

CLINICAL ETHICS

The need for a clinical ethics service and its goals in a community healthcare service centre: a survey

E Racine, K Hayes

See end of article for authors' affiliations

J Med Ethics 2006;32:564–566. doi: 10.1136/jme.2005.014589

Correspondence to:
E Racine, Neuroethics
Research Unit, Institut de
recherches cliniques de
Montréal (IRCM), 110
avenue des Pins Ouest,
Montréal, QC, H2W 1R7,
Canada; eric.racine@ircm.
qc.ca

Received
28 September 2005
In revised form
14 December 2005
Accepted for publication
17 December 2005

Objectives: To (1) assess whether according to healthcare providers, the creation of an ethics service responds to a need; (2) assess the importance of an ethics service for healthcare providers; (3) determine what ethics services should be offered and the preferred formats of delivery; and (4) identify key issues to be initially dealt with by the ethics service.

Design: A survey of healthcare providers in Québec's Centre Local de Services Communautaires (CLSC), healthcare institutions dedicated to community health and social services.

Findings: 96 (95%) respondents agreed that an ethics service was needed, and on average the ethics service project was judged to be very important. Preferred formats for ethics consultation and education were identified, as well as key concerns such as the need of respect for the patient as a person, elder abuse and ethical issues in home care.

Conclusion: This survey is helping in the implementation of an ethics service and can guide others in similar healthcare institutions.

Clinical ethics services are common in acute-care hospitals. The minimal form of an ethics service, the healthcare ethics committee (HEC), is commonly found in American hospitals,¹ and there is a growing interest for HECs in many countries such as the UK^{2–4} and Germany.⁵

Ethics services have been less discussed and perhaps less commonly implemented in the non-acute-care setting. For example, in the Canadian province of Québec, available data suggest that 24% of acute-care hospitals have an HEC but of 74 identified HECs in Québec only 3/58 (5%) are found in Centre Local de Services Communautaires (CLSC),⁶ healthcare service centres that offer a spectrum of medical, nursing, social and community health services such as vaccination, home care and prevention of elder abuse. (If the latest American survey would count the non-responders as evidence of absence of an HEC in a hospital, the American figure would be 36% (not 90%, as advanced by the authors of the study). Currently, 58 CLSCs are in operation. Some also operate in collaboration with acute-care hospitals (n = 1), with long-term care hospitals (n = 54) or with both acute-care and long-term-care hospitals (n = 34; source: Association des CLSC et CHSLD du Québec, <http://www.clsc-chsld.qc.ca/fr/accueil.aspx>). Québec's territory is divided into 168 CLSC districts (source: <http://www.msss.gouv.qc.ca/statistiques/atlas/atlas/general/glossaire.php#clsc>). Traditional emphasis on crises and emergencies in clinical ethics may have contributed to delays in the implementation of ethics services in the non-acute-care setting, while masking the needs in non-acute-care healthcare. Loewy⁷ has argued, for example, that "Ongoing patient issues are seen as crisis intervention, and crisis intervention, especially in the United States [...] has captured the public imagination and therefore invariably has been given priority over less dramatic tasks." Similarly, from a feminist perspective, DeRenzo and Strauss⁸ have sustained that "the problems that usually receive attention, the 'crisis issues', are problems that can be solved through immediate action or proclamation, whose significance is more immediately felt, and whose solution can come from selecting among a narrow range of

clearly demarcated options". Consequently, "non-crisis problems" according to these authors are neglected because they do not require immediate resolution or cannot be solved by a one-time intervention. Such problems receive low priority, often include systemic issues and their resolution accordingly requires "considerable reflection and assessment of current practices".

Despite this suspected focus on acute care, there are many ethical issues in non-acute healthcare as well, including several situations in home-care services⁹ and public health practices.¹⁰ Accordingly, healthcare providers and patients in the non-acute healthcare setting may currently be under-served in terms of clinical ethics services such as case consultation, ethics education and ethics guidelines and policies.

The objective was to create a complete ethics service that built on the existing HEC of the CLSC René-Cassin located in the west of Montreal but added extensive ethics education and policy services for its staff, as well as possibly for the staff of other CLSCs. To our knowledge, this had not been attempted in CLSCs and represented one of the first non-hospital-based clinical ethics services in Québec's public healthcare system that went beyond the traditional HEC. We therefore wanted to evaluate the relevance of our project and validate its objectives. Our approach to needs assessment is inductive. We wanted to let healthcare workers assess the relevance of an ethics service and identify its main components by providing them with lists of options to choose from.

METHODS

A survey was developed featuring questions on the relevance of an ethics service, on services to be included in an ethics service, on the specific format for offering them and on the ethical priorities for the professionals in the health and social service network. An extensive literature review on clinical ethics was undertaken to identify the main features of current ethics services and a spectrum of options in matters of ethics

Abbreviations: CLSCs, Centre Local de Services Communautaires; HEC, healthcare ethics committee; IRB, institutional review board

consultation, ethics education and policy or guidelines. We tested the content of the survey during a group workshop where professionals were asked to comment on the identified options for the future development of a clinical ethics service. This allowed further validation of answers in the survey—for example, to include options relevant to community and public health as well as social work, given the mandates of CLSCs. This also led us to add options that we had not included in the original survey (copies of the survey available on request). The final survey included questions to identify (1) whether according to CLSC healthcare providers, an ethics service would in fact respond to a need; (2) whether this project was valuable to CLSC healthcare providers in the form of a Likert 9-point scale; (3) main services of an eventual ethics service and the preferred formats for delivering them; and (4) top ethical issues to be initially considered by the ethics service.

We then dropped the survey in the mailbox of all healthcare workers of the CLSC in question (n = 205 at the time). In addition, given that we hope that some clinical ethics services be made available to other CLSCs, we sent four copies of the survey to the director of professional services of 28 other CLSCs in the Montreal region ideally for distribution to a nurse, a social worker, a doctor and a healthcare administrator. The chairperson of the institutional review board (IRB) waived the need for review and consent forms (CLSC René Cassin IRB).

RESULTS

The response rate was 30%. Of the 96 respondents, 32 (33%) were social workers and 22 (23%) were nurses. Other respondents included 9 (9%) administrators, 2 (2%) psychologists and 2 (2%) volunteers, but no self-identified doctors.

Ninety five per cent of respondents believed that the creation of an ethics service would answer a need. On a scale from 1 (not important) to 9 (extremely important), respondents judged an ethics service to be on average 7.1 (very important; median = 7). Only two respondents ranked the ethics service below 5. Most (34/96, 35%) gave it a value of 7 (very important) or 9 (extremely important; 22/96, 23%).

When asked what an ethics service should include, the key answers were consultation (91/96, 96%) and ethics education (84/96, 88%). Of the respondents (35/96, 36%) believed that an ethics service should include all items listed in table 1.

Respondents were then asked to identify how each individual service could best be offered. For ethics consultations, respondents chose the interdisciplinary group and the ethics consultant over the ethics committee and other less conventional formats such as the internet or a hotline. Preferred modes for ethics training were case discussions and ethics workshops. Newsletters and small critical reviews on an ethical topic were considered to be the best means of sensitisation to ethics and ethics information. Respondents emphasised that healthcare workers should be consulted in the writing of guidelines and policies (table 1).

Respondents were asked to identify from a list of topics and specific ethical issues which one should be prioritised by the ethics service. Issues on respect for autonomy, informed consent, confidentiality and privacy were most commonly selected (table 2).

This study has several limitations, such as the small number of respondents and a fair participation rate and the fact that we did not receive responses from a single doctor. The recruitment and participation of doctors in CLSCs has, however, been an ongoing source of difficulties in Québec's CLSCs and is at the core of a current health reform that will merge most CLSCs with long-term care institutions and acute-care hospitals. Furthermore, the survey has been designed to take into account issues relevant to community healthcare and service centres, for example, by including

Table 1 Specific services to be included in the ethics service and preferred mode of delivery identified by healthcare providers

Service	Frequency (%)*	Specific ways of delivering the service	Frequency (%)
EC	95	EC by interdisciplinary team	53
		EC by ethics consultant	52
		EC by ethics committee	38
		EC through 1-800 line	27
		EC through the internet	25
ET	88	ET through case discussions	83
		ET through ethics workshops	65
		ET through conferences	52
		ET through seminars	52
		ET through discussions animated by HEC	49
		ET through ethics bulletins	48
		ET through discussion with consultant	29
		ET through "ethics week"	23
		ET through films	18
		ET through electronic forums	15
Sen	78	Sen/EI through newsletters	80
		Sen/EI through small critical reviews	54
EIT	74	Sen/EI by queries to ethics consultant	35
		Sen/EI through literature updates	31
		P&G by consulting healthcare professionals and volunteers	89
		P&G by consulting literature	66
		P&G by consulting patients	64
AR	57	P&G by consulting others	13
		AR on difficult situations	73
		AR on different associated perspectives	49
		AR on discussion methods	45
		AR on ethical concepts and notions	43
PD	45		

AR, applied research; EC, ethics consultation; EI, providing ethics information; ET, ethics training; HEC, healthcare ethics committee; PD, public debate; P&G, policy and guidelines; Sen, sensitisation. *Taking into account the 35 respondents who selected the "all services" option. †Modes of delivery for sensitisation and ethics information are collapsed.

options specific to public health. We found indications that the respondents took the survey seriously—for example, by reading through all the options. The exhaustiveness of options, however, could perhaps limit validity outside the community healthcare setting. Further use of the survey should include careful considerations on the applicability and relevance of certain options. Finally, in our discussion, in accordance with a soft "is-ought" divide that recognises the interests and limits of empirical research in medical ethics,¹¹⁻¹⁴ we recommend pathways of action that are consistent with preferences expressed by healthcare providers. We are, however, aware that our recommendations should be re-evaluated as the implementation of the ethics service unfolds and new or more specific needs surface.

DISCUSSION

Respondents overwhelmingly felt that the creation of an ethics service answered a need and would be very important. Many qualitative comments in the surveys welcomed enthusiastically the clinical ethics service project. Survey responses supported the idea of a broadly construed ethics service that includes case consultation and also ethics training, sensitisation and information services. The inclusion of applied ethics research activities was felt less strongly by respondents, and we may thus need to explain and justify more thoroughly further research activities, which are essential to the regular assessment of the needs and goals of the ethics service.

Table 2 Specific ethical issues and topics that should be prioritised by the ethics service, as identified by healthcare providers

EI	Frequency (%)
Respect for autonomy and for patients	64
Free and informed consent	64
Confidentiality and privacy	60
Els in home care	60
Els in work relationships	53
Resource allocation	48
Els in patients with mental health problems	47
Elder abuse	46
Els in end of life care	46
Quality of life	45
Organisational ethics	42
Truth to patients	39
Els related to cultural and religious affiliations and preferences	39
Respect of healthcare intervention plans	36
Withdrawal/withholding of treatment	36
Extraordinary treatments	33
Euthanasia and doctor-assisted suicide	31
Disclosing medical errors	29
Pain and suffering	29
Use of restraints	27
Case discussion methods	25
Els in infectious disease	23
Advance directives	18
Els in Info-Santé*	19
Els in health promotion	16
Els in HIV	13
Els in greatly premature babies	10
Research ethics†	7

Els, ethical issues.

*Info-Santé is a free healthcare information line for patients.

†This was a test question to check the focus of the survey on clinical issues.

Preferences for specific forms of service delivery were also identified. Given the preferences expressed for individual consultants or an interdisciplinary consultation team, ethics consultation could be carried out by a core group of three or four people with a background in ethics who could serve both as individual consultants and also as part of a consultation team. Such a model has been described by Swenson,¹⁵ but other models are possible and consistent with the data.¹⁶⁻¹⁷ Although this does not follow directly from the data, the consultation team should ensure the representation of the different CLSC professions (eg, social work, medicine and nursing) and disciplines that can provide external input (eg, ethics, theology, anthropology and philosophy) in further enriching the discussions.¹⁸ Ethics education should be practice oriented and take interactive formats such as case discussions and workshops. Less conventional forms of training, such as online discussion forums, films, public debates and an “ethics week”, did not appeal to most people, and more explanation is needed if such formats are to be used. Writing of policies and guidelines should include various stakeholders and literature reviews to be credible to the staff. Ongoing ethics education can be offered through the creation of an ethics newsletter or by including an ethics column in the form of a special section of an already existing CLSC newsletter dedicated to elder abuse.

Key ethical issues to be dealt with revolved around patient autonomy, privacy, confidentiality and consent. The responses suggest that these are pressing concerns for the surveyed healthcare providers, and a recent inquiry into HECs in Québec also suggests that basic respect for and the autonomy of the patient are key ethical concerns.¹⁹ We also found in the “top 10” issues concerns for ethics in home-care services, ethics in work relationships, resource allocation, ethics in service delivery for patients with mental health problems and elder abuse. On the basis of the answers we received, these should be the initial priorities of the ethics service.

CONCLUSION

Acute care has been the main focus in both the clinical ethics literature and in the efforts to implement clinical ethics services. Non-acute healthcare centres as exemplified in Québec’s CLSCs, however, encounter major ethical issues in their own right. Before implementing a clinical ethics service in a CLSC to deal with such needs, a survey was conducted among healthcare workers with regard to the relevance of the project, the identification of key services and current topics of concern. We believe that doing so can provide a better assessment of needs and priorities and can also promote from the outset the inclusion of healthcare providers and their concerns in a needs-based and quality-improvement-oriented ethics service.

ACKNOWLEDGEMENTS

We thank Suzanne Lévy for handling the survey. We also thank the participants and members of the Healthcare Ethics Committee for their contribution.

Authors’ affiliations

E Racine, Neuroethics Research Unit, Institut de recherches cliniques de Montréal (IRCM), Québec, Canada

K Hayes, CLSC René-Cassin, Côte-St-Luc, Montréal, Québec, Canada

Writing of the paper for ER was supported by the Social Sciences and Humanities and Research Council of Canada and NIH/NINDS R01 #NS045831 (Judy Illes, Stanford University).

Competing interests: None.

Ethics approval: The chairperson of the IRB waived the need for review and consent forms (CLSC René Cassin IRB), given the minimal risks involved.

ER was an Inter in clinical ethics, CLSC, at the time of the research, and postdoctoral fellow at the Neuroethics Imaging Group, Stanford University, at the time of writing the manuscript.

REFERENCES

- 1 **McGee G**, Caplan A, Spanogle JP, et al. A national study of ethics committees. *Am J Bioethics* 2001;**1**:60–4.
- 2 **Slowther A**, Hope T, Ashcroft R. Clinical ethics committees: a worldwide development. *J Med Ethics* 2001;**27**(Suppl 1):i1.
- 3 **Mayor S**. Clinicians need better access to ethics advice, report says. *BMJ* 2005;**330**:1345.
- 4 **Sokol DK**. Meeting the ethical needs of doctors. *BMJ* 2005;**330**:741–2.
- 5 **Simon A**. Ethics committees in Germany: an empirical survey of Christian hospitals. *HEC Forum* 2001;**13**:225–31.
- 6 **Ministère de la Santé et des Services Sociaux**. *Rapport d’enquête concernant les activités des comités d’éthique clinique et des comités d’éthique de la recherche au Québec*. Québec: Direction des Communications, 1999.
- 7 **Loewy EH**. Consultants and committees: a cooperative and mutually educational enterprise. *Camb Q Healthcare Ethics* 1994;**3**:478–82.
- 8 **DeRenzo EG**, Strauss M. A feminist model for clinical ethics consultation: increasing attention to context and narrative. *HEC Forum* 1997;**9**:212–27.
- 9 **Liaschenko J**, Peter E. The voice of home care workers in clinical ethics. *HEC Forum* 2002;**14**:217–23.
- 10 **Dickens BM**. The challenges and opportunities of ethics. *Am J Public Health* 2005;**95**:1094.
- 11 **Solomon MZ**. Realizing bioethics’ goals in practice: ten ways “is” can help “ought”. *Hastings Cent Rep* 2005;**35**:40–7.
- 12 **Halpern SD**. Towards evidence based bioethics. *BMJ* 2005;**331**:901–3.
- 13 **Singer PA**, Pellegrino ED, Siegler M. Clinical ethics revisited. *BMC Med Ethics* 2001;**2**:E1.
- 14 **Sugarman J**, Faden R, Weinstein J. A decade of empirical research in medical ethics. In: Sugarman J, Sulmasy DP, eds. *Methods in medical ethics*. Washington, DC: Georgetown University Press, 2001:19–28.
- 15 **Swenson MD**. Ethics case review in health care institutions. *Arch Intern Med* 1992;**152**:694–7.
- 16 **Godkin MD**, Faith K, Upshur RE, et al. Project examining effectiveness in clinical ethics (PEECE): phase 1—descriptive analysis of nine clinical ethics services. *J Med Ethics* 2005;**31**:505–12.
- 17 **MacRae S**, Chidwick P, Berry S, et al. Clinical bioethics integration, sustainability, and accountability: the hub and spokes strategy. *J Med Ethics* 2005;**31**:256–61.
- 18 **Harrison C**. A Canadian perspective. *Am J Bioethics* 2002;**2**:18–20.
- 19 **Racine E**. *L’éthique clinique, les émotions et le processus d’analyse de cas: une étude qualitative et multi-site de comités d’éthique clinique québécois*. Montréal: Université de Montréal, 2004.