Taking the burden off: a study of the quality of ethics consultation in the time of COVID-19

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ABSTRACT

Background The quality of ethics consults is notoriously difficult to measure. Survey-based assessments cannot capture nuances of consultations. To address this gap, we conducted interviews with health professionals who requested ethics consults during the initial phase of the COVID-19 pandemic.

Method Healthcare professionals requesting ethics consultation between March 2020 and May 2020 at a tertiary academic medical centre were eligible to participate. We asked participants to comment on the consults they called and thematically analysed responses to identify features associated with optimal quality consultations.

Results Of 14 healthcare providers, 8 (57%) were women and professions were as follows: 11 (79%) medical doctors, 1 (7%) social worker, 1 (7%) physician assistant and 1 (7%) nurse practitioner. Two aspects of quality emerged: satisfaction and value. Themes within the domain of satisfaction included: responsiveness of the ethics consultant, willingness to consult, institutional role of the ethics service and identifying areas for improvement. When describing value, respondents spoke of the intrapersonal and interpersonal worth of consultation.

Conclusion Participants were generally satisfied with ethics consultation services, similar to opinions of those found in pre-COVID-19 survey studies. Our qualitative approach allowed for a richer exploration of the value of ethics consultation during the pandemic and has implications for ethics consultation services more broadly. Ethics consultation—emphasising both the process and outcome—created valuable moral spaces, promoting thoughtful and ethical responses to dilemmas in patient care. Future assessments should incorporate patient and family/surrogate perspectives and explore the domain of education as an additional quality measure.

INTRODUCTION

The COVID-19 pandemic has challenged policymakers, healthcare providers and healthcare institutions to address ethical dilemmas arising amidst crisis. In the context of the initial phases of the pandemic, clinical ethicists have been called on to develop health system policies and to resolve moral and practical dilemmas at the bedside. The contributions that clinical ethics consultants provide during the pandemic make imperative the need to assess the quality of ethics consultants, an area that has not been well studied.

METHODS

We interviewed healthcare professionals who were involved in an ethics consult between 11 March 2020 and 6 May 2020 at Michigan Medicine. This time frame corresponds with the first COVID-19 peak of admissions (227 inpatients) and on to the period when cases began to first decline. Interview data were collected between May 2020 and July 2020. While the interviews focused on several dimensions of the consult, we used an inductive, thematic approach to examine respondents’ comments related to the quality of the consultation. Our clinical ethics consult model is well established and uses small teams of funded faculty
Within a qualitative research paradigm, inductive analysis is used to illuminate the nature of a specific phenomenon occurring within the social world. Sample size in thematic analysis must then be sufficient to explore the features of the phenomenon under study—not to describe proportional relationships but to produce robust, patterned and coherent themes that emerge from the data, and explain why those features are the way they are. Fourteen interviews representing a range of healthcare professionals and consultation reasons provided rich enough to explore the features of the phenomenon under study and produce themes that were considered robust, patterned and coherent. The study design, collection, analysis and results as reported in this study follow the Standards for Reporting Qualitative Research framework.

### RESULTS

The fourteen healthcare providers (Table 1) represented 14 distinct ethics consultation (Table 2).

We identified two overarching domains related to the quality of ethics consultation: satisfaction and value. The themes within these domains were found across all healthcare professions and consultation types. We illustrate these themes using participant voices followed by unique numerical identifiers, P1–P14, (on-line supplemental material 2) that correspond with cases 1–14 (Table 2). In order to preserve anonymity, we do not distinguish by profession type.

#### Satisfaction

Participants spoke about their satisfaction with the ethics consultation process, which, for them, meant the degree to which the ethics service met their expectations and needs. Within this domain, several themes emerged: responsiveness of the ethics consultant, willingness to consult, institutional role of the ethics service and identifying areas for improvement.

#### Responsiveness of the ethics consultant

For 5 of our 14 participants, the consult was their first experience consulting the clinical ethics service. In general, participants felt that the ethics consultant was respectful, responsive, accessible and approachable. Further, the amount of time spent by the ethicist on the consultation was deemed sufficient to help the healthcare professional address the ethical concern.

#### Willingness to consult

All 14 respondents indicated that they were willing to consult the clinical ethics service again. This willingness was not just the result of the participants’ positive experience but also from their acknowledgement that complex ethical situations require deliberation with, and by, trained ethicists and are labour-intensive, involving multiple viewpoints. Participants stated that there is no formula or easily applied ‘guideline’ for resolving ethical problems, and that the clinical ethics service fills a gap in care and knowledge that otherwise would not be filled. As one respondent noted, there are ‘pretty clear’ guidelines for treating atrial fibrillation but there are no guidelines for resolving an intractable ethical dilemma.

While participants expressed their willingness to consult the ethics service again, they differed on the timing of when they would make requests in the future. While several respondents said they would call the ethics service earlier, a few stated they would prefer to consult only after all other options for addressing the issue had been exhausted. For example, one participant with

### Table 1 Participant demographics

| Participants | Gender | Profession |
|--------------|--------|------------|
| Age (years)  | 32 (26–41) | 11 (79)  |
| Female       | 8 (57)  | 1 (7) |
| Medical doctor | 11 (79) | 1 (7) |
| Social work | 1 (7) |
| Physician assistant | 1 (7) |
| Nurse practitioner | 1 (7) |
| Trainee | 9 (64) | 3 (1–7) |

### Data collection

An interview guide was iteratively developed by the study team. Our questions were based on a review of published surveys and normative literature discussing quality assessment and satisfaction in ethics consultation. Interviews were conversational in style, following prompts from the interview guide (online supplemental material 1). All interviews were conducted virtually via Zoom by author 1 who was not directly involved in the ethics consultation. The interviews were audio recorded and professionally transcribed. Identifying information was redacted from the interviews prior to analysis. Demographic data were self-reported by each participant (Table 1). The average interview length was 21 min (range: 12–36 min).

### Data analysis

Transcripts were coded using an inductive, reflexive, thematic analysis approach. Initial codes were developed by author 1 and author 4, and codes and themes were generated in discussion with all authors, all of whom have experience with ethics consultation. NVivo V.12 was used to organise and code the data. NVivo V.12 was used to organise and code the data. Identifying information was redacted. NVivo V.12 was used to organise and code the data. The average interview length was 21 min (range: 12–36 min).

#### Ethics consultants, all of whom meet healthcare ethics consultation criteria; further details about the clinical ethics consultation service are described elsewhere.

### Sample

Healthcare professionals (ie, physicians, nurses, social workers and so on) who requested a formal ethics consultation at Michigan Medicine, a large, tertiary care academic medical centre, between March 2020 and May 2020 (n=26) were eligible to participate. Two members of the study team (author 1 and author 2), invited 26 eligible healthcare professionals to participate in the study via email. Fourteen healthcare professionals agreed to participate: 1 declined and 11 did not respond. Profession and ethics consultation types were similar between respondents and non-respondents. Participation was voluntary. All interviews and transcripts were confidential.

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#### Data analysis

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### Tables

**Table 1** Participant demographics

| Participants n (%) or mean (range) |
|-----------------------------------|
| Age (years)                       | 32 (26–41) |
| Gender                            |           |
| Female                            | 8 (57)    |
| Profession                        |           |
| Medical doctor                    | 11 (79)   |
| Social work                       | 1 (7)     |
| Physician assistant               | 1 (7)     |
| Nurse practitioner                | 1 (7)     |
| Trainee                           | 9 (64)    |
| Time in current position (years)  | 3 (1–7)   |
numerous prior experiences with the ethics service had a lower threshold for placing an ethics consult.

Most participants expressed feeling comfortable with the outcome of the ethics consult. Even with a poor clinical outcome, the ethics consult served to empower clinical and ethical decision-making, promote patient safety, honour patient wishes, and facilitate team communication and cohesion.

In the context of COVID-19, there were a few participants who looked to the ethics consultant to help resolve personal uneasiness with the tension between public health ethics and patient-centred ethics. Troubled by the visitor restrictions imposed by the COVID-19 pandemic, the ethics consult was helpful in clarifying institutional policies that prioritised public health and safety over individual patient preferences. In this situation, the ethics consult provided acknowledgement of the tension and facilitated understanding and acceptance on behalf of the healthcare team in the midst of an objectively hard situation, helping the team address issues related to code status, non-sustaining treatment, medical uncertainty and family–provider disagreements.

Intrapersonal worth of ethics consultation
Participants described the value of ethical consultations in terms of the ‘moral space’ they created, allowing for reflection, analysis, negotiation and the processing of ethical problems. Within this domain, two themes emerged: the intrapersonal and interpersonal worth of ethics consultation. On the intrapersonal level, the ethics consult created a moral space that allowed participants to respond to the emotional, cognitive and behavioural demands presented by the ethical problem; on the interpersonal level, consults allowed participants to respond to other parties involved in the ethical question including patients, family members and team members.

Intrapersonal worth of ethics consultation
We found three subthemes of intrapersonal worth: emotional, cognitive and behavioural. Although we present these subthemes individually, it is important to note that they do not present in a linear or distinct fashion but co-occur and interact with one another.

| Participant | Primary reason for consult | Secondary reason for consult | Contextual issues |
|-------------|---------------------------|-----------------------------|------------------|
| 1           | Other (visitor policy)    | None                        | Other (parental/family coping) |
| 2           | DNR                       | None                        | Other (logistic delays) |
| 3           | Confidentiality           | None                        | Cultural/ethnic/religious; physician attitude toward treatment |
| 4           | DNR                       | None                        | Other (logistic delays) |
| 5           | Futility                  | Withdrawal or withholding artificial N&H | Staff–family communication dispute/conflict; staff–patient communication dispute/conflict |
| 6           | Surrogate decision-making | Withdrawal of other life-sustaining therapy | Staff–family communication dispute/conflict |
| 7           | Withdrawal of other life-sustaining therapy | Transplant issues | Intrafacility communication dispute/conflict; quality of life; staff–family communication dispute/conflict |
| 8           | Other (visitor policy)    | None                        | Other (parental/family coping) |
| 9           | DNR                       | Surrogate decision-making   | Other (parental/family coping); staff–family communication dispute/conflict |
| 10          | Other (visitor policy)    | None                        | Other (parental/family coping) |
| 11          | Refusal of recommended treatment | Discharge/placement | Staff–patient communication dispute/conflict |
| 12          | Refusal of recommended treatment | Isolated incapacitated patient | Staff–patient communication dispute/conflict |
| 13          | DNR                       | Isolated incapacitated patient | None |
| 14          | Surrogate decision-making | Advance directive | Staff–family communication dispute/conflict |

Adapted according to Nilson et al’s classification schema for ethics consultations. DNR, do not resuscitate; N&H, nutrition and hydration.
Emotional
Many participants described experiencing emotional distress attributed to a myriad of factors, including medical uncertainty due to severity of prognosis (for patients with or without COVID-19), logistical barriers imposed by the pandemic context that compounded the difficulty of promoting a patient’s best interest, and the inability of the team to respect a patient’s autonomy and/or meet the obligations of beneficence and non-maleficence. In these emotionally charged situations, the ethics consult served as a space for reflection on how to help participants process, cope with and alleviate emotional distress. Respondents acknowledged the gravity of the ethical issues at hand and the consult process was seen to provide a thorough assessment of the case. Participants also expressed that conversations with the ethicist served as a moral affirmation that the care that they were providing was ethically sound and justifiable. Furthermore, a few reported that the act of partnering with the ethicist throughout the consult helped lighten their emotional load and the weight of responsibility they carried for the case, making it easier to bear. It allowed the healthcare team to feel that they were sharing the moral space with the ethicist.

Cognitive
By providing a space to talk through challenging cases with the ethicist, participants expressed how the ethics consult was beneficial in helping to organise one’s thoughts and clarify points of medical and ethical uncertainty, such as with logistics and practicality of the situation. Participants mentioned that the ethics consult assisted with the cognitive processing needed for decision-making when facing ethically challenging cases. In other words, the consult offered an opportunity to ‘slow down’ in an otherwise fast-paced setting to confirm inclinations about the right course of action.

Behavioural
For some participants, the ethics consult empowered participants to act in accordance with ethically justifiable principles. For example, the ethics consult helped participants find a way to act that was consistent with their professional integrity, personal values, and aligned with professional codes of ethics that defined what it means to be a ‘good’ doctor, nurse or social worker. During cases of uncertainty, some participants even noted how the ethics consult facilitated a better understanding of their roles as providers. While a few participants believed that the ethics consult did not lead to changes in behaviour, for others, the recommendations from the ethics consults translated into actions that honoured patient wishes and best interests, prevented non-beneficial treatment or harmful care, and ensured that care was provided in a compassionate manner.

Furthermore, the role of bias was acknowledged by a few participants in their own decision-making as well as in others. Additionally, one participant stated their increased level of confidence in handling a difficult situation as a result of the consult. Furthermore, a few reported that the act of partnering with the ethicist throughout the consult helped lighten their emotional load and the weight of responsibility they carried for the case, making it easier to bear. It allowed the healthcare team to feel that they were sharing the moral space with the ethicist.

Interpersonal worth of ethics consultation
Ethics consults generally had a positive impact on relationships with patients and other providers. In some situations, relationships did not change and in others, the consult helped ease tense or fractious relationships. For some respondents, the ethics consult was seen as an opportunity to showcase to families and team members the time and effort invested in a case, causing a positive ripple effect that provided reassurance and emotional relief and making the attention given to the situation more apparent. On the patient side, one participant believed the ethics consult was valuable in helping a patient process information to ultimately enhance communication with their spouse.

DISCUSSION
Our qualitative assessment enriches our understanding of the measure and meaning of quality in clinical ethics consultation not only during the nascent phase of the COVID-19 pandemic but also more generally, having implications for clinical ethics services that extend far beyond the pandemic. Similar to survey-based assessment of ethics consults, we found that providers were, for the most part, satisfied with the structure, process and resolution of the dilemma that generated the consult. Unlike quantitative measures of satisfaction, which are inherently ‘thin’,27 our in-depth exploration of the consult process offers rich insights into the value of ethics consultation. For example, providers told us that ethics consults created moral space, allowing them to slow down and reflect on the many dimensions of presenting dilemma. Such reflective ‘moral spaces’ are necessary to help clinicians communicate values and ethical obligations in clinical practice, which are key components necessary for effective, collaborative ethical deliberation, negotiation and analysis about what is the right course of action.21 In such spaces, relationships are based on respect and those within the space feel free to explore the emotionally charged issues that arise when grappling with an ethical dilemma. Family and team meetings, as well as Schwartz rounds or debriefing sessions to address distress following difficult patient care events, also offer the possibility of creating moral spaces for ethical analysis.21 Our data demonstrate how our ethics consultation service was successful in creating such a moral space by helping to reconcile, address, and integrate the emotional, cognitive, behavioural and interpersonal components of ethical concerns. That this space was created during the height of the COVID-19 pandemic speaks to the value and importance of the service that was provided during this time, as well as the role of ethics consultation more broadly beyond the pandemic era.

The creation of moral spaces demonstrates that not only the outcome of the ethics consultation but also the process of participating in one are equally important, and thus the value of the consult extends beyond simply the resolution of the ethical dilemma.21 Typically, ethicality in ethics consultation has been conceptualised as the degree to which consultation recommendations and clinical practices are consistent with established ethical standards.21 However, there is ongoing debate about the
ability to empirically assess ethicality. The pluralistic values of stakeholders involved and the complexity of ethical issues in the clinical setting mean that seldom is there an agreed on set of ethical standards—or, even if there are agreed on ethical standards, consultation arises precisely because the application of the standards is unclear or problematic in the given situation. Given these factors, ethicality may be more readily captured qualitatively through assessing the ways in which the ethics consultation helped stakeholders uphold their own professional and personal values and facilitated communication and collaboration through a deliberative process. We learnt, for example, that team unity was accomplished through facilitated group deliberations that fostered a mutual understanding of, and an ethically justifiable resolution to, the case. As such, our data will inform future studies—both quantitative and qualitative—supporting the incorporation of the personal and organisational components that appear to be integral when assessing quality of ethics consultations. When asked, all participants expressed willingness to consult the ethics service in the future, but some did tell us that calling an ethics consult was seen as potentially stigmatising. This concern has been mentioned by others and can serve as a learning point for ethics services, encouraging them to de-stigmatise and destigmatising their role and process. Furthermore, several participants stated their desire to consult the ethics service more 'upstream'—that is, sooner—suggesting the need for proactive consultation. In that regard, interprofessional ethics rounds, that ‘upstream’—that is, sooner—suggesting the need for proactive participants stated their desire to consult the ethics service more service, similar to opinions of those found in pre-

CONCLUSION

We acknowledge the inherent limitations to our study. Given a modest sample in a single institution in the midst of a pandemic, our findings may not be generalisable to routine ethics consultation services. However, given the breadth of consult questions that arose during this time period in our study, the COVID-19 pandemic appeared to serve as a contextual feature rather than one that imposed distinct ethical problems. Replicating this study post-pandemic will determine if our findings are (or are not) specific to the COVID-19 era. We are also aware of bias on data interpretation and analysis, however, through reflexivity and acknowledgement of our personal influences on the data, we believe this has been mitigated. Future research could include exploring patient and/or surrogate perspectives of quality of ethics consultation; using a qualitative approach would be beneficial to garner rich data about this relational phenomenon. Further, examining the domain of education as another quality measure of ethics consultation practices is also of interest.

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