07

Healthcare Ethics Consultation and Conflict Resolution: Faith, Love, Feelings

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Most of us interact with a healthcare institution from time to time for many different reasons. Healthcare providers deliver healthcare in the United States in various ways, locations, systems, and payment sources. Over the past century, healthcare has changed dramatically from the country doctors of the past to the current multi-system, ever-expanding healthcare networks. Technology, such as mobile devices, phones, internet resources, tele-medicine, and health-tracking devices give healthcare consumers more options to access and receive healthcare services than ever before. Medical research has given rise to new medications, testing capabilities, surgical techniques, monitoring devices, and scientific understanding of disease and disability. As a result, inter-professional medical education has evolved to keep up with science and medical technology. However, even with all these technical and educational advancements, one thing in healthcare has remained constant over the centuries—human interaction between the sick and their healers.

Religion has always been an important part of life and death. We often celebrate birth and death with religious ceremonies that include God's love for us as well as our belief in the sanctity of human life. Along life's trajectory, we often have to make decisions regarding our health and the health of our loved ones, and these decisions may include our own spirituality through prayer and consultation with clergy. Multiple studies have shown that religion and spirituality are "important factors that influence medical decision making in the event of terminal illness."[1] As Christians, we believe in the sanctity of life and that medical care must show compassion. Compassion is a professional obligation of care providers. "It is this professional obligation to compassion that is why excellent pain management, indeed management of all symptoms, is so important to medical professionals who provide care to patients as they approach the end of their lives."[2] Adequate pain management is always important and takes on a greater obligation when people are in the terminal phase of life.

The intention for adequate pain management at the end of life is motivated by compassion with the intention that the pain medication palliate the pain, not to cause or hasten a person's death. The principle of double effect, then, is performing an action with the intention of good (increasing pain medication to decrease suffering) but knowing that the good action may have unintended consequences (the medication may result in the death of the person due to their underlying disease).[3]

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With human interactions of any kind, conflict may occur. The more stressful the human interaction is, the more critical the conflicts can be. Nowhere is such conflict more painful than within the context of illness. Critical life decisions of any kind can lead to stress, frustration, and anxiety. As a result, people often appeal to their faith in God, their love for each other, and their feelings about the situation, which may result in fear, anger, sadness, and confusion. When a person or their loved one(s) experience illness, especially a serious or life-threatening illness, a sense of helplessness is common and can often escalate quickly if there is a real or perceived conflict between the patient and the family and the healthcare team. This conflict can quickly lead to a lack of trust (patient/family vs. healthcare team), poor communication, and strain within the patient-provider relationship. It is at this time that a healthcare ethics consultation might be helpful in restoring positive communication and assisting with important healthcare treatment decisions.

A healthcare ethics consultation "is a set of services provided by an individual or group in response to questions from patients, families, surrogates, healthcare professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care."[4] Ethics refers to a branch of philosophy that "focuses on the reasons why an action is considered right or wrong" and asks us to justify a particular position in an argument through reason.[5] The current "standard of care" for a specific illness guides medical treatment recommendations for that illness. For example, if a person has pneumonia caused by a specific bacteria, there is a standard of care for what antibiotic should be given that is based upon research that has proven a particular antibiotic is the cure for that particular bacteria. Not to provide this cure or standard of care, therefore, would be considered ethically and professionally wrong. Alternately, there are clinical situations in which the standard of care is to palliate—to keep comfortable—as there are no treatments available that will cure what is ailing the person. This can lead to conflict between the patient/family and the healthcare team when the standard of care has the goal of comfort at end of life, but the patient/family (legal decision maker) wants full aggressive treatment including attempted resuscitation (CPR and other treatments used in resuscitative situations).

It has become very common in healthcare institutions, especially in the hospital setting, that ethics consultation "play a facilitative role in the resolution of ethics or other values-based conflict in patient care."[6] Each of us has our own faith, values, norms, and morality that we believe in and that often guide our everyday actions as well as our actions when involved with stressful life situations. When faced with end-of-life care decisions for a loved one, our life values may question our personal identity (Who am I in this situation I have not experienced before?), self-image (I want to do the right thing, but I don't want my loved on to die), self-esteem (Am I competent to make this decision when I am very distraught?) and sense of morality (Am I a good person If I don't want treatment for my loved one that may prolong life but cause pain?).[7] A clinical ethics consultation is meant to explore personal values within the context of the clinical situation and to further discuss value differences among those involved (patient, family, and healthcare team) openly and truthfully in order to see resolution and/or reconciliation.[8] Those who provide clinical ethics consultations must also be aware that there are limitations to what a consultation may provide and that "good solutions to ethical problems depend not on ethical analysis alone but also on a variety of things, including accurate factual information, effective communication skills, and the insights and contributions of a wide variety of professionals."[9] In addition, the consultant must acknowledge that there may not simply be one solution to the issue or conflict, but rather a range of acceptable moral options from which the legal decision makers may choose.[10] The ethics consultant works with many healthcare professionals within the consult context including the treating team of physicians, nurses, therapists, social workers, as well as chaplains and patient advocates.

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An ethics consultation also allows the patient/family members to have a moral space that allows for ethical reflection. "Patients and families need space to reflect on their lived values and to discover whatever is good for the patient from the perspective of the patient."[11] The treatment team enters this moral space with the family and patient when speaking about their lived values, which include lived faith, love, and feelings. There may be situations where the patient (if able to participate) and the family disagree with the treatment plan for the patient that the treating team thinks is the clinically appropriate course of action based upon the patient's physical exam, disease process, and overall prognosis. This can be stressful for everyone and can lead to mistrust and conflict. The following is a case example where there is conflict between the surrogate decision maker and the medical team.

Case Example:

84-year-old Helen was admitted to the hospital from a nursing home. She was brought to the emergency room because she was having trouble breathing. She was admitted to the same hospital 3

weeks ago for low blood pressure and discharged back to the nursing home a few days later when her blood pressure was under control. Her recent health history report from the nursing home includes advanced dementia, poor appetite, and high risk for falls (she fell six months ago and was admitted to the same hospital for assessment but did not have any broken bones).

She is not able to make her own medical decisions and has two adult children (Sue and Barb) who both live in different states than Helen. Helen does not have any form of advance care plan for medical decisions so both her adult children are making medical decisions for her via the state surrogate law for medical decisions.

Because Helen has been hospitalized three times in the past six months, her care team wants to have a care conference with both adult children to discuss future healthcare plans for a patient who is very frail, debilitated, and is at risk for ongoing health issues such as pneumonia and falls. Neither Sue nor Barb could meet in person, however, they were available to meet via conference call.

Prior to the phone conference call, Helen's doctor, physical therapist, social worker, and geriatric nurse specialist met to discuss medical goals of care. All team members agreed that the overall medical goal for Helen would be to keep her comfortable in her nursing home environment and that burdensome treatments should be avoided. They also wanted to speak with her children regarding end-of-life care and hospice services for Helen.

During the conference call, both Sue and Barb voiced concern for their mother and that they were aware how frail she is. They voiced regret that they do not get to visit her often due to travel distance and their job situations. The team members each gave an update regarding Helen related to their particular assessments and asked if either daughter had any questions. Sue voiced her sadness that Helen was so frail. Barb also voiced concern, but quickly stated that she expected that the nursing home and hospital would "do everything" to keep Helen alive because she has been praying that God will heal Helen. Sue did not say anything to this but when asked by the team what she thought about Helen's condition and what her mother would want if she could make her own decisions, Sue deferred to Barb. The meeting ended and the patient remained in the hospital with orders that should she have a cardiac or respiratory arrest, staff would engage with full aggressive attempts at resuscitation.

The team all agreed that an ethics consultation would be helpful as the team feels moral distress over the outcome of the team meeting.

In the case above, there is conflict between what the providers assess to be the standard of care for Helen and what level of care the daughters, as her decision makers, want. The conflict has to do with making Helen comfortable and enhancing her overall quality of life versus aggressive ongoing treatment that carries a heavy physical burden to Helen and which would not improve her poor health condition or enhance the quality of her life. Aggressive care treatments at the end of life often prolong the dying process rather than provide comfort to the patient.[12]

For the patient who lacks decisional capacity like Helen, health care decisions should be driven by the answers to these three questions:

1. Who is the legal decision maker?

Is there any kind of Advance Care Planning (ACP) documentation—power of attorney for healthcare, POLST form, or other accepted form of advance directive for healthcare? If there is no ACP document, most states have a "Surrogate Decision Maker" statute for healthcare decisions, which goes by priority status of family members.

2. What are the wishes of the patient related to health care or end-of-life care?

Were there any conversations between and patient and her family, friends, or healthcare providers? Did the patient ever speak about death, and if so, what did she say?

3. What treatments are medically indicated for this patient?

Medical treatment options should be related to the standard of care for the specific illness[13] as well as what treatments are medically indicated for a specific medical problem or disease process. Treatment decisions should also be related to the overall goal(s) of care based on patient health condition as well as personal/social cues from the patient or loved ones. For example, some people may have verbalized to their family that they would not want to live in a nursing home, but the time has come that they can no longer live alone and need more assistance than the family can provide.

Treatment option discussions can be difficult for the patient/family and providers because there may no longer be treatment options that can reverse the course of illness. During these conversations we want to affirm the life of the sick person, acknowledge the feelings of family and friends who love this person, and discuss the current plan of care options that honor the sick as well as care for the dying.

Helen's attending physician places a request for the healthcare ethics consultant (HEC) to meet with Helen's daughters to discuss possible end of life treatment/care decisions. The HEC receives the consult request from the team and begins to prepare for a follow-up meeting with the team and daughters.

After reviewing Helen's medical record and speaking with team members about Helen's hospital course and present condition, meeting dates and times were agreed upon and the patient's daughters were contacted and a date and time were agreed upon for the follow-up meeting (daughters via phone). Team members want to acknowledge Barb's faith as well as to honor their responsibility to refrain from treatments that would be of no medical benefit and may even cause more suffering to Helen.

When an HEC is called upon to lead a family/team meeting due to any type of care-related conflict or to assist with difficult conversations between team, patient, and/or family, the preparation usually consists of the following steps: clarifying the main concern(s), deciding who should be at the meeting, discussing all possible appropriate care options, and identifying the overall goal for the meeting. In general, the ethics consultant is contacted by a member of the family or a member of the clinical team to request a consultation to help clarify goals of care for the patient and to discuss the current medical treatment plan. This meeting also provides family members with the opportunity to ask questions about current care as well as what the clinical plan is for treatment and discharge.

Once the ethicist receives a request for a family meeting, they must assess who should attend the meeting, and this usually is facilitated with the help of a chaplain and/or social worker who may have had interactions with the patient and family already. In general, it is very helpful to have one of the physicians on the patient's team begin the meeting to explain the medical information related to what is currently going on with the patient and to answer questions the family may have. Other clinical staff who may be involved are nurses, social workers, therapists, chaplains, care coordinators, and discharge planners. The staff invited to the meeting really is dependent on what the goals of the meeting are and what provider information is of importance related to the goals. Once the clinical staff have been identified, any family/friends of the patient who should be at the meeting are contacted. If the patient is not able to make their own healthcare decisions, the legal decision maker should be identified and be part of the ethics/team meeting. In addition to organizing family and staff, the ethicist may also assist in arranging for a private room for the meeting as well as making sure interpretive services or electronic equipment are provided if needed.

There are a few other points to keep in mind while preparing for and running a family/team meeting. At the beginning, the ethicist introduces himself or herself, states the reason the meeting is being held, and asks others to introduce themselves. After introductions, clinical staff should review the healthcare status of the patient with family and answer any questions they may have regarding the clinical course thus far. At this point, the ethics consultant is able to restate the reason for the meeting as well as what, if any, decisions are being asked of the legal decision-maker. A few important points to keep in mind while running a family/team meeting include:

1. Set up the meeting room (be sure room is clean; provide water bottles and tissue; make sure equipment is available, in working condition, and that it accommodates privacy)
2. Stay patient-focused (review clinical goals of care the team has for the patient; recommended treatment options as well as alternatives)
3. Review what is known regarding family/patient wishes, values, and goals for the patient (may be known or unknown, or perhaps are goals that are not specific such as "we want mom to get better")
4. Review all possible meeting outcomes (ongoing treatment/care options) and prepare for each
5. Prepare an outline for the meeting and review this at the beginning of the meeting

The following is an example of an ethics consult meeting outline:

1. Introductions
2. Verbal expectations of participants (respect for other comments, refrain from abusive verbal/body language, etc.)
3. Time (have a timekeeper if needed)
4. Paper or whiteboard to make notes of questions or follow-up needs that cannot be accommodated at the time of the meeting
5. Plan for safety (have security available as needed)

During the meeting, the HEC should thank all participants for attendance, acknowledge those attending the

conference via call/video platform, document names and relationships of all in attendance, identify any meeting limitations (time, practitioner availability, family availability in person/by phone, etc.), establish meeting boundaries for re-direction should the conversation move too far from topic, and let participants know questions that need to be followed up on after the meeting will be communicated to them after the meeting.

A common way to begin a family/team meeting is to ask a few ice-breaker questions, for example, Tell us a bit about your loved one—did they have any hobbies, interests, or activities that they enjoyed? What kind of things were/are most important to your loved one? What are your biggest concerns right now about your loved one? What are you most fearful of at this time? As you move into a review of the current medical conditions of the patient, allow for questions that the clinical staff may answer as they come up. If other clinical staff are at the meeting, such as physical or occupational therapists, allow them to provide their updates and interact with family. Once the clinical staff is done talking with family, they often will leave the meeting but are available for follow-up questions.

At this point, it is time for the HEC to map out realistic care outcome options for the patient (this can be done on a flip chart or whiteboard). The care outcome options should have been explored during the clinical staff discussion and the HEC can further discuss the options given by the clinical staff. Family members often display a wide variance of emotions that may include anger, disbelief, relief, understanding, and even acceptance if they have been told that there is nothing more that can be done medically to cure what the patient has. The final step in the family/team meeting is to ask the legal decision maker (often with discussion from other family/friends at the meeting) to deliberate about the clinical options given by the clinical team, and to make the decision being asked of them on the patient's behalf. It is common for the decision maker to ask for more time to make the decision, as they may need to discuss with other family/friends who were not at the team meeting. If this is the case, it is helpful to have a date/time agreed upon for the HEC or clinical staff to follow up with as need.

The final step in the overall ethics consult is to comfort, console, and conclude. This step responds to emotional reactions with empathic language and behavior or with silence as the situation calls for. Assure family that the medical team will not abandon the patient or the family no matter what treatment course is chosen. Acknowledge the strength of the patient and loved ones during this difficult time and thank all participants for sharing in the meeting. Affirm any family members' reflection of their faith, their love and their feelings about their loved one and this stressful situation. Restate the plan decided upon, or that is being decided upon if more time is needed to make decisions and reflect on next steps in the process. Offer supportive care services, such as clergy/chaplains, social workers, or other services available to the patient/family. This is also the time to identify follow-up steps as a result of any decisions made in the meeting as well as to share contact information for follow-up needs.

In the case example given earlier about Helen and her daughters Sue and Barb, I leave it to the reader to explore what an ethics consultation meeting might have looked and sounded like as well as to reflect on any personal experiences with a clinical ethics consultant.

In conclusion, a healthcare ethics consultation is a service provided in many healthcare institutions that assist with medical decisions by organizing a multi-team meeting with patients and family members to gather information and answer questions that assist with difficult medical decisions. These meetings allow a moral space for questions, answers, reflection, and confirmation of faith, love, and feelings. Medical technology will continue to improve and enhance human life in ways that we can only imagine today. Along with all the advanced healthcare technology, current and future, comes the mounting burden of healthcare decisions we all may be asked to make regarding the use of this technology either for ourselves or for a loved one. Either way, the constant tension is not about time or space, but about being human and taking care of those in need.

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