

The “Big Five” in 100 Clinical Ethics Consultation Cases

Reviewing three years of ethics support in two Basel University Hospitals

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Abstract

Background: The study aims at shedding light into the practice of Clinical Ethics Consultation (EC) thereby making a contribution to better understanding its triggers, contents and outcomes. It was carried out in 2 (out of 3) local University Hospitals.

Material and method: 100 full ECs (50 ECs conducted at the somatic/USB, 50 at the Psychiatric University Hospital/UPK) over 3 years were analysed on the basis of its rich and highly standardised documentation.

Results: Overall, the majority of all ECs (84%) feature ethical issues referring to at least one of the following 5 topics: coercion (28%), care management (24%), treatment-plan evaluation (17%), end-of-life care (16%), or pregnancy / assisted reproduction (12%).

In USB ECs, the top 3 main ethical issues concern end-of-life care (28%), pregnancy / assisted reproduction (22%), and coercion (20%), followed by treatment limitation (8%), and care management (6%). The single most significant main ethical issue in UPK ECs is coercion (34%), followed by care management and treatment-plan evaluation (both 20%).

Discussion: The prevalence of end-of-life issues in somatic health care is in line with previous research, while the evidence for coercion as a major topic in ECs in general is new. Comparable studies are hardly available from other European centres, and the existing North American papers do not display a prevalence of this concern.

Conclusions: The thematic shift to a double focus on end-of-life decisions *and* coercion and the “big five” themes revealed altogether stimulate the catalogue of clinical ethics education, both for ethics consultants and health care professions.

Key words: clinical ethics support, ethics consultation, end of life, coercion, evaluation.

Background

The framework of this study includes two (out of three) local University Hospitals using a shared Clinical Ethics Support Service. The ethics leadership and core team for both is identical, whereas further staff resources, the institutional contexts as well as the Advisory Ethics Councils (AdvisEC) are different.

Ethics Consultation (EC) is, among other forms of Clinical Ethics Support (CES), in both houses practised on a professional basis in a “small team-approach” with ideally at least one specialised professional (senior ethics consultant) available for chairing and one or two (or more) colleagues to assist in giving interdisciplinary

views and writing the record. In most cases, the documentation is prepared by a specialised staff member (junior ethics consultant) and finalised together with the session chair followed by obtaining approval from the requesting party, a good practice which is not performed generally, but in some other centres [1]. While the University Hospital Basel (USB) is responsible for acute, somatic medical care of adult patients including e.g., intensive care, the Psychiatric Hospitals of the University Basel (UPK) cover acute mental health care for patients across all ages, including also forensic psychiatry; the USB has approximately 700 beds (35 262 discharged patients in 2015), the UPK 300 beds (3174 discharged patients in 2015); both institutions have in- and outpatient settings.

The study aims at shedding light into the practice of CES which most often is only visible for those actively participating thereby making a contribution to better understanding its triggers, contents and outcomes. Moreover, the data presented shall provide an empirical basis for further evaluation of CES outcomes and processes.

Approach of ethics support

The analysis of a service such as CES has to correspond to the essentials thereof. These do not only consist of descriptive characteristics such as the setting or the participants of the EC meetings, but also the philosophical assumptions of the CES approach, e.g., moral principles, rules of discourse or even meta-ethical assumptions. Here is a short characterisation of the service as studied.

Access and initiative: Overall, the EC service is focused “on demand” from all health care practitioners within the respective institution, but also open for patients, their family or legal substitute decision-makers [2], however, without encouraging direct requests of patients or relatives without involving the care team. The most regular and important involvement of the patient occurs through the clinicians’ informing the patients – or relatives – about the EC, presenting their views to the discussion and informing them about the conclusions in order to obtain their consent or prepare decisions.

Setting: ECs mostly take place on the respective ward where the demand comes from or, in case of a request being made from outside, e.g., by a patient relative, in

a neutral meeting room. The room should be quiet to allow undisturbed discussion.

Schedule: While most ECs at USB occur on demand as individual events, a proportion of those performed at UPK are part of an agreed-upon series of six to ten meetings in a row [3, 4]. Most ECs do not last longer than 60 minutes with some exceptions depending inter alia on the number of participants or participating wards, i.e., the complexity of the assembly.

Ethics support staff: The CES service is run by means of professional staff of the ethics department co-financed by both institutions. At USB, members of the AdvisEC compliment the core staff on a voluntary basis by actively contributing to ethical case discussions. This board includes 10 members of whom 4 (2 hospital chaplains and 2 nurses) underwent qualifications of ethics (consultation), the other members being physicians and lawyers as well as one academically qualified medical (clinical) ethicist. The UPK board is not practically involved in providing CES; it consists of 5 members (psychiatry, nursing, law including the same academically qualified medical ethicist).

Type of goals: As most of the ECs meetings are triggered by staff, their goals refer to reconsidering or optimising the respective treatment plan. Whenever goals are articulated apart from content-wise defined requests of health care professionals, the tenor of the wishes is to obtain assistance or guidance in finding one's way towards an ethically sound procedure and conclusion on open or controversial questions. Patients or their relatives rather formulate wishes for being heard and advised about their options – or concern – and help for making themselves be understood by their clinical vis-à-vis.

Form of outcomes: Explicit consensus is an important aim of EC reached and documented in the vast majority of cases. Any treatment (or other intervention, e.g., placement) decision will not be allowed to be delegated to an “ethical” authority. Rather, the responsibility for treatment decisions rests where it has been, i.e., the agreement between the physician in charge and the patient or substitute decision-maker. (Some decisions may be taken by nurses or social workers and the patient.) The locus of the decision-making responsibility may be clarified by means of an EC.

Elements of quality assessment: The following analysis of data and cases is part of a regular accompanying research activity. Secondary analyses performed within educational or research projects shed light onto more basic issues and stimulate ideas for developing the service. Besides, the careful documentation and the feedback forms from those requesting CES give valuable information.

Ethical framework of the CES approach as practised: Our approach refers to the four principles of biomedical ethics [5], the concept of a systematic change of perspectives [6, 7], an escalating repertoire of ways how to deal with the normative dimension [8] and elements of

discourse ethics [9, 10]. While these components offer a mainly rational or cognitive orientation to our EC practice, also another philosophical dimension is important for CES that is more difficult to articulate: the necessity to acknowledge human tragedy and existential challenges of despair and guilt, but also consolation and reconciliation. For an underlying basic attitude, modesty and awe (“aidos”) may be part of a common denominator [11].

Material and method

For this study we analysed the documentation of 50 ECs conducted at the USB and 50 ECs conducted at the UPK, Basel, Switzerland, between February 2012 and November 2015. Only fully documented ECs, prospective and retrospective, were included, sorting out other forms of CES, e.g., team-oriented or educational ethics meetings [4]. ECs conducted at the University Children's Hospital Basel (UKBB) are not included either.

The main fundament of data analysis is built by standardised records: Each EC meeting is concluded with a structured document (5–10 pages) for the patient chart including a short overview/summary (page 1); a synopsis of the involved perspectives (patient, relatives, health care team, institution, legal service); the underlying in-depth ethical analysis and reasoning; conclusions; any open (eventually basic) questions for follow-up. The document is approved by two ethics consultants (one senior) and at least one person on the side of the requestor (clinical staff member, patient/relative). A feedback sheet with standardised questions serves as brief evaluation by the requesting party after the meeting (return rate: 55%). ECs with less than “standardised short record” were excluded. We defined multiple categories concerning features of ECs as identified in the documentation record, such as: form of EC; requesting unit/profession; urgency; chair/moderator; number of participants; attendance of patient/relatives/substitute decision-maker; attendance of hospital legal service; medical issue; patient age/prognosis/decisional capacity; ethical questions raised by requesting party; main ethical issue (called “ethics focus”); further ethical issues; basic ethical questions; consensus; feedback from the requesting party on the EC and on implementation of results. The documentation was systematically screened and categorised by two reviewers. Data were anonymised, tabulated, and analysed using Microsoft Excel 2010 and IBM SPSS Statistics 23.

In order to classify the ethical content by reference to an independent source, we chose the highly reputed *Encyclopaedia of Bioethics* [12]. The ethical issues were defined lexically according to the following entries in [12], selected on the basis of relevance in a clinical health care setting: abuse, interpersonal; access to health care; advance directives and advance care plan-

Table 1: Short definitions and example questions of ethical issues

Ethical issue (alphabet.)	Short definition	Example question from ECs
Abuse, interpersonal	Physical or mental injury, sexual abuse, negligent treatment or maltreatment of a patient (child, elderly, etc.) by another person	Should visitation rights of the mother be limited due to psychological endangerment of the child patient?
Access to health care	Access of persons to health care and the institutional, social, legal or financial denial or impediment thereof	How to sustain treatment for a patient without right of residence?
Advance directives and advance care planning	Any planning and documenting by patients for decision-making in the event of future decisional incapacity	How to engage a forensic psychiatric patient with impaired competence in advanced care planning?
Assisted suicide	(Plan of) suicide of a person with the aid of a physician or members of an assisted suicide organisation	How to evaluate the wish of a chronic pain patient for assisted suicide?
Care management	Management and organisation of professional patient care and the impediment or lack thereof	How to deal with a care-intensive patient needing help, but wishes to be left alone?
Coercion	Using pressure, force or covert action to control the movement, treatment or behaviour of a patient against his will ¹	Coercive treatment for incompetent patient in case of self-harming behaviour?
Competence	Patient's capacity to make autonomous health care decisions, the impairment or lack thereof, and strategies to deal with it	How to deal with the patient's impaired decision-making due to addictive disease?
Confidentiality	Limiting access of not authorised persons to confidential patient information	May relatives be involved in treatment decision-making for a psychiatric in-patient?
Discrimination	Treating a patient or particular group of patients differently from the way in which other patients are treated, because of their skin colour, sex, sexuality, genes, etc.	Possible undertreatment of a patient due to immigrant status?
End-of-life care	Treating a patient at the end of life, e.g., life-sustaining surgery, resuscitation, artificially administered food and water, etc., and the limitation or stop thereof	Sustaining end-of-life treatment for a critical patient due to the relative's wishes?
Enhancement uses of medical technology	Using medical technologies to enhance human traits	*
Genetic engineering	Using recombinant DNA techniques to create genetically engineered cells or organisms	*
Genetic testing and screening	Using genetic technologies to collect samples of and to analyse DNA	*
Health care resources, allocation of	Distributing health-related materials and services among various uses and people at an institutional or individual level, and the rationing thereof	How to deal with limited resources in caring for a care-intensive patient?
Informed consent	An informed and autonomous authorisation of a medical intervention (or of involvement in research) by individual patients, or the lack thereof	How to honestly inform a patient with impaired competence?
Long-term care	Personal care, health care, and social services for persons whose functional impairments dictate that they need help with tasks of everyday living	Should the patient be transferred to a nursing home or discharged for home care?
Medical mistakes	Failure of a planned action to be completed as intended or the use of the wrong plan to achieve an aim in medical practice	How to deal responsibly with harm resulting from lack of (nursing) attention (injury following a fall).
Organ and tissue transplants	Retrieval, preservation, distribution, or transplantation of organs or tissue	*
* No example to be found in our data base.		

1 Our definition differs from that found in the encyclopaedia [12] which includes using threats to exert control over the patient. In our data base no EC case was found where "threats" had been a topic; in all cases, the problem labeled "coercion" addresses interventions to be administered without the patient's agreement, mostly due to mental disorder.

Ethical issue (alphabet.)	Short definition	Example question from ECs
Palliative care and hospice	Comprehensive, interdisciplinary care focusing primarily on promoting quality of life for patients living with a terminal illness and for their families	Should the patient be transferred to a rehabilitation centre or hospice?
Pregnancy / assisted reproduction	Ethical conflicts regarding the use of assisted reproduction technologies, pregnancy, or abortion	May abortion be performed due to foetal cleft lip and palate in the 22nd week of pregnancy?
Treatment limitation	Limiting other than life-sustaining treatment of a patient, e.g., pain treatment	Was it wrong to limit pain treatment for an incompetent patient due to the spouse's intervention?
Treatment-plan evaluation	Evaluating available treatment options or goals in patient care, including personal, social, cultural, and religious aspects	Evaluation of different treatment options regarding the patient's quality of life
Other		–

ning; assisted suicide*; care management*; coercion; competence; confidentiality; discrimination*; end-of-life care*; enhancement uses of medical technology; genetic engineering; genetic testing and screening; health care resource, allocation of; informed consent; long-term care; medical mistakes; organ and tissue transplants*; palliative care and hospice; pregnancy / assisted reproduction*; treatment limitation*; treatment-plan evaluation*; other*. (Items with an asterisk are renamed and/or refer to parts of or to multiple entries.) These items mainly refer to topics of medical ethics, not to the persons which are involved in the ethical problem (e.g., “family conflict”) or how the ethical problem is conceived by these persons (e.g., “moral distress”). For short definitions of the items based on entries in [12] and exemplary ethical questions from our data see table 1.

In contrast to other authors [13, 14] our study distinguishes between one main ethical issue (singular) and further ethical issues. This distinction is based on the methodological concept of articulating an “ethics focus” during an EC meeting [8] to structure and guide the discourse; this approach allows identifying and prioritising the ethical problems to be addressed primarily. The agreed upon ethics focus may differ from the requester’s original reasons for triggering an EC.

Results

Consultation characteristics

Formal characteristics of the studied ECs are shown in table 2. The majority of the ECs in both hospitals are prospective (79%). In the USB, ECs are requested in equal shares by the medical (30%) and the surgical divisions (30%), followed by gynaecology (26%). Requests from the emergency department (6%) and the intensive care wards (4%) are less frequent.

Most ECs in the USB are requested by (leading) physicians (70%), but a considerable minority is triggered by (leading) nurses (22%). In the UPK, almost two-thirds of the requests are made by adult psychiatry (60%), about

one-third by each of the two other hospitals (child and adolescent and forensic psychiatry) (36%) mirroring also the size of the three units. Most requests come from (leading) physicians (44%), followed equally by (leading) therapists including psychologists/pedagogues (22%), and (leading) nurses (22%). Patients or their relatives rarely request an EC (3% in total). While in the UPK ECs are seldom asked to take place within 48 hours or less, ECs in the USB are often categorised as urgent (24%) or very urgent (38%).

In both hospitals ECs are mainly moderated by a senior ethics consultant (USB: 76% resp. UPK: 98%); in the USB where several AdvisEC members are also available for chairing, ECs are moderated by others than an ethics consultant in 24% of the cases. Patient relatives are involved not often in ECs (USB: 12%; UPK: 2%); also patients rarely participate in ECs (USB: 8%; UPK: 6%). In the vast majority of cases (97.8% of all available data) the EC results in a consensus between the participants; often, this concerns a newly formed explicit agreement (92.8%). According to the available data the outcomes of the ECs are mostly implemented in practice afterwards (90.7%), if the patient has not died nor been transferred before this was possible (4.7%). The ECs and the records are considered helpful by the feedback respondents (94.4% resp. 98.8%) in almost all cases.

Patient characteristics

Demographic and clinical characteristics are shown in table 3. A slight female preponderance exists (57.6%), especially in the UPK (60%) regarding the patient discussed in the EC. In USB EC cases the median age of the patient is higher (49.3 y) than in the UPK (37.2 y). Patient competence is given in 34% of all USB EC cases, while only in 10% of all EC cases in the UPK; competence is more often impaired or questioned in the UPK (40% resp. 22%) than in the USB (24% resp. 12%). In total, the patient’s competence is either unclear, impaired or not given in 77% (only available data) of all EC cases.

Table 2: Characteristics of Ethics Consultation

Characteristic	Hospital		Total	% of total
	University Hospital Basel (USB)	Psychiatric Hospitals of the University Basel (UPK)		
Form of EC				
<i>Prospective Ethics Consultation</i>	44	35	79	79.0%
<i>Retrospective Ethics Consultation</i>	6	15	21	21.0%
Requesting unit				
<i>Adult Psychiatry</i>	–	30	30	30.0%
<i>Medical Division</i>	15	–	15	15.0%
<i>Surgical Division</i>	15	–	15	15.0%
<i>Gynaecology</i>	13	–	13	13.0%
<i>Child and Adolescents Psychiatry</i>	–	10	10	10.0%
<i>Forensic Psychiatry</i>	–	8	8	8.0%
<i>Emergency Department</i>	3	–	3	3.0%
<i>Intensive Care Wards</i>	2	–	2	2.0%
<i>Other</i>	2	2	4	4.0%
Requesting profession				
<i>Physician</i>	26	16	42	42.0%
<i>Leading physician</i>	9	6	15	15.0%
<i>Leading nurse</i>	5	7	12	12.0%
<i>Nurse</i>	7	4	11	11.0%
<i>Leading therapist</i>	0	10	10	10.0%
<i>Patient or relative</i>	1	2	3	3.0%
<i>Therapist</i>	0	1	1	1.0%
<i>Other</i>	2	4	6	6.0%
Urgency				
<i>Normal</i>	19	50	69	69.0%
<i>Urgent</i>	12	0	12	12.0%
<i>Very urgent</i>	19	0	19	19.0%
Moderation				
<i>Ethics consultant (senior)</i>	38	49	87	87.0%
<i>Other advisory ethics council member</i>	12	0	12	12.0%
<i>Ethics consultant (mentee)</i>	0	1	1	1.0%
Number of participants				
<i>Median participants (range)</i>	8.5 (2–19)	9.3 (2–18)	8.9 (2–19)	
Attendance of patient				
<i>Yes</i>	4	3	7	7.0%
<i>No</i>	46	47	93	93.0%
Attendance of relatives				
<i>Yes</i>	6	1	7	7.0%
<i>No</i>	44	49	93	93.0%
Attendance of hospital legal service				
<i>Yes</i>	27	1	28	28.0%
<i>No</i>	23	49	72	72.0%
Consensus				
<i>Yes</i>	45	43	88	88.0% (97.8%)*
<i>No</i>	0	2	2	2.0% (2.2%)*
<i>n.a.</i>	5	5	10	10.0%

* % of total: only available data

Characteristic	Hospital		Total	% of total
	University Hospital Basel (USB)	Psychiatric Hospitals of the University Basel (UPK)		
Feedback Forms				
Yes	31	24	55	55.0%
No	19	26	45	45.0%
Results implemented				
Yes	23	16	39	39.0% (90.7%)*
No	0	0	0	0.0% (0.0%)*
Delayed/pending	2	0	2	2.0% (4.7%)*
Patient died / transferred before	2	0	2	2.0% (4.7%)*
n.a.	23	34	57	57.0%
EC helpful				
Yes	30	21	51	51.0% (94.4%)*
Yes, partially	0	3	3	3.0% (5.6%)*
No	0	0	0	0.0% (0.0%)
n.a.	20	26	46	46.0%
Record helpful				
Yes	24	20	44	44.0% (98.8%)*
No	1	0	1	1.0% (2.2%)*
n.a.	25	30	55	55.0%

* % of total: only available data

Ethical issues

In USB ECs, the most frequently observed main ethical issues concern end-of-life care (28%), pregnancy / assisted reproduction (22%) and coercion (20%). Other less frequently observed main ethical issues are treatment limitation (8%), care management (6%), competence, treatment-plan evaluation (4%), allocation of health care resources, assisted suicide, long-term care, and medical mistakes (2%). Further ethical issues regard competence (12%), care management (10%), allocation of health care resources, treatment limitation (6%), palliative care and hospice, treatment-plan evaluation (4%), access to health care, discrimination, end-of-life care, and pregnancy / assisted reproduction (2%). The single most significant main ethical issue in UPK ECs is coercion (34%), followed by care management and treatment-plan evaluation (both 20%). Other less frequent main ethical issues include abuse (4%), advance directives and advance care planning, assisted suicide, end-of-life care, informed consent, and treatment limitation (2%). Further ethical issues cover care management (12%), treatment limitation, treatment-plan evaluation (4%), advance directives and advance care planning, coercion, competence, and confidentiality (2%). Overall, the majority of all ECs (84%) feature at least one of the following five ethical issues: coercion (28%), care management (24%), treatment-plan evaluation (17%), end-of-life care (16%), or pregnancy / assisted reproduction (12%).

Discussion

Despite the move towards empirical medical ethics in general [15], empirical studies on triggers, top themes and content matters of EC *practice* in medical centres in Europe are difficult to find according to systematic literature reviews, left alone any complete overviews of requests over a period of time [16, 17]. Regarding the evaluation of EC practice, theoretical papers have prevailed from the beginning of the interest in the subject [18] up till now [19, 20]. This paper seems to belong to the pioneer studies coming from European centres, together with studies from Oslo, Bielefeld, and Zurich [1, 21–23].

A limited number of studies describe the ethical issues of EC performed in U.S. [13, 14, 25] and Canadian [26] medical centres using different approaches. These papers suggested the prevailing of major themes such as [13] patient competence/capacity (82%), staff disagreement on care plan (76%), and end-of-life issues (60%). Tapper et al. [14] published their top list of topics generated by the frequent brief rather than the rare full ECs (only 29 in three years). Most frequent were issues regarding Level of (end-of-life) care such as: code status (46%) / curative vs palliative (37%) / withhold or withdraw from life-sustaining therapy (18%), followed by issues relating to communication between patient / surrogate and team (22%), and Informed consent (17%). The statements of DuVal et al.

Table 3: Demographic and clinical characteristics of Patient discussed in EC

Main ethical issue	Hospital		Total	% of total
	University Hospital Basel (USB)	Psychiatric Hospitals of the University Basel (UPK)		
Sex				
Female	30	27	57	57.0% (57.6%)*
Male	19	23	42	42.0% (42.4%)*
n.a.	1	0	1	1.0%
Age				
Median age (y) (range)	49.3 (15–92)	37.2 (6–72)	43.0 (6–92)	
Competence				
Impaired	12	20	32	32.0% (33.3%)*
Not given	14	11	25	25.0% (26.0%)*
Given	17	5	22	22.0% (22.9%)*
Unclear	6	11	17	17.0% (17.7%)*
n.a.	1	3	4	4.0%
Prognosis				
Unclear	6	19	25	25.0% (31.6%)*
Poor	10	10	20	20.0% (25.3%)*
Guarded	11	4	15	15.0% (19.0%)*
Good	8	5	13	13.0% (16.5%)*
Terminal	6	0	6	6.0% (7.6%)*
n.a.	9	12	21	21.0%

* % of total: only available data

on ethical dilemmas, however, are based on retrospective interviews with internists rather than the analysis of authentic EC records proposing the top themes of: end of life (79%), patient autonomy (63%), and conflicts between parties (38%). The most recent study of Wasson et al. [24] distinguishes between (several) ethical issues and (one) key ethical issue in each case – resembling the “ethics focus” in our CES approach. The most frequent ethical issues concern: decision-making (93.6%), goals of care / treatment (80.8%), and end of life (73.1%). Accordingly, key ethical issues concern withdrawing / withholding (12.8%), patient wishes / autonomy (12.2%), capacity (11.5%), and goals of care / treatment (9.6%).

On the one hand, according to these studies similar results could be expected for a major somatic University Hospital such as USB; on the other hand expectations regarding an innovative CES service as that in our Psychiatric University Hospital have been vague, due to the lack of published data. Tapper et al. [14] report that compared to other services psychiatry showed a very low consult incidence although psychiatric diagnoses were often involved in ECs (requested by others) according to their study (p. 437); no further authors mention EC in psychiatry at all.

The analysis of our sample of 100 EC cases (50 from somatic and 50 from psychiatric care) reveals the top

ethical issues in EC of both institutions. As expected from the North American surveys, end-of-life issues were the top theme in somatic care ECs. The top issue in psychiatric care ECs, however, was the question whether or not to apply coercion to the patient, ranking at the same time third, even in the list of top themes in the somatic context rendering coercion the overall dominant EC theme in both institutions. Issues concerning care management and treatment-plan evaluation are following next in the overall count, though occurring more frequently in psychiatric care. Pregnancy and assisted reproduction issues arise only in obstetrics and gynaecology. The only top theme of paramount relevance for both hospitals as expressed in our data is, thus, coercion.

Both top themes might have scored even higher if more EC requests had been included from the two ICUs at USB given the prevalence of ethical problems arising in intensive care [13, 14, 24, 26]. In Basel, however, the ICU teams have engaged in implementing our ethics project METAP, especially a self-supporting practice of internal ethical case discussion [10, 27, 28] prioritizing competence-building and reacting to ethical conflict without the help from an EC team.

While the ethical awareness for end-of-life issues among somatic health care professionals confirms the expectations, the evidence for coercion as the major

Table 4: Main ethical issues

Main ethical issue	Hospital		Total	% of total
	University Hospital Basel (USB)	Psychiatric Hospitals of the University Basel (UPK)		
Coercion	10	17	27	27.0%
End-of-life care	14	1	15	15.0%
Care management	3	10	13	13.0%
Treatment-plan evaluation	2	10	12	12.0%
Pregnancy / assisted reproduction	11	0	11	11.0%
Treatment limitation	4	1	5	5.0%
Abuse	0	2	2	2.0%
Assisted suicide	1	1	2	2.0%
Competence	2	0	2	2.0%
Advance directives and advance care planning	0	1	1	1.0%
Health care resources, allocation of	1	0	1	1.0%
Informed consent	0	1	1	1.0%
Long-term care	1	0	1	1.0%
Medical mistakes	1	0	1	1.0%
Other	0	6	6	6.0%
Total	50	50	100	100.0%

concern in ECs in general is new and deserves attention. Given the few studies available from other European or Swiss medical centres which do, except for Syse et al. [17], not display a prevalence of this concern, it is, thus, permitted to offer some speculative considerations for stimulating discussion.³

A methodological explanation may be that in other studies coercion is subsumed under other prevailing categories, such as patient autonomy or patient competence / capacity. In our view, coercion is too important to be missed by covering it in more general categories, but requires being addressed explicitly. None of the mentioned studies lists coercion as a separate issue. However, since hardly any of the studies deliver or refer to definitions of the ethical issues observed, this suggestion cannot be corroborated. In our view coercion and competence can (and should) be distinguished as coercion might be exerted to incompetent as well as to competent patients.

It is somewhat surprising that patient competence ranges low in psychiatric ECs, even lower than in USB ECs. As the reasons are unknown, we may only speculate. This result may be related to the fact that the professional expertise for capacity in this context lies in the hands of psychiatrists – whereas in the U.S. this task may, at least in some centres, be delegated to CES

services. Being in charge themselves, psychiatrists may feel they should not ask for ethical advice in this realm. However, while competence may not be raised as an ethical issue in itself, in many EC meetings, both at USB and UPK, questions about the patient’s decisional capacity are raised and discussed, at least by the moderator if not by the requesting parties.

When the earlier North American studies were conducted, overcoming paternalism – especially regarding decisions at the end of life – was a great challenge. Today, it seems that in Switzerland and much of Europe the respect for the wishes of competent patients has become a solid cornerstone of the health care ethos, i.e., a shared value and criterion of good patient care. In our clinical context, ethical difficulties continue to be observed in end-of-life care which is mirrored in its top rank in somatic care. But additionally, a new complex of concerns has emerged: with the strong attitude and consensus on respecting the patient’s autonomy, health care professionals face difficulties when being confronted with patients who nonetheless cannot decide for themselves or voice preferences that seem to be more or less obviously non-autonomous, i.e., based on mental alterations or utterly self-destructive. In such cases medical interventions may be instrumental to allow patients to regain their decisional capacity, even against their momentarily expressed wishes. Thus, using ‘coercion’ might serve on a mid- or long-term base their autonomy and the respect thereof better than forgoing treatment for resisting patients altogether. While the rhetoric of the autonomous patient sometimes is feared to marginalise other important ethical princi-

³ Also, unpublished data from Marburg, Germany, hint towards validation of the end-of-life CES focus: 15 out of 33 (45%) ethical case discussions (called “family conferences”) held in 2014 addressed a shift towards palliative care (2013; 13/19 = 68%; 2012: 17/41 = 41%). Personal communication from Prof. Gerd Richter, 11.12. 2015.

Table 5: Further ethical issues

Further ethical issue	Hospital		Total	% of total
	University Hospital Basel (USB)	Psychiatric Hospitals of the University Basel (UPK)		
Care management	5	6	11	11.0%
Competence	6	1	7	7.0%
Treatment limitation	3	2	5	5.0%
Treatment-plan evaluation	2	2	4	4.0%
Health care resources, allocation of	3	0	3	3.0%
Palliative care and hospice	2	0	2	2.0%
Access to health care	1	0	1	1.0%
Advance directives and advance care planning	0	1	1	1.0%
Coercion	0	1	1	1.0%
Confidentiality	0	1	1	1.0%
Discrimination	1	0	1	1.0%
End-of-life care	1	0	1	1.0%
Pregnancy / assisted reproduction	1	0	1	1.0%
None	25	36	61	61.0%
Total	50	50	100	100.0%

ples, our experience shows that health care professionals requesting EC acknowledge the necessity to seek a balance between competing ethical values rather than just following *prima facie* patient preferences in a simplified understanding of respect for autonomy.

For both top themes end of life and coercion the recent Swiss legislation (2013) plays an important role; it strengthens patient rights, e.g., by stating that advance directives are to be acknowledged; it also clarifies who the patient’s substitute decision-maker should be in the absence of an advance directive by ranking the patient’s next of kin into an explicit order beginning with the (marital) partner living in the same household. This gives patients and couples extensive rights to make decisions for themselves and for one another. However, experiences with family members who are overcharged by having to make such decisions or appear incapable of prioritising the patient’s values (over their own) are being observed [29]. In the law the instalment of a professional substitute decision-maker is a second line option, but often initiated hesitantly after difficulties have emerged already.

In many countries end-of-life issues have been among the most prominent content matters for national (ethics) guidelines. However, their application in clinical practice for solving ethical dilemma is less than self-explanatory [30, 31]. Coercive measures have been placed on the agenda by the Swiss Academy of Medical Sciences (SAMS) recently suggesting a new guideline put to discussion in 2015 [32]. Given the prevalence of ethical difficulties perceived by health care professionals in situations where they have to face the necessity of using coercive measures, tools such as guidelines

and policies have become more popular and may gain importance for problem solving [33]. While the national guideline is still on its way, local policies have been enacted, e.g., the USB’s “Minimal Standard for Measures Restricting Freedom” [34] or the UPK’s Policy on Isolation in Child Psychiatry [35].

Our study has merits and limitations. One of its strengths is to provide rich data giving insight into EC practice that has been little illuminated by empirical research so far. It is based on a very careful and systematic documentation of EC using intersubjective check-ups and – hardly ever reported in other studies – approval for the EC record by the requesting parties. Our sample of 100 EC cases is still (too) small for quantitative statistics. But it consists of so-called full ethics consultations – of which a major American centre reported just 29 over three years [14].

Conclusions

Altogether, the big five themes revealed by our analysis stimulate the catalogue of clinical ethics education, not only for ethics consultants and committee members, but also for health care professions who wish to live up to the expectations of good ethical practice. The thematic shift to a double focus on issues concerning end-of-life decisions *and* coercion as the top problems in ethics consultation suggests the adjustment of academic curricula and continuing education of both, health care professionals and clinical ethics consultants to these topics.

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Zusammenfassung

Die «Big Five» in 100 Fällen von Ethikkonsultation

Hintergrund: Diese Studie soll einen Einblick in die Praxis der klinischen Ethikkonsultation (EK) vermitteln und ein besseres Verständnis für deren Auslöser, Inhalte und Ergebnisse. Durchgeführt wurde sie in 2 (von 3) lokalen Universitätsspitalern.

Material und Methode: 100 sog. volle EKs (je 50 aus dem somatischen Universitätsspital/USB und aus den Universitären Psychiatrischen Kliniken/UPK) über 3 Jahre wurden auf der Basis einer reichhaltigen und hoch standardisierten Dokumentation analysiert.

Ergebnisse: Insgesamt finden sich in der Mehrzahl aller EKs (84%) ethische Fragestellungen zu wenigstens einem der folgenden 5 Themen: Zwangsmassnahmen (28%), Patientenmanagement (24%), Bewertung des Behandlungsplans (17%), Betreuung am Lebensende (16%) oder Schwangerschaft / assistierte Fortpflanzung (12%).

Im USB betreffen die Top-3-Themen die Betreuung am Lebensende (28%), Schwangerschaft / assistierte Fortpflanzung (22%) sowie Zwangsmassnahmen (20%), gefolgt von Therapiebegrenzung (8%) und Patientenmanagement (6%). Die herausragende ethische Einzelfragestellung in den EKs der UPK betrifft mögliche Zwangsmassnahmen (34%), gefolgt von Patientenmanagement und Bewertung des Behandlungsplans (jeweils 20%).

Diskussion: Die Prävalenz der ethischen Fragen am Lebensende in EKs der somatischen Patientenversorgung steht in Einklang mit der publizierten Forschung, während die Evidenz für Zwangsmassnahmen als Hauptthema von EKs generell neu erscheint. Vergleichbare Studien aus anderen europäischen Zentren sind kaum zu finden; die vorliegenden nord-amerikanischen Publikationen artikulieren keine Prävalenz für dieses Anliegen.

Folgerungen: Die Akzentverschiebung vom Thema Lebensende hin zu Zwangsmassnahmen und die ausgewiesenen «Big Five»-Themen stellen eine Her-

ausforderung für den Lernzielkatalog der Aus- und Weiterbildung der Ethik dar, nicht nur für Fachpersonen der klinischen Ethik und Konsultation, sondern auch für die Heilberufe insgesamt.

Résumé

Les cinq sujets principales des consultations d'éthique

Contexte: L'objectif de cette étude est d'éclairer les pratiques de la consultation d'éthique clinique (EC) et de contribuer à une compréhension plus profonde de ses déclencheurs, ses contenus et ses résultats. L'étude a été réalisée dans deux des trois hôpitaux universitaires de Bâle.

Matériel et méthode: 100 ECs complètes (50 ECs exécutées à l'Hôpital universitaire de Bâle/USB et 50 ECs aux Cliniques psychiatriques universitaires (UPK) ont été analysées sur la base d'une documentation strictement standardisée.

Résultats: En tout, la majorité des ECs (84%) comprenait au moins une des 5 sujets suivants: contrainte (28%), gestion du soin (24%), évaluation du plan de traitement (17%), soins de fin de vie (16%) et procréation médicalement assistée (12%). Les 3 questions principales des ECs à l'USB étaient les soins palliatifs (28%), la procréation médicalement assistée (22%) et la contrainte (20%), suivies par la limitation des traitements (8%) et la gestion du soin (6%).

Le sujet le plus fréquent des ECs à l'UPK était la contrainte (34%), suivi par la gestion du soin et l'évaluation du plan de traitement (tous les deux 20%).

Discussion: La fréquence du sujet fin de vie dans les soins somatiques est en ligne avec la recherche précédente. Par contre, la question de contrainte comme sujet principal dans ECs en général est nouveau. Des études comparables des institutions européennes sont rares et les documents existants de l'Amérique du Nord ne montrent pas de prévalence de cette question.

Conclusion: Le changement de direction thématique vers la concentration sur les deux sujets fin de vie et contrainte ensemble avec les cinq sujets principaux présentés stimulent le catalogue de l'éducation en éthique clinique, également pour les consultants d'éthique et les professionnels de la santé.

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