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Thematic Section

Research on clinical ethics and consultation. Introduction to the theme

Stella Reiter-Theil[1,]*, and George J. Agich[2]
[1]*Institute for Applied Ethics and Medical Ethics (IAEME), Medical Faculty, University of Basel, Missions Strasse 21A, Basel CH-4055, Switzerland (*author for correspondence, E-mail: S.reiter-theil@Unibas.ch); [2]BGeXperience Program, Bowling Green State University, 404A Moseley Hall, Bowling Green State University, Bowling Green, OH, 43403, USA*

Abstract. Clinical ethics consultation has developed from local pioneer projects into a field of growing interest among both clinicians and ethicists. What is needed are more systematic studies on the ethical challenges faced in clinical practice and problem solving through ethics consultation from interdisciplinary perspectives.The Thematic Issue covers a range of topics and includes five recent studies from various European countries and the USA, focusing on issues such as the ethical difficulties of end of life decisions, experiences with newly developed or well established ethics consultation services, and the expectations of physicians in various clinical fields who are still unfamiliar with clinical ethics consultation.The papers included illustrate the interface between different socio-cultural contexts and their ways of dealing with clinical ethics consultation. They deepen the dialogue on clinical ethics consultation that has emerged at the European and International level.

Key words: clinical ethics consultation, interdisciplinary methodology, research

The idea for this Thematic Section was triggered during the Second International Conference on Clinical Ethics Consultation, held 2005 in Basel (Slowther, 2005), which included a number of parallel sessions and posters that reported empirical studies of ethics consultation. At the First International Summit on Clinical Ethics Consultation held in Cleveland, 2 years earlier (Buerkli, 2003, Buerkli and Steinkamp, 2004), the program featured reports that described the activities of clinical ethics consultation, categorized and documented the experiences of specific services and reported various problems and approaches. However, systematic research studies were rare. This is understandable. In some countries (particularly in Europe) the development of empirical research on ethics consultation is hampered on the slow establishment of clinical ethics services or by a lack of collaboration between clinical ethics services and researchers (see the thematic issues of two journals on clinical ethics consultation (CEC) in Europe: *Ethik in der Medizin*, 1999, 11, 4 and *Journal of Medical Ethics* 2001, 27, suppl I; also: Reiter-Theil, 2001).

There are, however, other reasons, why clinical ethics–especially the practice of consultation–has not often been subject to research so far: research on clinical ethics is demanding. It is a new and complex field that seems to require interdisciplinary approaches. It is not adequate to simply combine different clinical disciplines, such as medicine and nursing, or to carry out abstract ethical analyses of clinical "objects"; innovative approaches may be necessary (Reiter-Theil, 2004). In order to achieve sound research results in clinical ethics, the clinical view has to be intertwined with the normative-ethical level of analysis in a methodologically adequate way. This means, of course, that the challenge of obtaining valid empirical material is multiplied by the difficulty of drawing out interrelationships between *the Is and the Ought* (to put it in traditional terms), between the data on the one hand and the values and norms on the other, instead of emphasizing the gap between the two (Putnam, 2002). This challenge is part of a larger concern, namely that despite a trend toward empirical research in bioethics in recent years, empirical research on clinical ethics remains underdeveloped (Ten Have and Lelie, 1998, Haimes, 2002, Sugarman, 2004, Nikku and Eriksson, 2006).

Sugarman and Sulmasy, (2001) have shown that there is such a thing as research *methods* in medical ethics and have argued in favor of multi-method approaches, including empirical studies. We under-

stand that a pluralistic orientation to methods will necessarily also require a dialogue between methodologies. The Sugarman and Sulmasy book appeared at the same time that George Agich addressed the question of method in ethics consultation in a target article in the *American Journal of Bioethics* (Agich, 2001). Some commentators on this article seemed content that clinical ethics had not seriously engaged in methodological discourse and challenged the political intent of this discussion (Smith, 2001, Veatch, 2001). To us, it seems that empirical research in clinical ethics and ethics consultation, in particular, will have a future only, if it does accept the need to adopt sound research methods and to commit itself to the goal of improving the quality of this work. Pluralism is thus not only applicable to theories, but also to methodologies–and this is one message of this Thematic Issue. Several approaches are used in the following papers. Each proves useful in different respects and for different purposes.

The content of the papers in this Issue covers a wide range of topics. It begins with an article of Sabine Beck, Andreas van de Loo and Stella Reiter-Theil (Beck et al., 2008) on ethical problems in intensive and end-of-life care–one of the major domains where CEC services are required, but not always available; evidence is given that there are clear problems in clinical decision-making due to insufficient discrimination between the permissible and the prohibited forms of treatment limitation in Germany. The article is an interview study with 28 intensive care physicians in most of the ICUs of Baden-Wuerttemberg (Germany). It deals with a problem that could–or should–be addressed in ethics consultation. Beck et al. highlight one of the persistent ethical challenges in modern intensive care, the withdrawal of mechanical ventilation. The study provides empirical evidence that even experienced physicians may lack valid and reliable criteria to distinguish between the permissible and the prohibited–which results in an attitude that favors over-treatment, even at the end of life, and paternalism (Reiter-Theil, 2003). Also, there seems to be considerable uncertainty among intensive care physicians regarding the conceptual basis required for decision-making.

Interview studies such as this one using (authentic) case vignettes have become accepted approaches within the field. It is no surprise that exploratory studies on delicate issues and taboos can effectively employ qualitative methods such as interviews with anonymous data analysis to provide insight into otherwise disguised problems. The conceptual and ethical confusion in the legal situation in Germany revealed by this study suggests that deep ethical problems will not magically disappear with the establishment of ethics consultation, but might be brought to light within the everyday practices of CEC services.

The next paper from Norway also reports an interview study. Reidun Foerde, Reidar Pedersen and Victoria Akre carried out interviews with eight physicians about their attitudes and responses to the consultation services offered by six different ethics committees (Foerde et al., 2008). They report that the clinicians are generally satisfied with consultation services and prefer to be involved actively in the entire process, including case deliberation. Besides their satisfaction with consultation services, the study also disclosed obstacles and challenges of ethics consultation, such as non-referral of a case to the ethics committee. On the whole, they regard the new CEC services in Norway positively while showing that clinicians feel challenged by certain basic operational procedures such as cases being "reported to a committee" to such an extent that the authors speak of "the medical culture's aversion against openness". This observation raises the question to what extent is ethics consultation perceived as a threat to the authority or self-image of Norwegian physicians and whether this perception is grounded in reality. This kind of concern is new in the field and is clearly connected with the question whether fear of retaliation deters requests for CEC.

Following up with the hypothesis that clinical staff may be afraid of consequences resulting from requesting an ethics consultation, Marion Danis, Adrienne Farrar, Christine Grady, Carol Taylor, Patricia O'Donnell, Karen Soeken, and Connie Ulrich ask the important question, "Does Fear of Retaliation Deter Requests for Ethics Consultation?" (Danis et al., 2008). Because of the proliferation of ethics consultation in the United States, the authors investigated their question using a questionnaire survey. The interface between the Norwegian paper by Foerde et al. and the report of Danis et al. from the USA illustrates how empirical research methods need to be appropriate to the context and developmental status of clinical ethics within the context of investigation. Qualitative approaches are best used for explorative purposes and to generate hypotheses where data and experience are limited, whereas quantitative studies can be used to test received opinions or beliefs. Danis et al.'s study is particularly interesting in this regard. In the context of North America, where health professionals and medical personnel are quite familiar with CEC, the data from their survey of nurses and social workers on their experiences with ethics consultation shows

that fear of retaliation is, nonetheless, prevalent to a certain degree even though it is not associated with a reduction in their willingness to request ethics consultation.

Two other countries with quite contrasting experiences regarding CEC are represented in this Issue: Bulgaria and The Netherlands. Bulgaria, a member of the European Union since 2007, is now beginning to bring ethics into the clinical context. Silviya Aleksandrova's (2008) study of the attitudes of hospital physicians in Pleven University Hospital shows that despite the lack of experience with ethics consultation or clinical ethics generally, there is a perceived need and openness among physicians for help in addressing ethical problems arising in the course of patient care. This questionnaire-based survey has an impressive response rate of nearly 90% of the hospital physicians and shows that Bulgarian doctors report similar ethical problems as do their colleagues in other countries. Their positive attitude towards ethics consultation does not, of course, reflect any experience of ethics consultation since these services are not developed.

Besides intensive and end-of-life care, other clinical fields have needs for ethics consultation and clinical ethics training. An ethics project focusing on psychiatry reported by Bert Molewijk, Henk Milius, Maarten Verkerk, and Guy Widdershoven reports a range of ethical difficulties in a Dutch clinic, including transitional problems in the work place (Molewijk et al., 2008). The Netherlands has adopted CEC relatively early compared with the rest of Europe and has adopted several different approaches to structuring ethics in clinical settings. The authors report the process and results of an educational approach they term *moral case deliberation* in a psychiatric hospital.

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