

Leading Ethical Decision-Making: Clinical Ethics Services in Australia

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Abstract

Decision-making in healthcare demands consideration of not only the clinical, operational or financial aspects of care but increasingly complex ethical issues. Meeting the physical and emotional needs of patients ethically, while acknowledging the distress and conflicting expectations and needs of staff, can be extremely difficult for all involved. It is vital that staff be provided with a 'safe space' to speak of the ethical challenges they are encountering if we are to take staff safety as seriously as we take patient safety. A Clinical Ethics Service (CES) established in accordance with the recently released National Health and Medical Research Council (NHMRC) consensus statement and the *NHMRC Clinical Ethics Resource Manual* can provide such a space.

This paper explores the who, what and why questions embedded in ethical decision-making. The work of a

CES will be outlined. Drawing of the Roger L Martin's concept of heroic leadership, stakeholder roles and moral orientations will also be explored. In addition, the often unspoken attitudes towards certain patients, 'likeable' and 'unlikeable' for instance, which threaten to influence views of 'worthiness' of care will also be explored.

Abbreviations: ACHS – Australian Council on Health Standards; CEC – Clinical Ethics Committee; CES – Clinical Ethics Service; NHMRC – National Health and Medical Research Council; SDM – Substitute Decision Maker.

Key words: clinical ethics services; ethical decision-making; staff safety.

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Introduction

Decision-making in healthcare demands consideration of not only the clinical, operational or financial aspects of care but increasingly, complex ethical issues demand our attention. Meeting the physical and emotional needs of patients, while acknowledging the distress and conflicting expectations and needs of staff, can be extremely difficult for all involved. Everyone, including leaders, need aware-

ness of their own values and beliefs as these largely drive expectations and behaviour when faced with such ethical decisions. [1] Importantly, as our values and beliefs can also impinge upon our ability to hear and understand opposing views, it is equally critical to understand and challenge the values and beliefs of other stakeholders, including organisations, and the culture in which they are entrenched, if full appreciation of any situation is to be gained. In addition, often unspoken attitudes towards certain patients, such as 'likeable' and 'unlikeable' for instance, threaten to influence views of 'worthiness' of care. It is vital that staff be provided with a 'safe space' to speak of the ethical challenges they are encountering if we are to take staff safety as seriously as we take patient safety. A Clinical Ethics Service (CES) established in accordance with the recently released National Health and Medical Research Council (NHMRC) consensus statement [2] can provide such a space. The accompanying *NHMRC Clinical Ethics Capacity Building Resource Manual* [3] provides a useful resource for organisations wishing to establish such a service.

This paper explores the role of a CES in assisting staff, who in turn support patients, by identifying and addressing issues such as moral distress, [4,5] compassion fatigue [6,-9] counter-transference, [10,11] understanding futility, patient vulnerability and autonomy, and the challenges these issues raise in ensuring the best ongoing care of all patients regardless if they are like us or not. It draws on the operationalisation aspects of a CES situated in a large Australian tertiary hospital in order to highlight the capacity building, practical support and ethical guidance such a service offers to both the practitioners and leaders of a healthcare institution. This service was established in 2008 and has assisted well over 700 staff per year with capacity building opportunities through small and large groups continuing professional development initiatives. In terms of providing practical support to clinicians, this service has assisted clinicians and executive directors at least once per month since its establishment. While the service has not yet undergone a specific evaluation/validation process, through its accreditation and credentialing processes, the hospital has been noted for having exemplary practice in terms of the provision of resources to assist and guide clinicians in their ethical challenges and associated complex decision-making practices. Of note, the CES also contributes to the hospitals Australian Council on Health Standards (ACHS) Equip National accreditation contributing to staff and patient safety (Standard 1 – Governance for Safety and Quality), and Standard 15 (Systems and Delegation 15.6 – Ensuring governing body involvement throughout the ethical decision-making process). [12]

What is a Clinical Ethics Service?

While clinicians are generally very skilful at sensitively and effectively navigating the ethical issues arising in care, the plurality of moral views in our increasingly heterogeneous society has given impetus to the establishment of clinical ethics services within Australia to provide an additional layer of support. [13] Technology use, and the inherent complexities this brings, has also cast a more focused lens on the ethical challenges of clinical care. [12] Some hospital accreditation processes in Australia, such as the ACHS, further acknowledge the role of embedded clinical ethics services in improving governance and decision-making in healthcare. [13] Currently in Australia there is no formal structuring, coordination or professionalisation of CESs. The approach generally adopted by existing Australian services therefore largely aligns with that advocated by the American Medical Association:

[CES] is educational and advisory in purpose. Generally, the function of the ethics committee should be to consider and assist in resolving unusual, complicated ethical problems involving issues that affect the care and treatment of patients within the health care institution. Recommendations of the ethics committee should impose no obligation for acceptance on the part of the institution, its governing board, medical staff, attending physicians, or other persons. However, it should be expected that the recommendations of a dedicated ethics committee will receive serious consideration by decision makers. [12, p.151]

Kerridge, Lowe and Stewart note that the assistance of a CES may be sought in cases 'where the goals or outcomes of care are interpreted differently by different individuals and where conflict arises due to explicit moral or philosophical disagreement'. [12, p.151]

The service of which the lead author is the coordinator has primarily adopted the approach outlined above. The main functions of the service are threefold:

1. to assist staff build capacity by means of providing educational opportunities;
2. to provide practical support to clinicians by means of ethics consultation; and
3. to support and guide the ethical climate of the organisation by means of policy review and development.

While there are many different models and structures in the way CESs can be set up, in our case, the CES is coordinated by a Clinical Ethicist, who performs these functions with the support of a Clinical Ethics Committee (CEC).

What does the Clinical Ethics Service do?

• 'Identifying the ethical aspects in the case' and 'getting the facts'

In general terms, a Clinical Ethicist initially adopts a 'problem finding' approach when called upon to guide and support clinicians navigate their way through a conflicting or challenging case situation. Some authors refer to this process as the first two steps of the CES process, i.e. 'identify the ethical problem' and 'get the facts'. [12, p.140] Such problem finding starts with who, what, why questions. For example, who are the stakeholders involved in this particular case? What values do these stakeholders hold? What triggered this requested change in treatment pathway? Was it prompted by a felt ethical conflict? If so, why has this conflict arisen at this particular time?

• **Stakeholder perspectives: exploring the who, what, why questions in this case.**

Whenever a case is referred to a CES or a CEC, the primary stakeholder should be readily recognised as the patient and his/her supportive carers. In respecting the principle of autonomy, due consideration must be given to the patient's right to autonomy and capacity to participate in discussions about her/his healthcare and capacity to provide informed consent. If such capacity is not deemed to be present, then the hierarchy of decision-making should be invoked with the patient's substitute decision maker (SDM) having the right to make decisions regarding care and treatment options. If no SDM is available then referral to the Public or Adult Guardian would be the next appropriate step to ensure that decisions made are respectful of the patient's autonomy and in his/her best interests.

The attending team – which, in complex situations, is likely to consist of practitioners from multiple medical disciplines and practices such as nursing, allied health etc – are also stakeholders. Therefore, their ethical orientations and values must also be considered. A primary value and ethical orientation of these stakeholders, and the general community, is the sanctity of human life and the protection of such. Daniel Callahan defines such an ethic as one built on the principle that *'every being that can biologically be justifiably described as human, and who has done no wrong, ought to have its life protected.'* [14, p.18] Callahan further contends this principle 'is fully compatible with the stopping of medical treatment when it will do the patient no further good'. [14, p.18] When practical support by means of an Ethics Consultation is sought, tension or distress, which arises from differing philosophical or moral positions or as a result of goals and outcomes being interpreted differently, is often present, as noted earlier. [12] For instance, in cases associated with the question of futile treatment, clinicians will likely be experiencing an ethical tension between the sanctity of life and the requested/desired treatment. However, consideration must primarily be given to the extent to which practitioners may feel funnelled towards a conclusion of futility when they are unable to reconcile their ethical and moral orientations must also be considered. Framing a situation as 'futile' may have been a professionally tolerable 'way out', a circuit breaker to an untenable and deeply distressing situation.

Both the hospital (represented by the executive team) and the broader community (in the form of other and future patients) are also stakeholders. Healthcare resources in Australia are finite, and although public funding may create

cultural expectations about 'free' and unlimited healthcare, all treatment cannot reasonably be made available to all patients at all times. Health managers, charged with the ethical responsibility of 'just' allocation of these finite resources in the broader interests of the community, may understandably seek to question the ongoing cost and opportunity cost, inherent within this ongoing cycle of care with apparently limited benefit. Uncomfortable as it is to acknowledge, resource allocation is unavoidably an ethical issue. [7]

• **Understanding stakeholder roles and moral orientations**

Our assumptions or attitudes about groups of people may subtly shape how we believe we should provide care for them...the attitudes of healthcare providers may not reflect the patient's reality and may affect the care provided [16, p.38]

Vulnerability is an inherent feature of being human – each and every one of us is at risk of *'physical, psychological, or emotional harm'*. [16, p.37] In navigating our way through such vulnerability it is widely acknowledged that we draw on shared cultural understandings that often consist of familiar, readily understood patterns or stories. [17,18] Despite the increasing attention given to the patient's voice, practitioners often see themselves as 'fully' responsible for their patients' welfare – they see themselves as 'heroic leaders' [19] in the recovery and/or rehabilitation of their patients. Through such 'heroic' behaviour they are frequently positioned (by themselves and others) as *superheroes or rescuers*. Patients, on the other hand, may be typically characterised as passive recipients of care, who are either *'good/worthy'* i.e. likeable, compliant and thankful, or *'difficult/unworthy'* i.e. unlikeable, aggressive, non-compliant or ungrateful. [20,21] Such positioning of practitioners and the dichotomous stereotyping of patients is both supported by and supports the 'unwritten rules of healthcare': 'the guiding values'. [19, p.9] Closely associated with such apportioning of perceived responsibility positioning of practitioners and patients is the ever present cycle of over-responsibility and under-responsibility. [19]

Roger L Martin contends that relationships are vulnerable to *'the Responsibility Virus'*; a phenomenon *'by which parties vacillate unproductively between heroic leadership and passive followership'* with a cycle of over-responsibility and under-responsibility ever present. [19, p.4] In positioning clinical staff in the role of superhero or rescuer, the burden of over-responsibility is taken up by, or placed upon them. Consequently, in positioning the patient as passive follower/recipient an expectation of under-responsibility is present.

[19] The Responsibility Virus is recognised as being driven by a fear of failure that results in the 'responsible' party claiming a disproportionate share of power. Inevitably, as the burden becomes too great, both parties enter a continually vacillating 'cycle of over/under responsibility'. [19, p.8] Drawing on the work of others, Martin contends that 'governing values' or 'rules' guide the way we interpret and deal with our world. [19, p.9] Like the dominant narratives we are embedded in, we are largely unaware of these 'rules' or 'values' until a disruption highlights that we have become out of sync both in terms of the expected narrative, and our expected roles within.

As noted earlier, an ethics consultation is often sought 'where the goals or outcomes of care are interpreted differently by different individuals and where conflict arises due to explicit moral or philosophical disagreement'. [12, p.151] In providing practical support, the role of the clinical ethicist is to pose questions that help tease out our own and others' moral orientations which may, in turn, 'provoke or demand a complex range of practical responses'. [22, p.2] Questions such as 'is the patient a "likeable" or "unlikeable" patient? Does she/he provoke in us a sense of allegiance, or a core value such as justice or as a desire to help? Or does she/he trigger feelings of dislike and distrust?'. Such questions are inherently important as the 'likeable' patient – the good/compliant patient – is often seen as more worthy of time and attention as 'compliance is not only assumed to be in patients' best interests, but is also equated with a "social good"'. [20, p.282] The 'unlikeable' patient – the patient who challenges, refuses or resists – on the other hand, often has her/his behaviour labelled as 'irrational' and 'deviant'. [21, p.306] Such patients are typically 'viewed as hindering the "normal" process and practice of health care' [21, pp.306-307] and therefore 'unworthy' of our time and attention. In making unfounded judgements, avoiding such patients or labelling them as difficult or troublesome, staff are at risk of violating professional boundaries. With the help of a CES, staff can be supported to recognise their own motivations, values and expectations as 'internal reactions need to be attended to, understood, and in one way or another, managed'. [15, p.411] Acknowledging that negative feelings towards patients exist can seem almost 'unsayable'; however, the ability to recognise these feelings as an unavoidable part of clinical life, is the first step in providing practical education, structure and support for staff to appropriately manage them.

How does a Clinical Ethics Service help? Building capacity and supporting resolution

Interactions between patients and health care professionals are at the heart of health care. These interactions have an essential ethical dimension that may at times be challenging. Supporting professionals and organisations to meet those challenges can help ensure that patient care is provided in an ethically appropriate manner [2]

By focusing on the non-clinical aspects of care with the Clinical Ethicist, and later through the CES, the conflicting expectations, values and positions of stakeholders can be elicited and worked on. Key considerations in terms of staff include moral distress, compassion fatigue, counter-transference, and the identification of treatment as medically or clinically futile. For the patient vulnerability and autonomy are key considerations.

The guidance provided by a Clinical Ethicist creates a 'safe space' for staff to speak of the ethical challenges they are encountering. Through the provision of this safe space, staff gain increased clarity and support, which in turn builds confidence, promotes understanding and increases individual and organisational capacity for ethical decision-making. Furthermore, through the expression of differing disciplinary treatment options, a shared re-alignment of goals and desired outcomes is likely to be achieved. A collaborative approach to care allows each staff member feeling more confident, supported and validated. However, it is often noted that the real benefit of the CES consultation is the validation of moral concerns and the burden of responsibility acknowledged and, in part, relieved. The presence of hospital executives as members of the CEC may further assist in this validation of feelings and demonstrate a genuine commitment to building a sound ethical culture in the hospital with sharing of responsibility.

For patients and their families, the increased clarity, consistency and transparency of shared treatment plans help set clear boundaries; more actively respects autonomy and promote greater patient responsibility.

Conclusion

Complex ethical decisions arise in healthcare on a daily basis. While most staff feel equipped to meet the clinical challenges of their work, many will feel uncertain at times when confronting the complex ethical terrain of healthcare. Access to a CES can provide staff support, build

individual and organisational capacity and foster a culture and climate in which patient and staff care is driven in an ethically mindful way. As accreditation bodies increasingly recognise the benefit of CES in improving governance and decision-making in healthcare, we anticipate that more healthcare organisations will recognise and acknowledge the importance of staff safety by implementing such services as a resource for staff. For more information on how to establish and run a CES, please see the NHMRC Consensus Statement on Clinical Ethics and the *NHMRC Clinical Ethics Capacity Building Resource Manual*. [2, 3]

Competing interests

The authors declare that they have no competing interests.

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