

Key Insights and Priorities for Evaluating the Effectiveness of Clinical Ethics Consultation

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Résumé de l'article

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CANADIAN
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In collaboration with / En collaboration avec

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Résumé

Lors du forum 2023 de la Société canadienne de bioéthique, 28 éthiciens praticiens des soins de santé et d'autres participants de tout le Canada, y compris des étudiants et des fellows en bioéthique, se sont réunis virtuellement pour un atelier collaboratif intitulé « Towards Evaluating Clinical Ethics Consultation Effectiveness: Engagement in a Scoping Review of Reported Outcomes ». L'atelier était ouvert à tous les membres de la communauté bioéthique qui s'étaient inscrits au forum, mais il était principalement destiné aux spécialistes en éthique clinique.

Mots-clés

consultation d'éthique clinique, résultats, recherche, professionnalisation

Abstract

During the 2023 Canadian Bioethics Society forum, 28 practicing healthcare ethicists (PHEs) and other attendees from across Canada, including bioethics students and fellows, gathered virtually for a collaborative workshop entitled "Towards Evaluating Clinical Ethics Consultation Effectiveness: Engagement in a Scoping Review of Reported Outcomes". The workshop was open to all members of the bioethics community who registered for the forum but was designed primarily for PHEs.

Keywords

clinical ethics consultation, outcomes, research, professionalization

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INTRODUCTION

During the workshop, attendees from healthcare institutions and ethics services nationwide engaged critically in discussion focused on the core outcomes and sub-themes identified in a recently published scoping review of reported outcomes in clinical ethics consultation (CEC) (1). The facilitators of the workshop included five of the authors of the review, which identified five primary outcomes of CEC: *quality*, *process factors*, *clinical factors*, *personal factors*, and *resource factors*. During large and small group discussions, workshop participants were prompted to consider the primary outcomes of CEC and were invited to reflect on the following questions:

- What do you believe to be the primary goals of CEC?
- What is a quality CEC and how do we know if it is effective?
- How do we know if CEC is doing a good or poor job of achieving its intended purpose?

Participants were asked to share any tools or methods they use at their organizations to evaluate CEC effectiveness.

The highly interactive discussion led to two key insights and three areas for further inquiry to support the overarching goal of professionalization of CEC (2). This work is currently being pursued by the Canadian Association of Practicing Healthcare Ethicists - Association canadienne des éthiciens en soins de santé (CAPHE-ACCESS) with the development of practice standards for the field and a code of ethics, and to advance research on CEC effectiveness.

KEY INSIGHT #1: GOOD PROCESSES LEAD TO GOOD OUTCOMES

In response to the prompt *How do we know if we're doing CEC well?* a theme that emerged from participant discussion was that good processes lead to good outcomes. Participants recognized that given the range of interpretations with respect to what constitutes a good CEC outcome, a focus on procedural considerations continues to be important to assessments of the value of CEC.

Transparency and fairness were highlighted as potential indicators of a good CEC process. Participants generally agreed that transparency can be achieved through detailed and accessible documentation and by fostering open communication throughout the CEC. An example of a transparent method of documentation was the provision of an ethics progress note in a patient's¹ health record that would be available to the patient and clinicians within their circle of care. Transparency can also be promoted by the ethics consultant's facilitation of open and respectful communication, for example, during family or clinical team meetings about the case.

Upholding a fair process was described as a way of ensuring that all parties with moral standing in a case are included in CEC as a matter of due diligence. Such parties can include, but are not limited to, patients, families, physicians, nursing staff, and social workers. Further, the principle of justice requires that particular attention is paid to equalizing power dynamics and encouraging all to have an opportunity to participate (3). This can be done by creating safe spaces during family meetings that encourage patients' and families' voices to be heard, or by mediating team discussions in a way that mitigates the effects of formal and informal hierarchies. Participants emphasized the importance of including and respecting all relevant perspectives during CEC as a way of building trust and maintaining open lines of communication; thus, the values of transparency and fairness overlap and reinforce one another.

KEY INSIGHT #2: QUALITY OVER QUANTITY: MEASURING THE VOLUME OF CEC REQUESTS

Despite an abundance of CEC literature evaluating the quality of CEC, which typically reports on the types of ethical issues and the volume of requests (4), participants acknowledged the limitations of using volume as a metric of CEC efficacy. They argued that empirical data do not necessarily reflect the subjective and nuanced nature of CEC including how it is accessed in clinical settings (and by whom), or the quality of the consultations themselves. As an alternative, participants suggested that the efficacy of an ethics service can be assessed by capturing indicators of the level of users' engagement with the service itself. For example, while CEC can formally be evaluated through surveys and other empirical tools, identifying the reasons why a particular department or clinical unit may have a low number of requests for ethics support may be harder to capture. One cannot easily evaluate the effectiveness of CEC if few or no consultations are requested. Yet, as our workshop participants suggested, the reasons for a lack of consultation requests can be valuable information: they may, for example, be due to a lack of awareness about ethics programs, clinician resistance to engage with ethics, or a perception that CEC is too time-consuming.

The need to demonstrate the value of CEC within health care institutions is ever present, but increasingly ethics programs are required to report their activities to institutional leaders in ways that allow quantification and comparison with other services (1). While PHEs representing various ethics services across the country reported various methods of CEC measurement, participants shared a common struggle with the interpretation of data. Efforts to engage in strategic planning exercises and quality improvement initiatives, however, present opportunities to overcome this challenge by leveraging the insights generated by CEC evaluation.

By using the data collected from CEC effectiveness measurements to inform strategic planning initiatives within healthcare institutions, hospital leaders can leverage opportunities to enhance their strategic planning exercises. For example, collecting data about which clinical units use ethics resources most frequently may yield insights about the composition of the patient population and its needs, and can therefore highlight institution-specific imperatives that policy development or revision might address. Early indications are that such uses of CEC data have the potential to increase stakeholder awareness of ethics services and the ethical dimensions of healthcare delivery by allowing for targeted interventions to build ethics capacity. Consequently, the shift to use CEC evaluation data to inform strategic planning and quality improvement initiatives may contribute to stronger and better supported ethics services, and to more equitable and inclusive provision of care.

OPPORTUNITIES FOR FURTHER INQUIRY

Pursuing standardization of CEC

CEC evaluation research requires not only achieving consensus on the relevant outcomes of CEC, but also standardization of key elements and process measures of ethics services nationwide to allow meaningful comparison across programs. Such key elements could include trained bioethicists, while process measures often refer to the quality of procedures associated with an ethics consult. CAPHE-ACESS, Canada's national association pursuing professionalization, is addressing the former. One of the organization's current initiatives is to develop standards of practice which may provide a framework for standardization of CEC (5). However, while this important work is ongoing, further engagement with the aim of developing a set of core outcomes for CEC evaluation would be helpful to move the field forward by reaching consensus on the most important outcomes and measures (1). Preliminary observations from this workshop reveal, for example, that moral distress ought to be engaged more explicitly in CEC evaluation through proactive exploration of the conditions associated with potentially morally injurious events. It was also argued that core outcomes related to equity, diversity, inclusion, and accessibility ought to be explored in greater depth. Equitable access to care and resources (including access to CEC), cultural safety, anti-racism, and anti-discrimination were further identified as subthemes and will require discussions regarding their working definitions and measurement (6).

¹ Throughout this paper, the term "patient" can be interchanged with "resident", "client" or anyone who is receiving health care.

Establishing a set of core outcomes for CEC evaluation research

Reaching widespread consensus on a set of core outcomes in CEC was validated as a worthwhile objective by workshop attendees. However, potential for disagreement surfaced with respect to the relative importance of specific outcomes as compared to others. This calls into question whether consensus can readily be reached. In the literature, arguments have been made for the integration of trauma-informed care (TIC) approaches in CEC that minimize the risk for retraumatization in patients in positions of vulnerability, with an attendant focus on outcomes related to inclusion, transparency, and collaboration with parties affected by decision-making (7). Other scholars have called for an ethics of care approach in CEC, which would prioritize attention to relationships and enhance empathetic involvement as outcomes of effective consultation (8). Participants in this workshop stressed the importance of integrating outcomes of this nature into efforts to evaluate CEC effectiveness but were unable to agree on whether these ought to be prioritized over other relevant outcomes, such as addressing moral distress or responding to the call to increase equity, diversity, inclusion, and accessibility. Discrepancies with respect to what ought to be classified as specific outcomes of CEC, or how those outcomes might be prioritized, are likely to arise due to the heterogeneous nature and varied contexts of ethics services across the country. This variability may, in turn, affect judgements concerning the relative value of particular outcomes. With each institution having its own perspective on the contextual significance of specific core outcomes relative to others in CEC evaluation, consensus must also be reached on how to prioritize these outcomes in response to the movement toward standardization.

Establishing an active community of practice

An online community member resource area, potentially hosted within CAPHE-ACCESS's website, was identified as an area of support that would be welcomed by the community of PHEs present at this workshop. This type of resource was described as particularly desirable for those practicing as independent or solo consultants. It was suggested that this could enable discussion with respect to challenging issues and provide a venue for sharing measurement tools, which could contribute to the development of more rigorous and valid instruments (9). A constructive and collaborative community space for PHEs may help to respond to yet another concern raised during the workshop; that is, the lack of guidance or information on the data collected by independent ethics consultants (i.e., those not employed by a hospital or healthcare institution). A community of practice network was proposed as a possible forum for such resource sharing, and it was noted that it could be populated with aggregated, anonymized, data that could subsequently be tailored to meet the specific needs of various types of organizations and ethics practices. Data such as the nature of an ethical issue and the role of the requestor is typically collected and stored in internal databases across the country, but other measures vary considerably (10). PHEs from nearly every institution represented at this workshop expressed a desire to share findings from CEC measurement more broadly in order to learn from one another and to improve the quality of ethics services through increased research and evaluation. Bioethics grand rounds were also proposed as a way to share insights and provide education, and it was suggested that PHEs may benefit from enhanced collaboration between institutions in order to promote resource-sharing on a broader scale. By creating a community member resource area through either of these methods, a repository for data collection related to CEC could be made more accessible and enable it to be more consistently used for research and evaluation. This would be a boon to non-research focused ethicists and stakeholders Canada-wide.

CONCLUSION

Overall, the discussion facilitated during this workshop generated promising insights and opportunities for progress in the evaluation of CEC effectiveness. Given increased calls for standardization within the field of bioethics, findings from this workshop can be used as a renewed starting point for establishing consistency in the evaluation of CEC. Further research exploring ethicist, patient, community member, clinician, and healthcare leader perspectives on CEC evaluation, as well as consensus-building activities for determining core outcomes of CEC, can provide opportunities for exploring appropriate methods of evaluating CEC. As the field of bioethics continues to evolve, it is clear that ethicists and non-ethicist partners across the country can contribute valuable insights concerning how to move the field forward in the most productive, efficient, inclusive, equitable, and, indeed, ethical way possible.

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REFERENCES

1. Bell JA, Salis M, Tong E, et al. [Clinical ethics consultations: a scoping review of reported outcomes](#). BMC Medical Ethics. 2022;23:99.
2. Simpson C. [Getting engaged: Exploring professionalization in Canada: Introduction to this Issue](#). HEC forum 2012;24(3):149-51.
3. Rogers W, Mackenzie C, Dodds S. [Why bioethics needs a concept of vulnerability](#). International Journal of Feminist Approaches to Bioethics. 2012;5(2):11-38.
4. Glover AC, Cunningham TV, Sterling EW, Lesandrini J. [How much volume should healthcare ethics consult services have?](#) Journal of Clinical Ethics. 2020 1;31(2):158-72.
5. Hartman L, Van Baarle E, Diepeveen M, Widdershoven G, Molewijk B. [Quality characteristics for clinical ethics support in the Netherlands](#). AJOB Empirical Bioethics. 2022;13(1):22-32.
6. Olszewski AE, Zhou C, Ugale J, Ramos J, Patneaud A, Opel DJ. [Disparities in clinical ethics consultation among hospitalized children: a case-control study](#). The Journal of Pediatrics. 2023;258:113415.
7. Lanphier E. [Trust, transparency, and trauma informed care](#). The American Journal of Bioethics. 2021;21(5):38-40.
8. Schuchter P, Heller A. [The care dialog: the "ethics of care" approach and its importance for clinical ethics consultation](#). Medicine, Health Care and Philosophy. 2018;21(1):51-62.
9. Cho MK, Taylor H, McCormick JB, et al. [Building a central repository for research ethics consultation data: a proposal for a standard data collection tool](#). Clinical and translational science. 2015;8(4):376-87.
10. Godkin MD, Faith K, Upshur RE, MacRae SK, Tracy CS. [Project examining effectiveness in clinical ethics \(PEECE\): phase 1—descriptive analysis of nine clinical ethics services](#). Journal of Medical Ethics. 2005;31(9):505-12.