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## Some personal experiences of providing clinical ethical consultancy in Switzerland

\_Narrative

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Let us tell you some of our own experiences as clinical ethical consultants in Switzerland. We draw on our modest experience over the last year, each of us working in two different Swiss hospitals. Our experiences clearly show repeating patterns in requests for clinical ethics consultation (CEC). These repeating patterns can be presented – very generally – in terms of two recurrent characteristics. The first is that physicians generally expect a very *concrete* answer to an ethical dilemma. It seems to us that they usually give more weight to the response itself, than to the methodology used to *find* a possible answer. The second characteristic is that healthcare professionals often appear to have «very good knowledge» of the bioethical «North American» principlist approach (based on the principles of respect for autonomy, beneficence, non-maleficence, and justice). Their «day-to-day knowledge» of this principle-based approach thus generates assumption about the process of consultation: they expect us to use this approach to help them deal with their ethical dilemma. In addition, they expect us to clarify which principle should prevail over another in each situation, thus often framing the ethical consultation as nothing more than adjudicating over a simple conflict of principles. We find it regrettable that clinical ethics seems to have developed into an ethics of biomedical principles.

Of course, we ask the reader to keep in mind that our reflections here are grounded in our own, clearly limited experience in the field of CEC, not in scientific research that could be empirically validated. However, in this short narrative we would like to make use of our personal reflections to present these recurrent situations in our practice, and so contribute to the current debate about CEC. And finally, we wish to give our opinion on possible future lines of research in the field, as we clearly face the need for more investigation into the methodological aspects of CEC.

Our first observation, that physicians often expect a concrete answer from us, might be interpreted in several ways. One is that the overspecialization of medicine and a general trend towards evidence-based medicine have combined to make physicians used to finding (seemingly) concrete answers to (seemingly) concrete clinical questions. As physicians often perceive CEC as «just another sub-specialty of medicine», they can hardly be blamed for expecting the same kind of answers from us ethicists. Being used to their current evidence-based practice of medicine, they assume by analogy that «ethical» answers should feature the same characteristics as all the other answers given by their «traditional» consultants. Our

second strand of interpretation can be related to some current characteristics of hospital practice, which are: an increasing volume of work, limited time to spend with patients, existence of multiple specialties able to give advice about every single part of medicine, economic restrictions, fear of litigation, and so on. These trends in healthcare obviously lead to a need for concrete and quick answers, as thorough analysis of each and every rationale clearly goes beyond the scope of hospitals' working context. We think that our analysis here might be a first step to understanding not only the «principle-based» expectations of the healthcare professionals, but also their attraction to principlism as a seemingly «simple» method of ethical case analysis. This brings us back to our second observation: the *predominance* of the four principles. Let's clearly keep in mind that it is one thing to talk academically about the undoubtedly thorough work of Tom Beauchamp and James Childress (the authors of the famous book *Principles of Biomedical Ethics*) (1), and another to examine how their work is interpreted and implemented in clinical practice. In clinical reality, the «four principles» were rapidly adopted by many medical professionals because principlism looks pragmatic and easy. It (deceptively!) suggests that you don't need a profound knowledge of the history and developments of moral theories and methods. For the defenders of the principlism, this application works sufficiently well for medical ethics. As described by R. Gillon, one of the Europeans advocators of principlism, the principles provide a sound and useful way of analyzing moral dilemmas (2). On the other hand, authors like John Harris have argued that «the four principles are neither the start nor the end of the process of ethical reflection», and that they «could be used as checklist approach to bioethics for those new to the field» (3). As indicated above we do not support either of these extreme positions, but rather think that limiting ethics consultation only to the simple conflict between principles is an incomplete analysis of the situation. We strongly believe that some time and space for a thorough discussion of any problematic case is warranted. And in our own situations of CEC we thus often explain that we are unable to provide a short, concrete answer to a moral dilemma in the absence of exploring and trying to understand many other components of the situation, including the context and different stories of all moral agents involved.

However, there are methodologies that tackle moral problem in a «non-principlist way». Take for example the so-called «moral case deliberation», prominently used in the Dutch health-care settings. Many different strands of moral deliberation have already been described (hermeneutic pragmatism, clinical pragmatism, hermeneutic dialogue, Socratic dialogue, the «Nijmegen Method», and so on) (4). In our work, we wish to implement similar approaches in our own working settings. One of the crucial methodological aspects of moral case deliberation is the following: moral case deliberation stipulates that the moral question is formulated by the healthcare providers themselves, and ideally, the deliberation should finish with a concrete response to their initial question. The ethicist plays the role of a facilitator, and not that of an expert. Of course, this is not always in line with current physicians' expectations, as described above. However, moral case deliberation permits an exploration of multiple dimensions of care, giving an holistic approach to the patient and situation, analyzing not only the ethical values and principles, but also the clinical details in many dimensions and the agents' wishes, needs, emotions and fears. Moral case deliberation finishes with a practical assessment of the situation and a reformulation of the moral question, leading ideally to a «response» to the request for CEC. Moreover, such deliberations are rooted in the European philosophical tradition, constituting a kind of equilibrium between classical American pragmatism, and the European accent on the philosophical foundations of the methodology.

To conclude: we are not trying here to provide simple answers to difficult questions about the methodologies of clinical ethics consultation. We think that this intense debate is in its infancy and we hope to have contributed to it by presenting some of our own experiences and interpretations. We firmly believe that empirical research into this important area should be encouraged, and we are glad to report that the Swiss Academy of Medical Sciences (SAMW) has started to fund research here (5). The SAMW also hosts an expert group (a «Subkommission»), headed by Prof. Samia Hurst; Geneva) to develop guidelines in the field of ethical consultancy in health care institutions (6). We will be glad to present some more of our experiences and the results of our own research in due course.

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#### References

1. Beauchamp TL, Childress J. Principles of biomedical ethics. New York: Oxford University Press, 2001; 1st ed, 1979; 5th ed.
2. Gillon R. Ethics need principles – four can encompass the rest – and respect for autonomy should be «first among equals». *J Med Ethics* 2003; 29:307–12.
3. Harris J. In praise of unprincipled ethics. *J Med Ethics* 2003; 29:281–6.
4. Cf. for example: Steinkamp N, Gordijn B. Ethical case deliberation on the ward. A comparison of four methods. *Med Health Care Philos* 2003;6(3):225–6. Or: Widdershoven, G et al. Empirical ethics as dialogical practice. *Bioethics* 2009; 23 (4): 236–248.
5. «Zur Erweiterung der Methodikkompetenzen im Bereich der Klinischen Ethikberatung in der Schweiz», Rouven Porz, KZS 02/09, funded by the Swiss Academy for Medical Sciences.
6. [www.samw.ch/dms/de/Ethik/RL/IB/d\\_Suko\\_EB\\_Auftrag/d\\_Suko\\_EthikBer\\_Auftrag.pdf](http://www.samw.ch/dms/de/Ethik/RL/IB/d_Suko_EB_Auftrag/d_Suko_EthikBer_Auftrag.pdf) (last access: 14 August 2009).