Identifying Disincentives to Ethics Consultation Requests Among Physicians, Advance Practice Providers, and Nurses

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Abstract

Background: Ethics consult services are well established, but often remain underutilized. Our aim was to identify the barriers and perceptions of the Ethics consult service at our urban academic medical center which might contribute to underutilization.

Methods: This was a cross-sectional single-center, anonymous written online survey, developed by the UCSD Ethics committee, distributed by Survey Monkey, in January 2019, to a total of 3,800 clinicians at a tertiary care academic medical center. This was a quality improvement project, so IRB approval was waived.

Results: Approximately 3,800 surveys were sent to physicians, advance practice providers (APPs) and nurses with a return rate of 5.5 - 10%. The majority of respondents had encountered an ethical dilemma although only half had ever requested an ethics consult. We found that there were 4 general reasons people did not consult Ethics: 1.) unawareness of the existence of or means of contacting the Ethics service. 2.) a priori perceptions that an Ethics consult would not be helpful or might slow down decision making. 3.) experiencing a poor quality consult in the past, including variability in knowledge and ability among various consultants, 4) a consult did not improve the situation, or lacked specific guidance from the consultant.

Conclusions: Based on our survey results, we proposed the following methods of reducing barriers to use of an Ethics consult service: 1) Consults need to offer specific recommendations 2) set expectations for the consultation process and outcome; 3) ensure that Ethics consultants have strong training; 4) more actively engage nursing staff, and 5) better inform clinicians about the availability of the Ethics consult service.

Background

Discussion of the function and purpose of ethics consult services has been ongoing in the literature since the 1970s[2–5]. Since that time, ethics consultation has become a codified entity by the American Medical Association[6], are mandated by the Joint Commission for Hospital Accreditation[1] and are endorsed by the Academy for Ethics in Medicine and the American Society for Bioethics and Humanities[7,8]. While not the initial purpose of ethics services, consultation in some studies has been shown to improve certain outcomes such as decreased length of stay and provider and patient/family satisfaction[9].

Despite being well established entities in hospitals throughout the U.S., the availability of and qualifications among ethics services appear to vary between—and even within—institutions[7,8,10,11]. Healthcare providers have heterogenous perceptions of ethics services' effectiveness that impact its utilization[10,12,13].

Quality improvement efforts have been conducted at institutions around the country in part to address the variations in quality[14,15]. Most recently, the American Society of Bioethics and Humanities has

implemented the Healthcare Ethics Consultant-Certified Program in order to establish a national standard for the practice of clinical healthcare ethics consulting.

Several reasons influence an individual's propensity for not calling an ethics consult even though an ethical dilemma is present. Reasons such as perceived delays in clinical decision-making, lack of confidence in the qualifications of the consultants, lack of familiarity with the process, desire not to involve more people in the care of the patient, and a sense that one should be able to manage patient issues oneself [10,13,16]. Prior studies have focused specifically on clinician satisfaction and barriers to ethics consultation[10,12]. However, there is scarce information on our understanding of the disincentives why clinicians (including physicians, APPs, and nurses) do not call an ethics consult after contemplating this possibility.[10,12,13,15]

Similar to other institutions[17,18], we conducted this survey-based quality improvement study to better understand the reasons for, perception of, and limitations to ethics consultation in a large academic urban tertiary referral center. Cognizant of inherent response-bias effect of any survey methodology, we focused on three main study aims: to 1) understand some of the reasons why physicians, APPs, and nurses had never requested an ethics consult, 2) understand the reasons providers who called an ethical consult previously would not consider calling one again, and 3) evaluate whether there is a significant difference in the reasons for which doctors, APPs, and nurses do not request an ethics consultation.

Methods

Design

This was a cross-sectional single-center, survey-based study.

Participants and Recruitment

In January 2019, we sent out an internally devised survey (Appendix 1) to 1,517 physicians, and 277 APPS to seek feedback regarding use of our ethics consultation service. The same survey was sent to approximately 2,000 nursing staff in July of 2019. The survey platform chosen was SurveyMonkey in order to optimize the user interface on mobile devices. This was considered a QI project which was exempt from IRB approval. As an incentive to complete the survey, we offered a raffle to win one of three $100 Amazon Gift cards, though participation was not required in order to enter the raffle.

Survey

Members of the ethics committee devised an internal survey to assess respondents' awareness of, previous experiences with, and perceptions regarding the Ethics consultation service (see Appendix 1). The questionnaire inquired first about the respondent's degree, specialty, service/location within the organization, whether they worked in an inpatient or outpatient setting, and length of employment at our institution. The second page contained the question "Have you ever encountered an ethical dilemma in

the course of caring for a patient?" to gauge internal validity, as the vast majority of individuals have encountered an ethical dilemma during their medical profession. We then asked respondents to indicate whether they had ever called an ethics consult, and if so, to indicate the reasons for requesting a consult. If they responded that they had never requested a consult, we asked them to identify reasons they had not done so. For those who had requested consults, we asked whether the consult and recommendations were helpful using a 0-100 scale (0 being "not helpful at all" to 100 being "extremely helpful"). We also included specific logistical questions, such as 1) Was the consult completed in a timely manner; 2) Do you believe the treating team acted on the Ethics service consultant's recommendations? Respondents were asked to indicate the likelihood that they would call for an ethics consult in the future (again, using a 0-100 scale). Respondents who indicated they would be unlikely to request future consults were asked to provide reasons via comments. Not all respondents answered all of the questions, so the number of responses to each question varied from the total.

Data analysis

Analysis included Chi-squared test (for categorical variables), Fisher's exact test (when the expected values in one of the cells of the contingency table < 5) or 2-sample t-test (for continuous variables) to test the statistical significance of difference between the MD/DO, NP/PA and RN/BSN. ANOVA was used to test the continuous score when comparing the differences between the MD/DO, NP/PA and RN/BSN. Significance was set at $p < 0.05$.

Results

Table 1: Survey results:

	Physicians	APPs	Nursing	p-value
	MD/DO	NP/PA	BSN/RN	
Employed at our institution ≥ 5 years:	*n*= 150	*n*= 35	*n*= 109	
Less than 5 years	28 (18.7%)	1 (2.9%)	15 (13.8%)	0.056
More than 5 years	122 (81.3%)	34 (97.1%)	94 (86.2%)	
Impatient Outpatient	*n*= 150	*n*= 35	*n*= 106	
Both	91 (60.7%)	13 (37.1%)	0 (0.0%)	<0.001***
Inpatient	27 (18.0%)	11 (31.4%)	101 (95.3%)	
Outpatient	32 (21.3%)	11 (31.4%)	5 (4.7%)	
encountered an ethical dilemma	*n*= 151	*n*= 33	*n*= 107	
No	12 (7.9%)	4 (12.1%)	16 (15.0%)	0.203
Yes	139 (92.1%)	29 (87.9%)	91 (85.0%)	
requested an ethics consult	*n*= 150	*n*= 33	*n*= 107	
No	73 (48.7%)	18 (54.5%)	70 (65.4%)	0.029*
Yes	77 (51.3%)	15 (45.5%)	37 (34.6%)	
Likelihood of consulting Ethics in the future	*n*= 145	*n*= 29	*n*= 97	
	66.99 (29.76)	64.17 (29.82)	65.64 (27.34)	0.867
Rate the effectiveness of the ethics consult participation and recommendations				
	n= 83	*n*= 13	*n*= 43	
	71.60 (23.76)	68.46 (36.58)	66.77 (27.32)	0.608
Consult completed in timely manner	*n*= 81	*n*= 14	*n*= 41	0.314
No	6 (7.4%)	4 (28.6%)	11 (26.8%)	
Yes	75 (92.6%)	10	30	

		(71.4%)	(73.2%)	
Do you believe the team acted on the ethics recommendations	*n*= 81	*n*= 14	*n*= 41	0.007**
No	6 (7.4%)	4 (28.6%)	11 (26.8%)	
Yes	75 (92.6%)	10 (71.4%)	30 (73.2%)	

Physicians and APP's:

We received responses from 150 out of 1,517physicians (10% response rate) and 35 out of 277 APP's (11.5% response rate), for a total of 185 responses. The respondents were from an array of specialties and subspecialties including: twenty one hospitalist/internal medicine, sixteen surgery (colorectal, general, cardiothoracic, neurosurgery), ten family medicine, eleven emergency medicine, ten psychiatry, nine ICU (pulmonary critical care, anesthesia critical care, neurocritical care), nine anesthesiology/pain, eight infectious disease/HIV, six pathology/neuropathology, six OB/Gyn, and one to three respondents from seventeen other subspecialties. The majority (80%) of respondents had been employed at UCSD Health for greater than 5 years. The majority of physicians (61%) worked in both the inpatient and outpatient settings. The APP's were divided equally between inpatient, outpatient, or both. The majority of respondents (92% MD/DO and 88% NP/PA) indicated that they had encountered an ethical dilemma at some point. Among physicians, approximately half (51%) had requested an ethics consult at some point in their past. However, since the overwhelming majority of ethics consults are requested in the inpatient setting, considering only those who practice at least a portion of their time in the inpatient setting, 118 respondents (65%) have requested an ethics consult previously. For APP's, excluding outpatient only providers, 63% had requested a consult, a similar rate as physicians.

Reasons identified for never having requested a consult included (Table 2): 1) never felt the need for help (41.1% physicians, 22.2% APPs); 2) unaware there was a consult service available (33% physicians and APPs); 3) Did not know how to contact the Ethics consultant (16.4% physicians, 27.8% APPs); 4) Worried the Ethics consult would slow things down or complicate the situation (9.6% physicians, 5.6% APPs) ; 5) Did not feel the attending would agree with the ethics consult request (2.7% physicians, 16.7% APP's); Other (65.8% physicians, 50% APPs). Some of the more common "other" reasons:

- "I was not the attending of record."

- "I was a consultant."

- "I consulted Risk Management instead."

Of those who had previously requested an ethics consultation, the average rating (on a scale 0-100) for the effectiveness of the consultation was 71.6 for physicians, and 68.46 for APPs. Their likelihood of

requesting a consult in the future was 67 for physicians and 64.17 for APP's on a 0-100 scale. 92.6% of physicians and 71.4% of APPs reported that the consult had been completed in a timely manner. 90.7% of physicians and 75% of APPs believed that the team had acted on the Ethics consultant's recommendations.

Of those respondents who were unwilling to call an ethics consultation in the future, general reasons given included: 1) prior experience with a consult was poor, 2) disagreement with recommendations, 3) variability in the quality of the Ethics consultants/recommendations, and 4) lack of specific recommendations from the Ethics consultant. Responses to this question were solicited solely by requesting comments, not selected from a pre-defined list of choices. We therefore could not quantitate the reasons provided.

Some specific comments included:

- "Prior experience with ethics consult would make it much less likely that I would ever request such a consult."

- "I disagreed with Ethics' recommendations which seemed just plain wrong."

- "Some Ethics consultants are much more helpful than others."

- "We will exhaust all other options before going to Ethics."

- "More physical presence would be nice to discuss recommendations in depth."

- "The incident I am thinking of had to do with 'yielding' to the wishes of the family, which could have been detrimental or fatal. I believe was just plain wrong under the circumstances.", - "In some cases, it has been 2-3 days before the consultant documents, and the documentation is very general or brief."

Nursing:

From the nursing (R.N./B.S.N.) survey sent to 2,000 individuals, we received 109 responses (5.5% response rate). The majority of respondents worked in inpatient settings (95.3%). They represented a variety of services including twenty three from cardiovascular unit, twenty two from surgical units, twelve from the neurocritical care unit, ten from the medical wards, ten from women and infant service, three from psychiatry ward, and five from clinics (Table 1). The majority of nurses (86%) had worked at UCSD Health for more than 5 years. Nursing reported having ever requested an ethics consult at a much lower rate (35%) compared to physicians and APPs. Specific reasons identified for never having requested a consult included (Table 2): 1) unaware of how to contact the Ethics consultant (31%); 2) never felt the need for their help (26%); 3) unaware there was an Ethics consult service (25%); 4) did not feel the attending would agree with the Ethics consult request (17%); 5) worried they would slow things down or complicate the situation (8%). Examples of other (28%) reasons quoted by respondents included:

- "Out of my scope of practice".

- “Ethics is powerless in the face of powerful surgeons”.

- “I followed the chain of command”

- “Did not know nursing could call Ethics”.

- “I’ve seen a consult but did not improve the situation.”

The nurses mean rating score for the effectiveness of the ethics consultation and recommendations was 66.7 on a 0-100 scale, and likelihood of requesting a consult in the future was 65.6 on a 0-100 scale. 73.2% reported that the consult had been completed in a timely manner, and 73.8% believed the team had acted on the Ethics consultant’s recommendations.

Respondents were asked to enter comments regarding reasons they would not request future ethics consults. Some of the comments included:
- “Ethics just rubberstamps for the doctors.”

- “Even with patients who have had ethics consults, unethical decisions are made.”

-“Ethics does not want to tell the medical team how to care for their patient.”

Table 2: Reasons for never requesting a consult

	Physicians MD/DO (*n* = 73)	APPs NP/PA (*n* = 18)	Nurses RN/BSN (*n* = 65)	p-value
Did not know there was an Ethics Consult service	24 (32.9%)	6 (33.3%)	16 (24.6%)	0.529
Did not know how to contact the Ethics consult service	12 (16.4%)	5 (27.8%)	20 (30.8%)	0.129
Never felt the need for their help	30 (41.1%)	4 (22.2%)	17 (26.2%)	0.127
Did not believe Ethics consults are helpful	0 (0.0%)	0 (0.0%)	4 (6.2%)	0.064
Slow down the decisions needed to be made or further complicate the situation	7 (9.6%)	1 (5.6%)	5 (7.7%)	0.919
Did not feel the attending of record would agree	2 (2.7%)	3 (16.7%)	11 (16.9%)	0.008**
Other	48 (65.8%)	9 (50.0%)	34 (52.3%)	0.208

Discussion

Participants who had never consulted Ethics:

The proportion of responses indicating no awareness of the existence of our Ethics consultation service or how to contact us which was unexpected and contrary to our perception that we are well known, and easy to contact, as we have a consultant available 24/7 who can be paged by anybody involved in the care of the patient.

The reasons individuals chose not to request a consult a priori reflected perceptions that there was a lack of value in ethics consults, including the belief that we would not be helpful, would slow down or complicate decision making, or that the attending would not agree with the recommendations. This finding is similar to other studies previously published[12,18,19]. Some of these perceptions may reflect some of the reality of the ethics consultation process, which does need to allow time for a more deliberative process, as well as some faulty expectations of the purpose and role of an ethics consult. Ethics consultations are advisory, and thus cannot mandate any specific change in the treatment plan. The treating providers ultimately determine treatment.

There was a statistically significant difference between physicians and APPs/nurses who identified “did not feel the attending physician would agree with an Ethics consult” as a reason for not requesting a consult. This difference highlights the hierarchical nature of any hospital, particularly an academic teaching hospital. Ethics consult services are unique from other consult services by virtue of the fact that consult requests can be initiated by other members of the team with or without the consent of the attending physician. Despite that access, other team members believe they should not request a consult without the consent of the attending, so this presents a significant barrier for them.

Many individuals indicated that when faced with an ethical dilemma, they did not feel they needed help resolving the dilemma (41.1% of physicians, 22.2% of APPs, and 26.2% of nurses). This may reflect the assumption that every clinician demonstrates ethically sound decision-making skills without the need for an ethics consult to resolve every ethical dilemma encountered. The remaining uncertainty, however, is whether some of these situations might have benefitted from the involvement of an ethics consult, but the clinicians did not recognize the need for help.

Participants who had consulted Ethics, but would not re-consult:

The reasons individuals who had consulted Ethics in the past gave for not planning to re-consult Ethics in the future provides insight into areas of potential improvement in our consult service. There were some deficiencies, including variability in expertise among consultants, absence of specific guidance, and lack of physical presence of the consultant.

In comparing the responses of nursing compared to physicians and APPs, nurses more frequently expressed a perception of being less able to impact the course of care for a patient. This was reflected in statements such as “Ethics does not want to tell the medical team how to care for their patients”, “waste of time”, “Ethics just rubberstamps decisions made by surgeons”, and “even with patients who had an Ethics consult, unethical decisions were made.” These comments convey the nurses’ hopes that an Ethics consult would effect a change in the care of a patient, and frustration when it did not. This sense of powerlessness can often contribute to moral distress and burn out among nursing[20,21]. Also notable was the lower percentage of nurses (73.2%) and APPs (71.4%) compared to physicians (92.6%) who believed the team had acted on the Ethics consultant’s recommendations. This reflects the reality that the attending physician is ultimately the person who determines the course of action which will be taken. If

he/she did not initiate the Ethics consult request, there is a lower likelihood they will act on the recommendations.

Limitations

This project had several limitations. The greatest limitation was the low rate of responses, just 10% for physicians, 11.5% for APPs, and 5.5% for nursing. Some of the reasons for this: 1) We were not able to limit the survey distribution to only inpatient clinicians; 2) We were only able to send the survey out one time to each group, and 3) We were not able to publicize the survey before sending it out.

In addition, for those who did respond, many of them did not respond to all of the questions, so some questions had an even lower rate of response. Despite these limitations, the absolute numbers of respondents were higher than many similar surveys in the literature and comprised of a broad sampling of specialties and subspecialties. Future survey studies could be done with greater focus on particular services or disciplines. Another limitation was the limited data collected regarding reasons respondents would not re-consult Ethics. We utilized only comments that respondents could complete, rather than a pre-defined list of possible options. Consequently, only a limited number of respondents took the time to enter a comment explaining their reasons for not re-consulting.

In addition, this survey represents the responses from one institution located in the southwestern corner of the United States. Our results may not be the same for other institutions.

Conclusions

These data suggest that ethics consultation services could be more effective by 1) offering more specific recommendations in addition to ethical analysis; 2) set expectations for the consultation process and outcome; 3) ensure that Ethics consultants have strong training; 4) more actively engage nursing staff, and 5) better inform clinicians about the availability of the Ethics consult service. Since the completion of this QI survey, we have taken specific steps in order to accomplish these goals including:

1. Ongoing education and training of our Ethics consultants.
2. Implementation of a feedback survey after each consult is completed.
3. Biannual all staff Ethics seminars for increased visibility and education of nursing staff.
4. Weekly ethics rounds in two of our ICU's, one of which is led by nursing staff.
5. Ongoing efforts to standardize and improve the quality of our documentation of consults utilizing the Ethics Consultation Quality Assessment Tool (EQUAT)[22].

Abbreviations

APP: advance practice providers

Declarations

Ethics approval and consent to participate: Study was exempted by the University of California San Diego Human Research Protections Program.

Consent for publication: Not applicable

Availability of data and materials: The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests: The authors declare that they have no competing interests.

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Authors' contributions: LC, JL, EC, LD, CY all contributed to the development and dissemination of the survey. LC, JL, EC provided major contributions to the writing of the manuscript. LF provided substantive revisions and edits. YZ conducted data analysis.

All authors approved the submitted version of the manuscript. LC acted as the corresponding author.

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Aditional File

1) Survey Tool

1) By participating in this survey, you are not guaranteed to win a prize; however, you do not need to participate in the survey to have a chance of winning a prize. Will you participate in our survey?

Yes

No

2) Please indicate your healthcare role:

MD/DO

NP/PA

RN

3) MD/DO:

Resident

Fellow

Attending

4) How long have you been an attending MD/DO? NP/PA? RN/BSN?

< 5 years

5-10 years

> 10 years

5) What is your specialty?

6) Do you currently work in the inpatient or outpatient setting?

Inpatient

Outpatient

Both

7) Have you ever encountered an ethical dilemma in the course of caring for a patient?
Yes

No

8) Have you ever requested an Ethics Consult while training or employed at UCSD?

Yes

No

9) If yes, how many consults have you requested in the past 2 years?

10) What kind of help were you hoping for? (choose all that apply)

Assistance with treating an unrepresented patient

Clarify the appropriate surrogate

Limitation/withdrawal of treatment or change of code status

Mediate conflict

Address uncertainty regarding the patient's decision-making capacity

Other:

11) How would you rate the Ethics consultation participation and recommendations?

0 – 100 scale from "not helpful at all" to "somewhat helpful" to "extremely helpful"

12) Was the consultation completed in a timely manner?

Yes

No

13) Do you believe the treating team acted on the Ethics consultant's recommendations?
Yes

No

14) What is the likelihood that you will call for an ethics consult in the future?

0-100 scale from "definitely not" to "somewhat likely" to "extremely likely"

15) Any additional comments/feedback: