Clinical ethics support services in New Zealand—tailoring services to meet the needs of doctors

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ABSTRACT:

Aims: To better understand senior doctors’ attitudes to clinical ethics support services at Capital and Coast District Health Board (CCDHB), in order to better tailor clinical ethics support services in New Zealand to the needs of doctors.

Methods: We conducted in-depth semi-structured interviews with 14 senior doctors at CCDHB in 2011 and 2012. Data analysis was inductive and iterative.

Results: Doctors primarily rely on informal avenues of peer consultation for support when making difficult ethical decisions. Many participants saw a potential role for formal ethics support, but expressed concern about how ethics support services would fit into their clinical practice. Primary concerns included the accessibility of support services and moral responsibility for ethical decision making in clinical settings.

Conclusions: Doctors are more willing to engage in ethics support services where they are able to participate in, or at least observe, the decision-making process.

Ethical challenges are an inevitable part of the practice of medicine, a vocation that serves people when they are vulnerable. Clinical ethics support services (CESS) aim to assist doctors in complicated ethical decision-making. In New Zealand, CESS are relatively new and have emerged as a clinician-led initiative. In North America and Europe CESS have become increasingly prevalent in and integrated into healthcare delivery. Several models have emerged for the delivery of this support, ranging from formally trained clinical ethicists who work as professional consultants to hospital ethics committees comprising both clinical and lay members. A growing literature is contributing to principles of best practice in clinical ethics support.

Appropriate training in ethical reasoning for clinicians and ongoing access to support in ethical decision-making across the span of a clinical career improves doctors’ well-being and enhances patient care. A study by Kälvenmark et al conducted in 2003 found that moral distress was experienced at higher rates by clinicians who felt they did not have adequate support structures to help them process ethical concerns.

The New Zealand Health and Disability Commissioner and the courts recommend doctors engage in “broad consultation in difficult clinical situations”, but do not specify mechanisms by which this should occur. In New Zealand there are eight CESS, some serving more than one District Health Board (DHB), and the majority of these have been established since 2008. The most prevalent model is that of a committee-style advisory group composed predominantly of clinicians. In July 2012, the Health Quality and Safety Commission (HQSC) offered a grant to support the establishment of a New Zealand Clinical Ethics Network to support existing Clinical Ethics Advisory Groups (CEAGs) and facilitate the establishment of new services around the country. The HQSC grant highlights a turning point in New Zealand where CESS are being increasingly recognised as critical to safe and reflective medical practice. As such, it is an important time to take stock and reflect on how CESS can be designed to best meet the needs of
clinicians. Our study was independently funded and not part of the HQSC grant.

There is a surprising lack of literature on the role, function and effectiveness of emerging CESS in New Zealand. In 2004, Pinnock and Crosthwaite published survey results regarding health professionals’ views of the Auckland Hospital’s Clinical Ethics Advisory Group (Auckland CEAG).9 However, to date there has been no previous qualitative study of CESS in New Zealand. Qualitative methods generate nuanced data that allows in-depth exploration of complex themes. We use the CEAG established at Capital and Coast District Health Board (CCDHB) in 2010 as a case study for an in-depth qualitative investigation of the role CESS can play in supporting ethical decision-making in New Zealand hospitals. The CCDHB CEAG Terms of Reference identify two central purposes:

- to provide a consultative, advisory and supportive mechanism to assist healthcare professionals to make informed ethical decisions in their management of patients
- to facilitate education in the area of ethics and to foster a culture of ethical awareness at CCDHB so as to equip healthcare professionals with the means to approach ethical problems and conflicts in clinical practice.10

When a case is referred to the CEAG it is considered at their regularly scheduled monthly meeting or, in urgent cases, can be reviewed within 24 hours. The referring clinician provides relevant clinical and ethical details of the case. Patients and their families are not informed that the case has been referred and are not involved with CEAG processes. The CEAG then has a closed session in which they discuss possible approaches to managing the ethical issues. CEAG members have access to patient medical records if necessary. The CEAG provides a formal non-binding opinion in writing to the referring clinician.

**Methods**

We recruited participants by emailing invitations to senior doctors. All senior doctors at CCDHB were invited. We chose senior doctors because the culture of ethical behaviours in a team is often shaped by the most senior clinician and senior clinicians are more likely to have experience of ethical dilemmas to draw on because they have more years of clinical practice. We ensured our sample included surgeons and paediatricians for the following reasons. Previous research showed that surgeons were much less likely than other clinicians to use CESS.12 Paediatric clinical ethics typically require a different decision-making framework to that used in adult medicine;13 as a result, some larger centres overseas have developed separate paediatric clinical ethics committees.14 Within these parameters, we wanted heterogeneity, therefore recruitment was limited to the first three volunteers from each sub-specialty. Interviews were guided by an 18-point questionnaire, with questions grouped under four general headings: clinicians processes for ethical decisions making, ethical decision making in the hospital, services provided by the CEAG, the clinical ethics environment in New Zealand. Interviews were recorded and transcribed verbatim. ED coded the transcripts and ED and AB analysed the results. We conducted an iterative inductive thematic analysis, whereby some emerging themes were integrated into the interview template. The New Zealand Central Regional Ethics Committee approved the study (CEN/11/EXP/073).

**Results**

Between 2011 and 2012 ED conducted 14 interviews, ranging from 40 minutes–2 hours duration. All participants gave written informed consent. Recruitment finished when data saturation was reached. This is when no new broad overarching themes were being revealed by each subsequent interview set.15 Participants’ clinical specialities are listed in Table 1. The four main themes relate to awareness of the role of CCDHB CEAG, comparison of informal ethics support to formal CESS, clinician involvement in CESS ethical deliberation and ethical deliberation as a clinical responsibility. These are the key themes arising from the data, and do not correlate exactly to the topic sections of the questionnaire.
Awareness

Many participants were unaware or misinformed of the purpose of the CCDHB CEAG. Two of the participants had referred a case to the CEAG (3 and 14) and four others had been peripherally involved in such cases (2, 6, 7 and 13). Participant 12 sits on the CEAG as a clinical representative. Most of the remaining participants had not heard of the CEAG. Even among the clinicians who were aware of the CEAG, most did not have a clear understanding of its functions or how to access it, including clinicians who had already referred cases to the service. Common misconceptions included whether the advice provided by the CEAG was legally binding or whether accessing it obviated the need for seeking medicolegal advice in instances where there were legal quandaries in addition to ethical ones.

Comparing informal ethics support to formal CESS

Participants reported that the primary source of ethical support available to doctors is informal, such as seeking the opinions of senior colleagues. Most participants reported feeling well-supported and comfortable about seeking ethics support from peers. Study participants raised three specific concerns about CEAG, reflecting their views that it would not provide superior ethical support compared to their existing informal mechanisms:

- referring a case for consultation to the CEAG is more laborious than a quick corridor consult; it requires a greater investment of time and energy on the part of both the clinicians accessing the service and those volunteering to provide it. Participant 5 stated “[An ethics committee is] a slow bloody organisation. For individuals it's too slow...Where you're dealing with policy and larger picture things, I think that's where it works really well.”
- the training of CEAG members in ethics is not necessarily greater than the senior colleagues that the doctor might otherwise consult, at least at present.
- despite their diverse clinical backgrounds, members of the CEAG may not necessarily have the specific clinical expertise necessary to grasp the intricacies of the cases referred to them.

Participants described a range of barriers to accessing ethics support (whether informal or formal), which included isolation and a medical culture inhibiting both help-seeking behaviours and constructive criticism. Interestingly, it was common for participants to describe their own team or specialty as supporting open non-judgmental ethical debate, but to assert that other specialties were less receptive. Many clinicians emphasised that the culture of medicine makes it very difficult to raise concerns about the practice of peers—particularly senior peers—and that this can be a barrier to dialogue about ethical issues. “In medicine we're not very good at criticising people...The more senior the person gets, the harder it is...” (11) Several participants reflected that they found seeking ethical advice as a junior doctor more challenging, and expressed concern that the same barriers may exist for their junior colleagues today. Participants noted that junior staff, in addition to facing the inherent disadvantage of being less experienced, came up against cultural and systemic barriers to being able to seek adequate support in managing ethical concerns. “...going cap in hand to your boss and asking for advice on things like this is often perceived as a sign of weakness.” (9) Some participants felt that having formal services might provide an additional avenue for staff seeking ethics support.

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Table 1: Specialties of participants (in alphabetical order).
For participants, one of the most significant differences between ad-hoc support systems and using a formal ethics support service was that formal support is external to the group of people involved in patient care. Several participants felt that the value of the CEAG was that it could provide an objective sounding board in challenging cases, noting that at times maintaining perspective was difficult when one was immersed in a case. Participant 4 argued that seeking an independent ethical opinion was a sign of appropriate, reflective practice. Participant 3 noted “My experience of it was it actually helped me to see the situation from a slightly different perspective...I found it empowering...rather than stripping me of my clinical autonomy.” Conversely, other participants expressed concern that an external ethics advisory group would be out-of-touch with the specific clinical realities that contextualise ethical decisions in medicine. Participant 5 stated that “if you're working in a very specialised area of practice, the ethics of what you're dealing with rotates extremely strongly around knowledge of the topic or the clinical area with which you're grappling.”

Many participants believed an ethics support service should enhance ethical capacity of the clinical workforce. These participants felt that services should help clinicians attain a degree of ethical competence such that external ethical consultation was required only in exceptional circumstances. Participants offered their perspectives on the role a CESS might play in providing or supporting ethics education. Key ideas were that ethics education needed to be practical and integrated into the workplace and that it needed to break down cultural barriers to open ethical discourse.

Clinician involvement in CESS ethical deliberation

Many participants were concerned that referring clinicians are shut out from the process of ethical deliberation at CEAG. Participant 7 said he felt concerned with the lack of transparency when he was involved in referring a case to the CEAG. “I presented my case, but then the rest of the stuff was held behind closed doors. And you want to be involved in that discussion...it shouldn’t be secretive—which it isn’t—but that's what it feels like.” Several participants emphasised that any model for ethics support must involve clinicians in the process if it was to be accepted by the hospital community. Participant 1 pointed out that when clinicians were not involved, they did not learn from the consultation process. “I think discussions, which are iterative, would be a lot better.”

Ethical decision-making as a clinical responsibility

Some argued that ethical decision-making is a clinical responsibility that should not be abrogated. Others contended that accessing ethics support has the potential to enhance ethical decision-making and thus is a mark of responsible practice. These views influenced participants’ perspectives of the value of clinical ethics support.

All clinicians expressed the view that clinical ethics is a core competency for any doctor. Some felt that to “outsourcing” ethical decision-making to a CESS is to remove the decision-making role from the individual who a) has a professional obligation to fulfil that role and b) is in the best position to make that decision, by virtue of their expertise in the given field of practice. Some participants expressed concern that a CESS may be making unreasonable claims to moral authority by offering to solve clinical ethical problems. Participant 8 stated that there was no reason the CEAG should be any better at making ethical decisions than a well-trained, experienced group of health care professionals from a range of backgrounds. “...If we cannot come to the conclusion altogether, who else could come back and tell us, “Oh, this is exactly the way to go?” However, participant 2 suggested that the role of the doctor as the ultimate decision-maker did not preclude the involvement of a CESS, but rather imposed parameters on it. “An ethicist...can help define the problem but at the end of the day it's still going to be a clinician's decision.” (2)

Summary

Clinicians held a broad spectrum of views about the value of clinical ethic support services. There was, however, consensus on the importance of clinical ethics to the medical profession, which has been further reinforced by the HQSC backing efforts to ensure CESS are available to clinicians nationwide. The practical considerations in the provision of clinical ethics support
are indicative of the environment in which doctors have to make ethical decisions: they are often under stress and time pressure and they know that they will bear responsibility for clinical outcomes. Participants took their ethical responsibilities as doctors seriously and wanted to feel better equipped to manage them.

Discussion

Our key findings were that within CCDHB we found some common misconceptions about the role of CESS, that clinicians were wary of giving up decision making capacity in difficult ethical cases and that clinicians wanted CESS to improve general ethical reasoning capacity among staff. Our study suggests that support services should work within the pace and complexity of clinical realities if they are to be accepted by doctors as a useful tool for medical practice in New Zealand.

International literature reveals that clinician perceptions of what CESS can offer determine how likely they are to engage with services. Much of the wariness expressed about the CEAG by participants in this study was fuelled by misunderstandings about what the CEAG does or claims to do. Our research suggests that efforts to disseminate accurate information about the role and procedures of CESS may lead to wider uptake of their services. However, we also note that some DHBs in New Zealand do not have access to a CESS, and that at other DHBs a CESS may exist on paper but may not be currently active. Some misunderstanding is to be expected given that the formal ethics support service had only been in place at CCDHB for two years at the time of the research. Some clinicians’ misgivings stemmed from the fact that in New Zealand CESS are in their infancy, largely being composed of volunteers, many of whom lack formal qualifications or training in ethics. In addition, many CESS are still in the process of establishing formal procedural guidelines even as they begin to accept and consult on their first clinical cases. The dearth of formal curricula to train and accredit CESS has been identified internationally as a problem and research and funding has been increasingly devoted to developing quality assurance mechanisms such as formal qualifications and evaluation processes.

Only a handful of participants had direct experience with the CESS, but all participants had at some stage used informal mechanisms, such as peer consultation, to help resolve ethical issues. Participants seemed to assume that formal CESS were intended to serve as a substitute for these and found this problematic, arguing that the mechanisms of a formal CESS were too unwieldy to be used for the multitude of day-to-day ethical issues faced. This echoes the findings of DuVal et al and Førde et al that doctors perceive the time consumed by accessing formal ethics support to be a major barrier to accessing services. However, CESS are not a substitute for clinician competence in managing ethical issues. There are two things that a CESS should be able to offer clinicians that informal systems cannot. The first is a just, independent process of resolving ethical dilemmas that uses a transparent and systematic approach to ethical deliberation. The second is an opportunity for education and professional development in managing ethical issues.

Some clinicians were reluctant to refer cases because they felt this amounted to relinquishing autonomy over decision-making while retaining accountability for patient outcomes. Even participants who recognised that the clinical ethics consultation is advisory in nature, stated that they would feel compelled to follow CEAG advice. Our research shows this is a major barrier to accessing clinical ethics consultation. This corroborates studies from other jurisdictions. Davies and Hudson identified that among clinicians who were most resistant to accessing ethics support services, their main concern was that they felt devolving decision-making to a third party was an unacceptable abdication of clinical responsibility. Conversely, Orlowski et al found that doctors most likely to refer cases for ethics consultation were also most likely to be the clinicians who perceived ethical decision making to be a shared responsibility. Clinicians in our study recognised that they are accountable for their clinical decisions irrespective of how the decision was made.

Clinician involvement in CESS processes would have three advantages. The first is that clinician participation would improve the transparency of ethical deliberation, promoting clinician trust in the procedures
and, as such, their buy-in to the outcomes. The second benefit is that where clinicians are given the opportunity to be involved in deliberation, it becomes an educative experience that equips them with the knowledge and skills to better address ethical issues arising in the future. An ethics support model that offers ethical reasoning skills to referring clinicians could enhance the ethical culture of the institution as a whole. Third, involving doctors in deliberation quells concerns that the ethics committee may not understand the clinical nuances of the cases concerned, by providing a forum in which the referrer brings that expertise to the table. This would be in line with research ethics review in New Zealand where researchers are invited to listen to the committee's discussion of their protocol.

There are several limitations to the study. We interviewed only senior doctors. Future research should investigate the views of junior doctors, who face a unique set of challenges in managing ethical issues, in particular shaped by hierarchical medical culture, and the pressure of juggling training requirements and strenuous on-call demands. Future research should also investigate the needs and views of other health professionals at the hospital such as nurses. A second limitation is the relatively small pool of participants from a single DHB. Given New Zealand's small and close-knit medical community, it may well be the case that similar cultures of ethical decision-making exist in other regions. Further research is needed to establish this, but our study suggests some potential challenges that may exist for newly established CESS in other areas of the country.

**Conclusion**

Doctors in our study reported primarily using ad hoc strategies of peer consultation to manage ethical issues. Not all doctors felt equally able to access informal support and junior doctors may face additional barriers. Many participants were unaware that formal clinical ethics support was available to them at CCDHB and most did not know how formal ethics support worked. Some participants felt that to seek case consultation was to abrogate clinical responsibility and thought that doctors should be able to manage ethical issues themselves. The concerns identified through our research do not present immutable obstacles to CESS. Rather, this feedback gives fledgling support services the chance to optimise services to maximise their utility to clinicians.

**Emerging CESS in New Zealand should:**

1. actively disseminate information about their aims and processes to clinicians to enhance transparency and to clarify misunderstandings about their role
2. involve clinicians in the process of case consultation to increase user trust and to take advantage of the educative value of case consultation
3. conduct monitoring and evaluation of the service to ensure that it achieves and maintains clinical relevance.

At a time when CESS in New Zealand are in their infancy, this study offers a unique insight into the culture of clinical ethical decision making in CCDHB. Given the close-knit nature of the New Zealand medical community and the movement of staff between District Health Boards, the findings are likely to have relevance to emerging CESS throughout New Zealand. Our study indicates key areas of perceived strengths and weaknesses of the existing clinical support services that could inform ongoing evaluation and restructuring of the services to better tailor them to clinician needs.
Competing interests:
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REFERENCES:
10. Terms of Reference - Capital and Coast District Health Board Clinical Ethics Advisory Group. (2011). The Terms of Reference were updated in 2014 and CEAG policy now includes an expectation that the referring clinician will have advised the patient that ethics advice is being sought. Actual contact between CEAG and patients may happen on a case by-case basis. (Personal communication Hazel Irvine, Chair CEAG, CCDHB, 2016).


