Evaluating Clinical Ethics Consultation: A European Perspective

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This paper focuses on the topic of evaluation of clinical ethics consultation. The concept of evaluation seems to contain an internal tension: On the one hand, evaluation is seen (by some authors) as distorting the conceptual and normative content of the case(s) under scrutiny[1] and, on the other, the evaluative act is the most important use of judgment and an inescapable part of everyday life (e.g., the decision to buy a certain car or eat certain food is based on our own evaluations). As such, we maintain that evaluation is essential. Commonly, "evaluation is the systematic investigation of the merit or worth of an object (program) for the purpose of reducing uncertainty in decision making."[2]

Acknowledging the challenges of the evaluative task, this paper presents an evaluation strategy for clinical ethics consultation. The evaluation structure is discussed on the basis of our own experience in clinical ethics over some 15 years in various institutions and a systematic literature search. Specifically, we will address the following four questions:

1) How should a clinical ethics consultation service be structured to meet the needs of those seeking support in ethically challenging situations?
2) Which criteria should guide an evaluation of clinical ethics consultation?
3) What can we learn from empirical results published so far?
4) What conclusions can be drawn?

Background

Clinical ethics consultation (CEC) has gained increasing importance in Europe[3] during the past decade, about 20 years later than in the United States,[4] and research on or evaluation of ethics consultation has started to appear in the European literature[5] only recently. Drawing a complete and authentic picture of the situation in Europe is difficult across the multitude of languages, yet a review of publications in English, German, and French reveals that, at the institutional level, European hospital ethics committees (HEC) are growing in number and in the diversity of their tasks and duties.

One important and much debated aspect of HEC activity concerns whether and how ethics support services such as consultation are provided to clinicians, other caregivers, families, and sometimes patients as well. Clinical ethics consultation, where it exists, is called "on request" for ethically challenging situations and difficult treatment decisions,[6] that is, the service is voluntary and relies strongly on the ethical awareness and motivation of those providing it. The

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various forms of clinical ethics consultation are predominantly oriented toward assisting the healthcare providers in patient care and related decisionmaking, thus, ultimately striving to improve the patient's welfare.

In Europe, ethics consultation has developed at various rates depending on the country and societal context. Great Britain, for example, focused on a national strategy to establish hospital ethics committees on a large scale, with a primary emphasis on educational issues or policy development, rather than on case consultation.[7] The Netherlands developed both hospital ethics committees and consultation services, propagating synergies between the two.[8] In Spain, the situation is now shifting from implementation and accreditation procedures to increased demands on HECs and new questions about evaluation.[9] Starting in church-run hospitals, Germany also has shown a strong commitment to establishing hospital ethics committees, increasingly connected with efforts to offer ethics consultation.[10] In France, medical centers normally do not have committees or other structures offering consultation services, except l'Hôpital Cochin at Paris,[11] but the "Espace éthique" approach is gathering clinicians from various regions who are interested in developing different models of consultation and support.[12] Switzerland benefits from the Swiss Academy of Medical Sciences and its support for HECs and clinical ethics consultation. An International Conference on Clinical Ethics Consultation, held in Basel in 2005, also stimulated both the development of ethics consultation and related research in that country.[13] As regards countries in Eastern Europe, ethics committees are gaining importance. Although little is known about the structure of their ethics consultation services, both the need for such services and the lack of trained staff for ethics consultation are documented.[14]

The Clinical Ethics Consultation Service

Definition

Fletcher and Siegler provided an early consensus statement: "Ethics consultation is defined as a service provided by an individual consultant, team, or committee to address the ethical issues involved in a specific clinical case. Its central purpose is to improve the process and outcomes of patients' care by helping to identify, analyze, and resolve ethical problems."[15] For example, Boesch-Willi and colleagues report on two different kinds, one being classified as ad hoc discussion, the other as systematic ethics consultation on request with an expert from outside.[16] White distinguishes three levels of consultation services: Level 1 consultation involves answering uncomplicated questions by a single member of the services, whereas, on Level 3, full multidisciplinary reviews are provided to address difficult ethical dilemmas. Level 2 involves "facilitating a decision-making process with the health care team, patient and/or family, and is performed by the ethics consultation service member on-call."[17]

Despite this broad range of meaning, we will use the terms *clinical ethics consultation* and *consultation service* as synonyms denoting a short, structured, multiprofessional meeting centered on an ethical problem or dilemma and facilitated by specialized members of the ethics consultation team, with the goal of identifying and solving the problems addressed. Phone calls, quick clarifications in corridors, as well as deliberations without involvement of the

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clinicians-in-charge[18] are not included in this definition. They are part of healthcare ethics or hospital ethics committees' work, but not specifically an ethics consultation, at least as we conceive it.

Organization, Request, and Utilization

In European countries where ethics consultation services are growing, the task force report of the American Society of Bioethics and Humanities (ASBH) is often used as a reference for the organization of consultation services.[19] This is also true for the ethics consultation service at our institution. The implementation of this ethics consultation service in 2005 responded to the need for structured and professional ethics support for hospital staff. The service consists of staff members with long-standing professional experience and a variety of ethics qualifications who provide ethics consultation services on request. Consultations can be requested by whoever is in need: patients, surrogates, legal guardians, and families or members of the healthcare team (physicians, nurses, other allied health professionals). The question or conflict should be clearly expressed at the time of the request, and background information (e.g., history of the patient) has to be available at the time of the consultation. As a rule, two members of the service respond to the request: A consultant and a supporting co-consultant (writing the report) serve as facilitators and chair the consultation meeting. Neither is a member of the requesting department.

The consultants seek to create a respectful atmosphere of trust and privacy. The patient him- or herself should be involved if possible. If he or she is not able to articulate his or her own values and preferences, a surrogate or legal guardian is invited to participate. In any case, the patient or his or her surrogate is informed about the meeting in advance. Family members' contributions often are helpful for the interpretation of advance directives or presumed patient wishes and preferences. For this reason, we support the participation of relatives, even though we are aware of the burden that may result from the meeting for them. To minimize distress, we clarify roles and responsibilities of the participants: According to German law, treatment decisions remain with the patient or his legal surrogate and the physician-in-charge. The patient or legal surrogate has the right to refuse treatment.

Procedure and Documentation

The consultation is oriented at helping to make ethical decisions.[20] Our evaluation strategy combines three different European models of ethics consultation: The Nijmegen approach suggests a four-step procedure with an emphasis on the moral question to be solved,[21] the Basel method integrates reflection on principles and a systematic change of perspectives,[22] and the framework from Leuven involves the "ethos" of personalism.[23]

As a first step, medical, nursing, religious, and social aspects are assessed. Communication problems and misunderstandings are identified and distinguished from the ethical issues. Within a time frame of about 60 minutes, various options and their pros and cons are discussed until the majority of participants agree to the results. Minority views with specific arguments are recorded. A recommendation is based on the information gathered, different options for

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action are identified, a variety of perspectives is considered, and a consensus is reached, as far as possible. Results and main arguments are documented in the medical file and signed by the physician-in-charge and the ethics consultants. Details for the patient's care plan or instructions for the nursing team or other healthcare providers are articulated and signed by the attending physician, the nurse, and the ethicist. However, decisions can be canceled at any time by repeating the procedure. As a rule, the physician-in-charge also informs involved parties who would not or could not join the consultation, for example, other clinical staff members or the patient and/or his or her relatives. A consensus-based decision functions as a recommendation for the physician-in-charge and the patient or his or her legal representative.

The process and result of ethics consultation need to follow ethical values and principles. (We document the consultations with respect to the items outlined in Table 1.) At the same time, the decision ought to reflect patient-specific values and preferences in accordance with the values and treatment options of the healthcare team.

Criteria for Evaluation of CEC—Conceptual Frameworks

Initial Frameworks, Impulses, and Obstacles

Evaluation of clinical ethics consultation has been a topic of concern in the field since the Conference on Evaluation of Case Consultation in Clinical Ethics in Chicago in 1996.[24] Fox, Tulsky, and others reported with enthusiasm about the early conceptual frameworks for future research and provided detailed methodological approaches clearly addressing obstacles and pitfalls and offering proposals for managing them.[25] The ethics community itself served as the stakeholder in establishing the effectiveness or quality of ethics consultation. Main topics for evaluation, such as structure, process, and outcome, were formulated especially with respect to effectiveness.[26] Furthermore, it seemed feasible to develop common research questions, methods, evaluation strategies, standards, and instruments.[27] Measurable outcome criteria were categorized into four broad content domains: (1) ethicality, (2) satisfaction, (3) resolution of conflict, and (4) education.[28]

The first three of these content domains are of special interest for us. The domains are defined as follows: *Ethicality* refers to the "primary goal of ethics consultation ... to promote practices consistent with ethical norms and standards. Outcomes in the domain of ethicality, then, reflect the degree to which clinical practices conform to established ethical standards."[29] *Satisfaction* is defined as a "subjective construct—a function of someone's personal attitudes and impressions."[30] Finally, the major outcome variable in the *resolution of conflict* is "the degree to which involved parties construe that conflicts have been resolved."[31]

In Europe, perhaps due to the stage of development, evaluation of CEC has developed along a more casuistic path. Case-based reflections and single case interviews are prominent and can be seen as preliminary steps for the creation of research hypotheses.[32] Services are documenting their cases and may carry out some follow-up inquiries,[33] often unpublished. More Ph.D. and M.D. theses are searching outcome variables of clinical ethics consultations retrospectively or on the basis of case series.[34] In general, major effort is necessary if European CEC is to join the community of CEC evaluation.[35]

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Table 1. Evaluation Record of Clinical Ethics Consultation (in Addition to Minutes of the Consultation)

Statistics and ethical issues/problems/dilemmas

Date of request					
	Patient's age				
	Gender	m / f			
	Diagnosis				
Requesting Person/ Department / Clinic					
Ethical isues/ problems/dilemmas					
	Intensity of treatment	(Presumed) patient's preferences, values, will / autonomy	Request for treatment	Communica-tion	Other
Problem referred to					
Date CEC					
Recommendation					
	Intensify treatment	No change	Palliative care	Discharge / transfer	Other
Consensus	yes / no:				
First CEC / continued CEC					
Participants	Physi-cians	Nursing staff	Relatives	Legal representative	Patient
	Pastor	Consultant (chair)	co-chair	Other	

Informal feedback of requestor (and more participants if possible), recorded through counselor 2-7 days after consultation

How was the consultation process perceived: fair, helpful, satisfactory? What has been particularly helpful? Were the recommendations put into practice? Any practical problems? Suggestions for further consultation – changes? Is it necessary/desirable to have another consultation for the same patient/problem?

Discharge (quality management questions to the patient / legal representative)

1. Did the physician or the nurse in charge talk with you (the patient /the legal representative) about the treatment aims and perspectives? Y/N
2. Were your perspectives included in the treatment proposals?
fully somewhat rather not not at all
3. Did you have confidence in someone of your care team / or whole care team?
fully somewhat rather not not at all

Looking back at the pioneering work carried out in the United States, it is surprising to find that only a few outcome studies from North America on clinical ethics consultation have been published since 1996.[36] What might be the reasons for this gap, considering the enthusiasm of the initial implementation of CEC services? The following problems point to some of the reasons:

1) Clinical ethics consultation had been developed and established before evaluation was considered or even planned, and the means for realizing

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studies were lacking. Without a stable structure and a certain number of comparable consultations, sound evaluation was difficult to perform.[37] Still, in the early stages, "pilot" evaluation was used to detect pitfalls and benefits of ethics consultation.[38]

2) The objectives of CEC evaluation are too complex to evaluate easily. The content domains set up by the Conference on Evaluation of Case Consultation in Clinical Ethics pursue several different goals. Appropriate instruments for evaluating these domains are difficult to develop. In addition to the domains mentioned above, other criteria emerged, for example, the reduction or prevention of staff burnout or moral distress in daily work,[39] supporting medical staff in making difficult decisions, rather than providing solutions,[40] as well as issues of cost effectiveness.[41]
3) The requirements for sound evaluation create problems affecting the quality of the studies. Several of the empirical studies published thus far show methodological shortcomings: The sample size often tends to be (too) small, control groups are missing, and responder versus nonresponder analysis is lacking. Response rates in retrospective investigations vary between 17% and 66%. A number of studies focus only on a single aspect without considering the general importance of the result or its relation to other studies.

Despite these problems, evaluation has made progress, although the early goal of standardizing evaluation of consultation has not (yet) been reached.

Levels of Evaluative Criteria

The goals of ethics consultation supply the framework and the criteria for the evaluation of the outcome of the consultation. In practice, though, the goals vary and depend on the participating persons and the specific problems addressed in the consultation. This leads to the methodological difficulty of evaluating outcome criteria that cannot be defined in advance because the appropriate outcome ("which goal is to be reached") is only identified within the consultation *process* itself. In addition, the participants vary with every consultation; for these reasons, standardization is only possible on a rather abstract level. Although Molewijk and colleagues claim a significant difference between "moral case deliberation" and ethics consultation service, their proposal of a "responsive evaluation method" is on the right track for ethics consultation as a field.[42] Such an approach can do without predetermining the evaluative criteria in advance and, instead, identify the actual consultations.

Taking these complex and contingent outcome processes into account, we thus identify the following as preliminary criteria that are feasible and could allow for some comparability and standardization:

a) *Content criteria*: Are the ethical dilemmas or problems and the treatment options clearly identified? For example, should treatment be intensified, is palliative treatment indicated, and which of the possible options is most likely in accordance with the preferences of the patient? Are the values and preferences of the patients clarified, understood, and respected by the care team, or are there reservations about some preferences of the patient and the family? Possibly, the care team is not the right one for the patient's problem, and the patient should be referred to another clinic or even discharged.

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b) *Structural criteria*: Who should participate in the consultation, and in what role? For example, is everyone who is necessary for the consultation invited and participating in the session (also patients and representatives)? Does the consultant (and co-consultant) chair the session? What is the time frame of the consultation?
c) *Process-oriented criteria*: Does every participant have the chance to speak and be heard? For example, do participants have the chance to change perspectives or express emotions without intimidation and improve their ethical skills through active participation in the discussion?
d) *Outcome-oriented criteria*: Did the consultation have an appropriate result, for example, were preferences and values clarified? Was a recommendation or decision reached? Was the consultation fair and satisfying for the participants?

The investigation of the expectations and values of the patient on the one hand and the concepts and values of the healthcare providers on the other addresses both process and outcome at the same time. In cases of conflict, we seek to bridge the different positions in a participatory process including a change of perspectives.[43] Identifying conflicting values of the involved parties also points to the mutual dependency of patients and providers. This ''dual contingency'' is one decisive reason for the difficulty of developing standardized evaluation measurements for outcome, because the ''content of the specific criteria used to measure the success of 'ensuring respect for individuals' values' will be contingent on the specific values of the patient and/or other parties involved.''[44]

Empirical Studies of Ethics Consultation

Structure and Process as Outcome Criteria

The PEECE study (project examining effectiveness in clinical ethics) in Canada is a large-scale study that assesses the effectiveness of clinical ethics services by comparing and contrasting variations in structure, activities, and resources. Phase 2 of the project was designed especially to examine the consultation process, but publication of results is still pending. The outcome of Phase 1 of this study points to high variability in structures and processes, without clear conclusions about their advantages and disadvantages.[45] Earlier studies demonstrated that consultation had a high impact on the ethical sensitivity of the participating physicians.[46] One third of the participants identified ethical issues that requestors had not recognized and more than 75% changed patient management considerably (41%) or slightly (36%) after consultation.[47]

Satisfaction as an Outcome Criterion

A number of studies have assessed satisfaction as an outcome criterion[48] by encompassing various target groups such as patients, families, and different healthcare providers. Methods and evaluation differed in details, with Likert scales being used frequently to express satisfaction with respect to the process and outcome of the consultation. The majority of responders reported being satisfied and rated the consultation as helpful—two categories that do not necessarily correlate, as Orr and colleagues have demonstrated.[49] Physicians or

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other healthcare providers repeatedly reported more satisfaction than did family members.[50] Of those who expressed some dissatisfaction, still one third thought the ethics consultation had been very helpful. Satisfaction and degree of change in treatment showed a positive correlation: Responders were more satisfied when they believed that the ethics consultation had resulted in more of a change in treatment.[51] Dissatisfaction was related to a variety of reasons; single causes could not be clearly identified.[52] In one study, miscommunication or communication gaps primarily seemed to be the reason for dissatisfaction among families, independent of the result of the consultation as such.[53]

Cost as an Outcome Criterion

Schneiderman and colleagues[54] investigated the effectiveness of ethics consultation in a prospective, randomized controlled study, seeking evidence-based outcomes. They showed that ethics consultation was associated with a significant reduction of hospital days and of life-sustaining treatments in patients who did not survive to discharge. The authors conclude: ''Ethics consultations also reduce hospital costs without diminishing the quality of care. Hence, ethics consultations seem to be useful in resolving conflicts that may be inappropriately prolonging non-beneficial or unwanted treatment at the end of life.''[55] This result combines an assumed advantage for the patient with cost-saving results.

Critical Appraisal

The wide range of methods, goals, and purposes makes the question of selecting the appropriate criteria for evaluating ethics consultation a very difficult one. Each of the goals mentioned above may be ethically justifiable in specific cases and under certain circumstances.

Ethics consultation seems to enhance ethicality and sensitivity toward ethical issues in teams. Nevertheless, it remains unclear whether or how this may also be reached by other means. Patient, surrogate, or family satisfaction with the consultation may be a good criterion, especially when respect for their values has been an issue in the CEC process. The Conference on Evaluation of Case Consultation in Clinical Ethics deliberately addressed satisfaction as an outcome criterion, but it seems that satisfaction is not sufficient as a criterion measure or an overall measure for the effectiveness of an ethics consultation. Satisfaction is one possible subjective reflection of the consultation, but it is not the goal of consultation. Ethicality could be infringed and participants still might be satisfied with the process and the result of the consultation. To rely on an analogy, we prefer to assess a kind of Rawlsian ''procedural justice,'' that is, whether the participants experienced the process of consultation as fair.[56] The ethical dimension of ''justice as fairness'' includes all affected persons, even those who are absent. Satisfaction—as a subjective category—is immanently related to a person or a group. Furthermore, it has to be asked whose satisfaction should be addressed, the patient's, the administration's, or the physician's? Justice as fairness opens the horizon because it appeals to the need to follow a fair process and include all interested persons in the consultation.

In a recent study by Cohn et al.,[57] healthcare professionals and family members were asked whether the consultation was respectful of their values and whether

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it was fair. Responses were obtained on a 5-point Likert scale. Similar to the results on satisfaction, the healthcare professionals tended to value consultation more than did family members, but with regard to the criterion of being ''respectful to values,'' no statistically significant difference was found between the groups. It may be asked whether the study participants had fully understood the question, because no psychometric information about the questionnaire was given. Nevertheless, this study suggests a possible shift toward the domain of ethicality—with this linkage, even the criterion of satisfaction appears in a more favorable light.

The criterion of cost effectiveness may also be a legitimate criterion if the resources being saved were used for goals of higher (ethical) priority, so that saving money would not count as a value in itself, but as a means toward achieving good consequences. Presently, issues of appropriate micro-allocation are not regularly addressed in ethics consultation, but given the pressure resulting from scarce resources and the evidence of implicit rationing at the bedside,[58] this might become necessary.[59] If ethics consultation proves to be an effective instrument for reducing costs in hospitals under some circumstances, the risk of using CEC to limit quality of care under economic pressure might grow.[60]

The next questions to ask, then, regards who is supposed to benefit from ethics consultation (the patient, the healthcare professionals, or the organization that operates the hospital) and whether the identified benefits are consistent with the ethical framework of CEC. Cost reduction without diminishing the quality of care may be a goal within a framework of quality standards and needs to be discussed as an ethical issue.[61] What is defined as appropriate or good care is already part of the ethical conflicts being addressed in consultations. Therefore, studies examining the issue of cost reduction should also consider consequences of consultation on quality of care.

Application

To develop a more systematic assessment of ethics consultations, we developed an evaluation record (Table 1). Our strategy shows that evaluation can be started, even on a small scale, with a systematic approach incorporating the points discussed above. Our records demonstrate that even though only limited resources of time and staff are available for clinical ethics, which is a very common experience in the majority of European healthcare institutions, the evaluation requirement need not thwart the provision of consultations out of fear regarding extra paperwork for the clinicians themselves.

If documentation of CEC is mandatory in an institution, the statistical basis is laid: The issue, question, or problem of the requestor is recorded as well as basic data about the index patient and the treatment setting (Tables 1 and 2). Consultation notes and minutes address participants, ethical dilemmas, or conflicting values, patient history and current status according to all involved in the treatment process (including the physician-in-charge, nursing staff, other therapeutic staff, and family members), main arguments, recommendations, next steps, and minority views (if any).

In addition, after 2 to 7 days following the consultation, the consultant contacts the requestor for feedback. Including all participants of the consultation into feedback is still pending. During this short interview (phone call) or personal

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Table 2. Statistical Outcome of Consultation (Amounts)

Variable	Frequency [Range]
Time, investigation period	30 months [Jan. 2006–June 2008]
Number of consultations [sex]	42 [28 female; 14 male]
Age of patients	55.4 ± 25 years [3–92 years]
Involved departments	42.9% ICU
	7.1% Long-term artificial respiration
	35.7% Medical and surgical wards
	9.5% Psychiatry
	4.8% Neurology
Request/issues/problems/dilemmas	61.9% Intensity of treatment
	19.0% Presumed patient's wishes
	11.9% Communication problems
	7.1% Other reasons
Participants (frequency of participation)	100.0% Ethics consultant
	100.0% Physicians
	92.9% Nurses
	61.9% Co-consultant
	35.7% Pastors
	35.7% Relatives
	35.7% Legal representative
	2.4% Patient
Decision/consensus	90.5% Consensus
	9.5% Dissent
Case continued—second CEC performed	2.4%
Feedback/arguments	100% Fair—why/why not
	94.4% Helpful—why/why not
	91.6% Satisfied—why/why not
Recommendation put into practice	100% Put into practice
Suggestions for further consultations	

communication, the consultation asks the requestor whether he or she found the consultation helpful and fair and whether he or she is altogether satisfied. Suggestions and additional comments can be made. This method of follow-up has been criticized on the grounds that the evaluative interview is performed by the person who chairs the consultation, thus creating a bias. We cannot completely rule out a certain distortion, yet without resources for a full research project at this time, our options for data gathering are limited.

One of our major problems is insufficient resources for interviewing patients and representatives after discharge. We focus on staff participating in a consultation and on those who did not request the CEC (the latter forming a sort of control group). Often, patients or relatives spontaneously contact us for feedback about the consultation. This feedback is welcomed, but its suitability for outcome evaluation is limited. Following White and colleagues,[62] we currently make use of the general feedback gathered by quality management after discharge. The feedback at discharge is anonymous and cannot be related to concrete consultations or interventions unless patients disclose consultations voluntarily. Nevertheless, the feedback may offer sectional impression about what we see as being crucial for the criterion of "ethicality." We have therefore added three questions to our evaluation form (Table 1) asking about aims, perspectives, and

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confidence. We included the question about confidence because this is a prerequisite for expressing one's own wishes or perspectives.

We would rate it as a positive outcome

a) if the number of consultations (structured in the way described above) increased,
b) if more relatives and patients attend or request consultations,
c) if more CECs were requested and by a larger range of hospital units, and
d) if the recommendations were endorsed by many participants and put into practice.

Finally, we would want to see that consultation is appreciated as a process of bridging different values and that the discussions in CEC are experienced as expressing justice as fairness.

The problems of evaluation of ethics consultation service have stimulated intense discussion; efforts are being made to find ways of including quality criteria such as respect for the patient's values in combination with the perspectives of healthcare providers. Although the challenges of getting ethics consultation established continue,[63] the necessity of evaluation is clearly recognized: ''As the field of clinical ethics continues to grow and gain prominence, the need to attain knowledge about benchmarks, best practices, and measurement of effectiveness is becoming increasingly significant.''[64] In the meantime, even in Europe ethics consultation has gained a positive reputation, and healthcare providers are interested in active participation.[65] The empirical preconditions for systematic evaluation have improved tremendously over the past few years, given the growing number of countries and institutions establishing CEC services. Presently, our aim is to get evaluation started with a pragmatic data collection strategy taking into account the uncertain state of the art and the limited resources. Even with these preliminary measures, we hope that the instruments can prove useful and stimulate further activities, not only for large-scale research projects on CEC evaluation, but also for a decent minimal standard requirement that should pave the way for networking projects in the near future.

Notes

1. Degnin FD. Max Weber on ethics case consultation: A methodological critique of the conference on evaluation of ethics consultation. *Journal of Clinical Ethics* 1997;8:181–92; Goldenberg MJ. Evidence-based ethics? On evidence-based practice and the ''empirical turn'' from normative bioethics. *BMC Medical Ethics* 2005;6(11):E1–9.
2. Mertens D. *Research Methods in Education and Psychology: Integrating Diversity with Quantitative and Qualitative Approaches*. Thousand Oaks, CA: Sage; 1998:219.
3. Fournier V, Pousset M. [Cochin Hospital Clinical Ethics Center: The first two years] (in French). *La Presse Medical* 2006;35:960–6; Glasa J. Establishment and work of ethics committees in central and eastern European countries. *Medical Ethics & Bioethics* 2002;9:9–12; Hurst SA, Reiter-Theil S, Perrier A, Forde R, Slowther AM, Pegoraro R, Danis M. Physicians' access to ethics support services in four European countries. *Health Care Analysis* 2007;15:321–35; Reiter-Theil S. Ethics consultation on demand: Concepts, practical experiences and a case study. *Journal of Medical Ethics* 2000;26:198–203; Reiter-Theil S. Ethics consultation in Germany: The present situation. *HEC Forum* 2001;13:265–80; Slowther A, Bunch C, Woolnough B, Hope T. Clinical ethics support services in the UK: An investigation of the current provision of ethics support to health professionals in the UK. *Journal of Medical Ethics* 2001;27:i2–8; Steinkamp N, Gordijn B. Ethical case deliberation on the ward. A comparison of four methods. *Medical Health Care and Philosophy* 2003;6:235–46; Steinkamp N,

https://doi.org/10.1017/S0963180109090604 Published online by Cambridge University Press

Gordijn B, Borovecki A, Gefenas E, Glasa J, Guerrier M, et al. Regulation of healthcare ethics committees in Europe. *Medical Health Care and Philosophy* 2007;10:461–75.
4. Aulisio MP, Arnold RM, Youngner SJ. Health care ethics consultation: Nature, goals, and competencies. *Annals of Internal Medicine* 2000;133:59–69; The report of the American Society for Bioethics and Humanities. Core competencies for health care ethics consultation. In: Aulisio MP, Arnold RM, Youngner SJ, eds. *Ethics Consultation*. Baltimore: Johns Hopkins University Press; 2003:165–209.
5. Aleksandrova S. Survey on the experience in ethical decision-making and attitude of Pleven University Hospital physicians towards ethics consultation. *Medical Health Care and Philosophy* 2008;11:35–42; Borovecki A, ten Have H, Oreskovic S. Ethics committees in Croatia in the healthcare institutions: The first study about their structure and functions, and some reflections on the major issues and problems. *HEC Forum* 2006;18:49–60; Førde R, Pedersen R, Akre V. Clinicians' evaluation of clinical ethics consultations in Norway: A qualitative study. *Medical Health Care and Philosophy* 2008;11:17–25; see note 3, Hurst et al. 2007; Hurst SA, Reiter-Theil S, Slowther AM, Pegoraro R, Forde R, Danis M. Should ethics consultants help clinicians face scarcity in their practice? *Journal of Medical Ethics* 2008;34:241–6; Neitzke G. Confidentiality, secrecy and privacy in ethics consultation. *HEC Forum* 2007;19:293–302; Reiter-Theil S. The Freiburg approach to ethics consultation: Process, outcome and competencies. *Journal of Medical Ethics* 2001;27:i21–3; Reiter-Theil S. Balancing the perspectives. The patient's role in clinical ethics consultation. *Medical Health Care and Philosophy* 2003;6:247–54; Reiter-Theil S, Agich GJ. Research on clinical ethics and consultation. Introduction to the theme. *Medical Health Care and Philosophy* 2008 11:3–5; Robles PH. Evaluation of healthcare ethics committees: The experience of an HEC in Spain. *HEC Forum* 1999;11:263–76; Williamson L, McLean S, Connell J. Clinical ethics committees in the United Kingdom: Towards evaluation. *Medical Law International* 2007;8:221–38.
6. See note 3, Reiter-Theil 2000; Agich GJ. Joining the team: Ethics consultation at the Cleveland Clinic. *HEC Forum* 2003;15:310–22.
7. See note 3, Slowther et al. 2001; Slowther A, Johnston C, Goodall J, Hope T. Development of clinical ethics committees. *British Medical Journal* 2004;328:950–2; see note 5, Williamson et al. 2007.
8. See note 3, Steinkamp et al. 2007.
9. See note 5, Robles 1999.
10. See note 5, Neitzke 2007; see note 3, Reiter-Theil 2001; see note 5, Reiter-Theil 2001.
11. See note 3, Fournier, Pousset 2006.
12. Guerrier M. Hospital based ethics, current situation in France: Between "Espaces" and committees. *Journal of Medical Ethics* 2006;32:503–6.
13. See note 3, Hurst et al. 2007; see note 5, Hurst et al. 2008; see note 5, Reiter-Theil, Agich 2008.
14. See note 5, Aleksandrova 2008; see note 5, Borovecki et al. 2006; see note 3, Glasa 2002; see note 3, Steinkamp et al. 2007.
15. Fletcher JC, Siegler M. What are the goals of ethics consultation? A consensus statement. *The Journal of Clinical Ethics* 1996;7:122–6 at p. 124.
16. Boesch-Willi A, Hoesli-Krais I, Fahnenstich H, Hetzel P, Reiter-Theil S. Informal ad hoc case discussion versus systematic ethics case consultation in a neonatal intensive care unit (NICU)—Comparing practicability, transparency and practical impact. *Abstract for the 4th International Conference Clinical Ethics Consultation* (ICCEC), Poster Session on Education and Qualification in Clinical Ethics Consultation, Rijeka, Croatia, 2008.
17. White JC, Dunn PM, Homer L. A practical instrument to evaluate ethics consultations. *HEC Forum* 1997;9(3):228–46 at p. 230.
18. See note 5, Førde et al. 2008.
19. See note 4, Aulisio et al. 2000.
20. Agich GJ. The question of method in ethics consultation. *American Journal of Bioethics* 2001;1:31–41.
21. See note 3, Steinkamp, Gordijn 2003.
22. Reiter-Theil S. Klinische Ethikkonsultation—Eine methodische Orientierung zur ethischen Beratung am Krankenbett. *Schweizerische Ärztezeitung* 2005;86:346–51.
23. Schotsmans P. Personalism in medical ethics. *Ethical Perspectives* 1999;6:10–19.
24. Tulsky JA, Fox E. Evaluating ethics consultation: Framing the questions. *Journal of Clinical Ethics* 1996;7:109–15.
25. Fox E. Concepts in evaluation applied to ethics consultation research. *Journal of Clinical Ethics* 1996;7:116–21; Fox E, Arnold RM. Evaluating outcomes in ethics consultation research. *Journal of Clinical Ethics* 1996;7:127–38; Fox E, Tulsky JA. Evaluation research and the future of ethics

https://doi.org/10.1017/S0963180109090604 Published online by Cambridge University Press

consultation. *Journal of Clinical Ethics* 1996;7:146–9; Tulsky JA, Stocking CB. Obstacles and opportunities in the design of ethics consultation evaluation. *Journal of Clinical Ethics* 1996;7:139–45.
26. See note 25, Fox 1996.
27. See note 25, Fox 1996; see note 25, Fox, Arnold 1996.
28. See note 25, Fox, Arnold 1996:128.
29. See note 25, Fox, Arnold 1996:128.
30. See note 25, Fox, Arnold 1996:131.
31. See note 25, Fox, Arnold 1996:133.
32. See note 5, Neitzke 2007; see note 5, Reiter-Theil 2003; Sass HM. Ethical decision making in committee. A view from Germany. *Notizie di Politeia* 2002;18:65–81.
33. See note 5, Williamson et al. 2007.
34. Boesch-Willi A. *Schwierige ethische Entscheidungen in der Neonatologie*. Basel: Systematische Fallanalysen von Ethikkonsilen; 2007; see note 5, Robles 1999.
35. See note 5, Reiter-Theil, Agich 2008.
36. See note 4, Aulisio et al. 2000; see note 5, Reiter-Theil, Agich 2008.
37. See note 5, Williamson et al. 2007.
38. See note 16, Boesch-Willi et al. 2008; see note 5, Førde et al. 2008.
39. Aiken LH, Clarke SP, Sloane DM, Sochalski J, Silber JH. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA* 2002;288:1987–93; Begat I, Ellefsen B, Severinsson E. Nurses' satisfaction with their work environment and the outcomes of clinical nursing supervision on nurses' experiences of well-being—A Norwegian study. *Journal of Nursing Management* 2005;13:221–30; Corley MC, Minick P, Elswick RK, Jacobs M. Nurse moral distress and ethical work environment. *Nursing Ethics* 2005;12:381–90; Kälvemark S, Höglund AT, Hansson MG, Westerholm P, Arnetz B. Living with conflicts—Ethical dilemmas and moral distress in the health care system. *Social Science and Medicine* 2004;58:1075–84.
40. DuVal G, Clarridge B, Gensler G, Danis M. A national survey of U.S. internists' experiences with ethical dilemmas and ethics consultation. *Journal of General Internal Medicine* 2004;19:251–8.
41. Schneiderman LJ. Effect of ethics consultations in the intensive care unit. *Critical Care Medicine* 2006;34:S359–63; Schneiderman LJ, Gilmer T, Teetzel HD. Impact of ethics consultations in the intensive care setting: A randomized, controlled trial. *Critical Care Medicine* 2000;28:3920–4; Schneiderman LJ, Gilmer T, Teetzel HD, Dugan DO, Blustein J, Cranford R, et al. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: A randomized controlled trial. *JAMA* 2003;290:1166–72.
42. Molewijk B, Verkerk M, Milius H, Widdershoven G. Implementing moral case deliberation in a psychiatric hospital: Process and outcome. *Medical Health Care and Philosophy* 2008;11:43–56.
43. See note 22, Reiter-Theil 2005.
44. Craig JM, May T. Evaluating the outcomes of ethics consultation. *Journal of Clinical Ethics* 2006; 17:168–80 at p. 170.
45. 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;31:505–12.
46. La Puma J, Stocking CB, Silverstein MD, DiMartini A, Siegler M. An ethics consultation service in a teaching hospital. Utilization and evaluation. *JAMA* 1988;260:808–11; Perkins HS, Tolle SW. Evaluation of ethics consultations. *American Journal of Medicine* 1993;94:116.
47. See note 46, Perkins, Tolle 1993.
48. Heyland DK, Tranmer JE. Measuring family satisfaction with care in the intensive care unit: The development of a questionnaire and preliminary results. *Journal of Critical Care* 2001;16:142–9; Orr RD, Moon E. Effectiveness of an ethics consultation service. *Journal of Family Practice* 1993;36:49–53; Orr RD, Morton KR, deLeon DM, Fals JC. Evaluation of an ethics consultation service: Patient and family perspective. *American Journal of Medicine* 1996;101:135–41; Schneiderman LJ, Gilmer T, Teetzel HD, Dugan DO, Goodman-Crews P, Cohn F. Dissatisfaction with ethics consultations: The Anna Karenina principle. *Cambridge Quarterly of Healthcare Ethics* 2006;15:101–6; see note 17, White et al. 1999. Yen BM, Schneiderman LJ. Impact of pediatric ethics consultations on patients, families, social workers, and physicians. *Journal of Perinatology* 1999;19:373–8.
49. See note 48, Orr et al. 1996.
50. Cohn F, Goodman-Crews P, Rudman W, Schneiderman LJ, Waldman E. Proactive ethics consultation in the ICU: A comparison of value perceived by healthcare professionals and recipients. *Journal of Clinical Ethics* 2007;18:140–7.

https://doi.org/10.1017/S0963180109090604 Published online by Cambridge University Press

51. See note 48, Orr et al. 1996.
52. See note 48, Schneiderman et al. 2006.
53. See note 48, Yen BM, Schneiderman LJ 1999.
54. See note 41, Schneiderman 2006; see note 41, Schneiderman et al. 2003.
55. See note 41, Schneiderman 2006:362.
56. Rawls J. *A Theory of Justice*. Cambridge, MA: Harvard University Press; 1971.
57. Cohn F, Goodman-Crews P, Rudman W, Schneiderman LJ, Waldman E. Proactive ethics consultation in the ICU: A comparison of value perceived by healthcare professionals and recipients. *Journal of Clinical Ethics* 2007;18:140–7.
58. See note 3, Hurst et al. 2007.
59. See note 5, Hurst et al. 2008.
60. Paul NW. Klinische Ethikberatung: Therapieziele, Patientenwille und Entscheidungsprobleme in der modernen Medizin. In: Junginger T, Perneczky A, Vahl CF, Werner C, eds. *Grenzsituationen in der Intensivmedizin: Entscheidungsgrundlagen*. Heidelberg: Springer; 2008:207–17.
61. Fox E, Tulsky JA. Recommendations for the ethical conduct of quality improvement. *Journal of Clinical Ethics* 2005;16:61–71.
62. See note 17, White et al. 1997.
63. Phillips DF. Ethics consultation quality: Is evaluation feasible? *JAMA* 1996;275:1866–7.
64. See note 45, Godkin et al. 2005:511.
65. See note 5, all references on Europe.

https://doi.org/10.1017/S0963180109090604 Published online by Cambridge University Press