that physicians sometimes offer. Thus, it would be important to know more about the kinds of disagreements and value conflicts in this study and how they were addressed. It also would be useful to assess whether independent reviewers agreed with the recommendations of the consultations.

Finally, the conclusion that patients or surrogates viewed the consultations as helpful rests on somewhat weaker evidence than the objective outcomes. In follow-up interviews, surrogates who did not speak English were excluded. Values conflicts and disagreements with such families may be particularly acute. Many cultures reject core assumptions of the US approach to end-of-life decisions: that it is desirable for patients to anticipate future illness, to give directions for future care, and designate a single person as proxy. Also in light of problems with translation services, it would be important to know whether non–English-speaking families understood the goal and process of ethics consultation. Moreover, 13 surrogates disagreed with the recommendations of the ethics consultation. It would be helpful to know more about the nature of disagreements and recommendations in these cases, provided that such information could be pre-

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sented without compromising patient confidentiality. The ethical concern is whether such serious dissatisfaction was associated with shortcomings in the consultation.

Like any good research, this study raises additional questions that need to be addressed. First, the results suggest that ethics consultations should be more widely used in ICUs in institutions with established ethics consultation services. Disagreements in the ICU are common. Although such disagreements may not be intractable, the study by Schneiderman et al suggests that ethics consultations may help resolve them in a timelier manner. The challenge in a nonresearch setting is how to identify such cases and offer an ethics consultation. Implementation of this intervention would be different if members of the health care team did not acknowledge disagreements and value conflicts, rather than simply not thinking of an ethics consultation. As the authors caution, it remains to be seen whether wider use of ethics consultation is useful outside of ICUs or in institutions with ethics consultation services that are not well established and experienced. In addition, the impact of ethics consultations in culturally diverse populations must be regarded as unproven.

Second, the process of consultation needs to be described in more detail to identify components that are associated with desirable outcomes. The study by Schneiderman et al demonstrates that rigorous evaluations of ethics consultations are possible. Future studies need to address other important questions. Ethics consultations vary in terms of who carries them out, how the patient or surrogate was involved in the consultation, what communication skills the consultants used to try to reach consensus, and how recommendations were communicated. The heated debate over whether ethics consultations are best carried out by individuals, teams, or committees ought to be answered with empirical data. The American Society for Bioethics and Humanities has recommended core competencies for ethics consultations. It will be important to determine which core competencies are most strongly associated with positive outcomes.

Third, the goals of ethics consultation should be reconsidered and broadened. Schneiderman et al focused on reduction of “nonbeneficial” interventions and satisfaction of surrogates and physicians. However, nonbeneficial in the sense of this study can be identified only in retrospect. Some patients are willing to undergo burdensome treatments with a high probability of adverse outcomes. They or their surrogates may benefit from another few days of ICU care to determine prognosis more clearly. From their perspective, additional ICU care may be beneficial, even though the patient will eventually die. More importantly, other goals for ethics consultations also are important. For example, ethics consultations should address palliative care, both because it is desirable for its own sake and also because it may help resolve conflicts. Focusing on limiting inappropriate use of medical technology emphasizes what physicians will not do for the patient, rather than what they can do to palliate physical, psychosocial, and spiritual distress. Appropriate limits on life-sustaining technology may not be the most salient issue for some seriously ill patients, who may be concerned with relief of symptoms, preparation for death, achieving a sense of completion, and being treated as a whole person. Eliciting and responding to patient concerns may help establish common ground, while focusing on disagreements over life-sustaining interventions may polarize the situation further. Moreover, palliative care is essential because seriously ill patients who die in the hospital often experience considerable unrelieved pain and other symptoms in their final days. Effective palliative care can be provided in ICU settings, and detailed recommendations for doing so are available. Discussions of palliative care can be framed as “hoping for the best but planning for the worst” and can occur while life-sustaining interventions are continued in the ICU. Such discussions might align the medical team with the patient, explore emotions that often complicate patient and surrogate decisions about end-of-life care, and help reach a mutually acceptable plan for care. Although ethics and palliative care consultation services usually have different organizational structures, they should be closely coordinated.

Fourth, ethics consultations can help improve the quality of medical education. They may identify areas needing improvement, such as misunderstandings about clinical ethics or shortcomings in physician communication with patients and families. Moreover, an active ethics consultation service can offer hands-on training for residents and faculty members. Such training would likely engage learners actively, through addressing dilemmas in real cases. Also ethics consultations can teach physicians how to integrate different skills, including clarifying the clinical issues, analyzing bioethical issues, and communicating effectively. Finally, additional research can foster more effective education. Suggestions for resolving ethical conflicts at the end of life are often distilled from practical wisdom and theoretical models of patient-physician communication. Studies like that by Schneiderman et al offer the additional prospect of sound empirical evidence on what is effective in resolving ethical dilemmas.

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Raising the Passing Grade for Studies of Medical Education

Stephen J. Lurie, MD, PhD

Physicians spend much of their time listening and responding to patients' concerns. Studies have found, however, that clinicians' interpersonal skills are not always as good as their patients might wish. In response, several medical organizations have called for improved training and competence in communication skills. The Association of American Medical Colleges, for instance, has included “communication in medicine” as a central aspect of its Medical Schools Outcomes Project, which is intended to guide curricula in all US medical schools. Beginning in 2004, the National Board of Medical Examiners will require all US medical students to travel to a testing center for an evaluation of their clinical skills, including communication. The Accreditation Council for Graduate Medical Education now requires all US residency programs to provide instruction in “interpersonal and communication skills.” By the time this year’s class of entering medical students will have completed their residencies, they may find that their interpersonal skills will be subject to lifelong examination. In a recent address to the American Board of Medical Specialties (ABMS), Baird stated that “an expanded assessment of interpersonal and communication skills would be a useful new endeavor for ABMS.”

Given this broad consensus on the need to improve communications skills, the overall quality of the evidence for how to teach these and other aspects of professionalism is surprisingly poor. Much of this educational literature is not quantitative at all but, rather, comprises opinion pieces, anecdotal reports, and position articles. In their overview of professionalism curricula, Stephenson et al concluded that “Medical education is not short of excellent ideas about how to improve courses and create the professionals needed by society. What is in much shorter supply is evidence about the effectiveness of such teaching.” Goldie described a similar lack of suitable studies to evaluate the outcomes of ethics curricula for medical students. Thus, despite a broad consensus on the need for high-quality studies, little evidence exists to guide educators in how to design the best possible programs, or how to evaluate and improve them.

There are many inherent difficulties in conducting high-quality educational research. Perhaps the most immediate of these is a lack of money and time. Although society has an interest in training physicians who can communicate effectively, such curricula have limited market potential and thus may not compete favorably for corporate support. Grant monies are also limited. Even assuming a more favorable funding environment, a range of methodological obstacles would remain. Educational interventions and outcome measures are expensive and time consuming, and the best of these are always personalized to specific environments and learners. The resulting small sample sizes limit generalizability and statistical power.

Another problem is the difficulty in measuring outcomes that relate to the intent of education. Although better communication would ideally lead to improved patient outcomes, such clinical variables are quite problematic as measures of clinicians’ competence. In this issue of THE JOURNAL, Landon and colleagues describe the many limitations of clinical outcomes to assess physicians’ quality of care. The difficulties of clinical outcomes to assess educational interventions would add another layer of confounding, including problems with randomization, blinding, and contamination of the intervention. Taken together, these chal-

See also pp 1157 and 1183.

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