

A Comparison of General Medical and Clinical Ethics Consultations: What Can We Learn From Each Other?

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Abstract

Despite the emergence of clinical ethics consultation as a clinical service in recent years, little is known about how clinical ethics consultation differs from, or is the same as, other medical consultations. A critical assessment of the similarities and differences between these 2 types of consultations is important to help the medical community appreciate ethics consultation as a vital service in today's health care setting. Therefore, this Special Article presents a comparison of medical and clinical ethics consultations in terms of fundamental goals of consultation, roles of consultants, and methodologic approaches to consultation, concluding with reflections on important lessons about the physician-patient relationship and medical education that may benefit practicing internists. Our aim is to examine ethics consultation as a clinical service integral to the medical care of patients. Studies for this analysis were obtained through the PubMed database using the keywords *ethics consultation*, *medical consultation*, *ethics consults*, *medical consults*, *ethics consultants*, and *medical consultants*. All English-language articles published from 1970 through August 2011 that pertained to the structure and process of medical and ethics consultation were reviewed.

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For the past 3 decades, ethics consultations have become more commonplace in the provision of health care, especially in major hospitals throughout the United States. Although ethics consultations address value-laden conflicts that involve particular patients in the medical setting, rather than the clinical management of these patients, the model of medical consultation has had a significant influence on the manner in which ethics consultations are conducted.^{1,2} However, it is also true that the field of clinical ethics, shaped as it is by law, moral philosophy, religion, and even the social sciences since the 1970s, has significantly informed the nature of ethics consultation as a service to health care professionals.³ The movement to integrate ethics consultation into the mainstream of medical care has not been without controversy. Criticisms have focused on the need for rigorous and standardized clinical training of consultants and structured and systematic approaches to the evaluation of ethics consultation and quality improvement efforts that characterize other forms of medical consultation.⁴⁻⁶

Given these criticisms and the emerging multidisciplinary nature of clinical ethics consultation as a clinical service in health care, it is important to examine just how the format of a clinical ethics consultation differs from, or is the same as, other medical consultations. Articles have thoughtfully appraised the association of psychiatric and ethics consultation and the importance of distinguishing the two in clinical practice.⁷⁻⁹ Care and Wocial¹⁰

and Childers et al¹¹ have published articles on the tensions and overlap between palliative care and ethics consultations in dealing with end-of-life issues. Kaldjian et al¹² have presented a strategy of clinical ethics reasoning within the umbrella of clinical reasoning. However, to our knowledge, the structure and process of clinical ethics consultation have not been critically compared and contrasted with those of other medical consultations. Such an effort is important to help the medical community appreciate the role of ethics consultation as a vital service in today's health care setting. This comparative work can also assist ethics consultants and those who supervise consultation training and direct ethics consultation services in strengthening the clinical nature of ethics consultation training and performing and identifying areas that could benefit from quality improvement efforts.¹³

The objective of this article is to explore similarities and differences between clinical medicine and clinical ethics consultations in terms of fundamental goals of consultation, roles of consultants, and methodologic approaches to consultation. The article concludes with reflections on important lessons that ethics consultants and internists can learn from each other. Studies for this analysis were obtained through the PubMed database using the keywords *ethics consultation*, *medical consultation*, *ethics consults*, *medical consults*, *ethics consultants*, and *medical consultants*. All English-language articles published from 1970 through August 2011 were reviewed. Empirical articles and commentaries pertaining to



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the structure and process of medical and ethics consultations were selected for inclusion in this study. The bibliographies of selected articles were also reviewed for any relevant articles not identified in the literature search.

GOALS OF CONSULTATION

Emanuel and Richter's¹⁴ definition of a *consultant* is adapted to encompass both medical and ethics consultants. A consultant is a practitioner "with special expertise asked to help in the care of a patient by another."^{14(p.1785)} The goal of medical consultation is based on the first 2 principles of the American Medical Association's (AMA) ethical principles pertaining to consultation. These principles are juxtaposed with the consensus statement from Fletcher and Siegler¹⁵ on the goals of clinical medical ethics (Table).

AMA Principles of Consultation

The 2 main AMA principles of consultation are as follows. First, consultations are indicated on request in doubtful or difficult cases or when they enhance the quality of medical care. Second, consultations are primarily for the patient's benefit.

Consensus Statement

"Ethics consultation is a service provided by an individual consultant, team or committee to address the ethical issues involved in a specific clinical case. Its central purpose is to improve the process and outcomes of patient care by helping to identify, analyze, and resolve ethical problems."^{15(p.125)}

Both formulations emphasize that the ultimate rationale for each type of consultation is to improve the quality of patient care. The question posed by contrasting clinical ethics consultations from medical consultations is, "In what unique ways do each improve quality?"

ROLE OF CONSULTANTS

The consensus statement underscores what La Puma and Toulmin¹ identify as a distinguishing feature of consultation, shared by clinical medicine and ethics: the focus on a specific, active patient case. "A clinician is one who understands a particular patient's history, personal situation, and medical illness sufficiently well to help in managing the illness."^{1(p.1110)} Just as the medical consultant deals with the medical facts of a particular patient for whom the consultation is provided, the ethics consultant also deals with the particularities of each patient case. However, the particularities at play in ethics consultation pertain to the larger fact pattern of this individual patient as a person. The medical

prognosis; patient, surrogate, and family preferences; quality of life and values; and relevant contextual features¹⁶ are all essential to understanding the problem at hand and providing a basis on which to make an appropriate and helpful recommendation, whether in medical or ethics consultation. We argue that seeing and treating the patient as a whole person are fundamental ethical obligations of all physicians even when no specific ethics issue is involved, as Tumulty¹⁷ eloquently argued more than 40 years ago. Empirically inadequate attention to these humanistic dimensions in medical training and practice appears to be a common factor in or reason for ethics consultation.¹⁸

Both the referring physician and the medical consultant are similarly working on medical problems and in that effort are using related medical and scientific means to reach a desired outcome for the patient. The cardinal difference between the 2 types of consultations is that when an ethical problem arises, the nature of the issue is no longer medical and scientific but rather a set of embedded value-laden preferences related to rights and obligations of various parties. The timely resolution of ethical problems can make a difference in how effectively goals of care for the patient are agreed on and accomplished and may, some preliminary studies suggest, not only improve the quality of care but also affect its cost.¹⁹ Clearly, ethics consultants, unlike medical consultants, are not involved in the actual management of patients' illnesses but in the underlying decision-making process in which various ways of managing the case medically are considered.

Referring clinicians who are often generalists turn to medical consultants for assistance in patient management because of their superior expertise and experience in a specialty or subspecialty of clinical medicine. Referring physicians who turn to ethics consultants are not seeking medical recommendations or expertise. Usually, the need for an ethics consultation occurs when there is an impasse in defining goals of care because certain key value-laden decisions have not been made. Therefore, the expertise of the ethics consultant lies in a different realm: it has to do with understanding the prevailing ethical and legal guidelines and principles that determine procedural priority of rights and obligations and the skills to use communication and negotiation to reach an acceptable consensus for moving ahead. As DuVal et al²⁰ point out, physicians ideally would have mastered sufficient ethics knowledge and skills to resolve all but the most challenging ethics consultations independently. However, given the realities of contemporary medical practice, what can be expected from most physicians is the ability to recognize the need for an ethics consultation in the same way a physician should recognize the need for a

TABLE. Comparison of Medical and Ethics Consultation Approaches

Medical Consultation Principles	Ethics Consultation CASES
<ul style="list-style-type: none"> • Understand what is being asked • Determine timeliness 	<ul style="list-style-type: none"> • Clarify the consultation request
<ul style="list-style-type: none"> • See the patient/talk to the team • Review the medical record 	<ul style="list-style-type: none"> • Assemble the relevant information
<ul style="list-style-type: none"> • Provide clear and concise recommendations • Always offer options • Respect professional boundaries 	<ul style="list-style-type: none"> • Synthesize the information
<ul style="list-style-type: none"> • Teach and train • Communicate verbally and in writing 	<ul style="list-style-type: none"> • Explain the Synthesis
<ul style="list-style-type: none"> • Remain involved as long as needed 	<ul style="list-style-type: none"> • Support the consultation process

cardiology or neurology consultation without being able to acquire the requisite level of specialty expertise to obviate the referral.

Interestingly, expertise in ethics consultation, unlike medical expertise, which is the sine qua non of medical consultation, has recently been much discussed and debated in the United States.²¹ The nature of expertise in clinical ethics consultation, how competency is attained and demonstrated, and whether consultants in ethics should be certified, like their colleagues in other disciplines, are among the most contentious questions in contemporary bioethics.²² Active discussions and planning are currently under way within the American Association for Bioethics and Humanities regarding national standards for credentialing clinical ethics consultants. Clinical ethics expertise can be established through fellowship training or other advanced postgraduate education, but it is often gained informally through the same type of apprenticeship model used in clinical medical education.²³ Regardless, referring practitioners also respect past clinical experience, whether in ethics or medical consultations, because it inspires confidence in the accuracy and comprehensiveness of the consultant's clinical judgment.¹

APPROACHES AND PROCEDURES

In 1983, Goldman et al²⁴ published the widely cited "ten commandments of effective consultation," which Salerno et al²⁵ modified in 2006 as the "principles of effective consultation." The principles include the following: (1) determine the question, (2) establish urgency, (3) look for oneself, (4) be as brief as appropriate, (5) be specific and concise, (6) provide contingency plans, (7) honor the turf, (8) teach with tact and pragmatism, (9) talk is essential, and (10) follow up. We compare these principles with the CASES Approach to Ethics Consultation of the Veterans Health Administration National Center for Ethics,²⁶ chosen because it is one of

the most clinically based models. CASES includes the following steps: clarify the consultant request, assemble the relevant information, synthesize the information, explain the synthesis, and support the consultation process.

Determine the Question

This first step is as crucial for ethics consultation as it is for medical consultation, and it is a difficult task for less experienced consultants in both fields to identify the chief symptom and develop a differential diagnosis.¹² Failure to clarify that the referral question is appropriate for the type of consultation requested can result in a misguided course that may be hard to correct and could lead to dissatisfaction of the referral source and even adversely affect patient care. In a 1982 article, Perl and Shelp⁷ illuminated how psychiatric consultation can mask moral dilemmas, and this phenomenon is not restricted to psychiatry. Conversely, consultations initially framed as ethics issues may be more suitable for palliative care consultation, legal counsel, human resources, or compliance officers. Training in ethical principles and skills in analytic reasoning and argumentation can equip ethics and clinical consultants with the tools needed to properly identify ethics issues and distinguish them from various other concerns.²⁶ Requests for consultations to help with ethical issues take many forms. A 2007 article identified the reasons for 255 ethics consultations during a 10-year period at a tertiary academic medical center and compared these with prior empirical studies of ethics consultations. The authors identified the most frequent concerns addressed in ethics consultation to be code status, withholding or withdrawing of life-sustaining therapy, decisional capacity, end-of-life care, advance directives, patient autonomy, and staff, professional, or family conflicts.²⁷

Communication difficulties are frequently identified as a source of confusion in properly identifying questions in medical and ethics consultation,

reinforcing the importance of personally speaking with the consulting practitioner.²⁸ The referring practitioner recognizes the need for specialty consultation but may be less aware of the exact nature of the problem, how to frame it as a question, and what type of expertise is needed. Not uncommonly, ethics consultants are contacted for many types of non-medical problems, such as legal uncertainty, family conflicts, end-of-life questions, and spiritual concerns. Part of the work of ethics consultants is to assist physicians in problem identification and the type of expertise needed (eg, lawyer, social worker, or chaplain).

Establish Urgency

Prompt response to medical consultation is a factor associated with referring practitioner adherence to consultation recommendations and satisfaction with the consultation process.²⁹ When ethical issues present a limited time frame for resolution (eg, clarification of a do-not-resuscitate order for a patient in respiratory distress), ethics consultants must be available immediately in the same way physicians have always been. La Puma and Toulmin¹ emphasize that responding to urgent needs for consultation is intrinsic to being a true clinician. This requirement reflects a growing trend to hold ethics consultants accountable for the timeliness of their response and to formalize ethics consultation.²⁶ Most ethics consultations are not urgent in the sense of requiring immediate resolution. Most involve a process of discussion and negotiation in which the parties involved reach a consensus—a process that may involve multiple meetings and span days or even weeks.

Urgent ethics consultations and even The Joint Commission requirement that “an ethics mechanism be available” represent a real challenge for institutions in rural areas and small communities that have limited resources.³⁰ Much of ethics consultation work remains a voluntary and collateral duty at many facilities, limiting the availability of trained consultants. Ethics consultation may benefit from adaptation of some of the innovative solutions piloted to broaden access to subspecialty medical consultation, especially in rural communities, such as telehealth consultation, organization of regional experts in consortiums, online education programs, and outreach efforts from academic institutions to underserved areas.³¹⁻³³

Look for Oneself

Ethics consultation was born at the bedside, and despite the explosion of ethics resources, the patient remains at the center of the ethics consultation as has traditionally been the case in any medical con-

sultation. The ethics consultation primer requires the consultant to provide a reason for failure to perform a face-to-face visit with the patient or directly communicate with the surrogate.²⁶ This aspect of consultation also reinforces that the consultant has a clinical and ethical relationship not only to the referring practitioner but also to the patient. The advice of Cohn and Macpherson to medical consultants performing perioperative risk estimations could profitably apply to clinicians performing ethics consultations: “This information should be obtained or confirmed independently, and the consultant should make an extra effort to obtain any additional existing information felt to be necessary to the evaluation. The consultant must also be able to function in the absence of complete data as it may be lacking, unavailable or irrelevant to the question being asked.”³⁴

Because many requests for ethics consultations involve patients who lack capacity, ethics consultants spend much of their time communicating with the patient’s surrogate or family. When the patient is very sick and at risk for complications, including death, surrogates and families are faced with grave decisions fraught with uncertainty; they too experience moral distress.³⁵ Helping the family and surrogate distinguish the patient’s wishes and values from their own desires is a major role of the ethics consultant. In this role, the ethics consultant is facilitating the patient’s autonomy and also serving to provide moral support to the family and surrogate.

Be as Brief as Appropriate

There is little consensus on “how brief is appropriate” for either type of consultation. However, evidence from evaluations of medical consultations would suggest the more precise and concise the recommendations, the more likely the referring practitioner is to follow them.³⁶ An opposing trend has been developing in ethics consultation, which as it matures is moving toward more systematic formats. Advanced ethics consultation models, such as CASES and the Clinical Bioethics Workup from Georgetown, are detailed and comprehensive responses to ethics questions.^{26,37} An argument can be made that multitasking generalists would consider a succinct ethics write-up more accessible and useful. For instance, the most famous method, the 4 boxes method of Jonsen et al,¹⁶ can, in skilled hands, provide a complete and useful ethics analysis in a brief presentation that may be more accessible to busy practitioners. This is an area in which more research is needed in both fields to determine the optimal length and content of an adequate consultation.

Be Specific and Concise

Evaluations of ethics consultations suggest that education is one of the most effective aspects of the service.^{18,38} As with ethics education in general, there is a growing recognition of the need for ethics consultation requested by trainees and practitioners to be casuistic, commonsense, and clinically oriented rather than theory laden, overly philosophical, and abstract.³⁹ That is to say, the ethics consultant's education of the clinical team must be practical in nature and have the immediate result of assisting practitioners in dealing with difficult issues that thwart the possibility of accomplishing important medical goals.

Provide Contingency Plans

This maxim may at first glance seem to have no translation to ethics consultation, yet it is easily interpreted in terms of the cardinal aim of ethics consultation to "facilitate moral deliberation about ethically justifiable options."²⁶ Part of supporting and empowering any referring clinician is giving them choices that are clinically or ethically appropriate from which they can select in a process of shared decision making with the patient. Offering alternatives, or "what-ifs," is consonant with the role of ethics consultants as neither pure authorities nor facilitators but what the American Society for Bioethics and Humanities has called "mediated facilitators."⁴⁰ For example, it may be consistent with the wishes of a patient with a limited prognosis to either continue life-prolonging treatment for a brief period to ascertain whether there is any recovery or to move to comfort care. There are often no bright lines of differentiation among such options. It is often less important for the ethics consultant to be able to point to a "right answer" than to know which potential answers are within the range of acceptable alternatives relative to the standard of care in medicine and the patient's known wishes and best interests.

Honor the Turf

This is a feature of medical consultation that on first consideration seems to have no parallel in the ethics world and yet may be the most fruitful area for moral reflection. Increasingly, medical consultants are asked to cotreat patients, and this is one of the emerging issues of consultation etiquette; although it is virtually unexplored, cotreatment of patients is also an ethics concern.²⁵ After all, one of the keys to effectiveness of ethics consultation is that the consultant be a nonjudgmental and objective facilitator who does not have a vested or conflicted interest. Yet some clinical ethicists advocate for a case management role for the consultant.¹ However, the role

of ethics consultants should not involve the medical management of patients. Physicians in the end must use the recommendations of both ethics and medical consultants to make prudent medical decisions. For example, an ethics consultant who finds out from advance directives and discussions with family surrogates that the patient would not want to receive artificial life support if the prognosis is grave cannot decide to withdraw treatment. He or she can recommend withdrawal of treatment based on the facts of the case and preponderance of evidence to support moving in a certain direction, but an ethics recommendation is not a medical order.

The latter observation underscores the non-binding nature of ethics consultation recommendations, although it should be recognized that medical consultation recommendations are also not binding. In both situations it is the right and responsibility of the consulting physicians to evaluate and implement the respective recommendations as they deem appropriate for their particular patient situations. Negative reinforcement, such as fear of institutional sanctions or lawsuits, and positive motivators, such as respect for consultant expertise and wish to provide evidence-based care for patients, motivate physicians generally to adhere to medical recommendations.

Ethics consultants in most institutions do not exercise the same degree of influence, and research shows that some physicians believe ethics consultation can make a difficult situation worse and is not a productive use of time.²⁰ Childers et al¹¹ have shown how palliative care consultation has had an increasing effect on care plans through specialty expertise and integration into clinical treatment.

This may be a promising direction because it locates the "power" of an ethics consultation in clinical competence and the authority of moral suasion while respecting the prime directive of ethics consultation services to be advisory rather than decisional entities. Perkins and Saathoff³⁸ and La Puma et al⁴¹ conducted small studies in the 1980s, which found that clinician-ethicist consultations at university medical centers had a considerable and beneficial effect on how clinicians conducted clinical care. For ethics consultation to be binding in the sense of best practice would require consultants to develop a clinical identity and expertise that equals that of medical consultations and to develop an institutional presence and organizational utility that warrants the strong support of leadership. For this evolution to occur, valid and reliable evaluation tools and quality improvement methods must be developed and implemented so the utility and value of ethics consultation can be persuasively demonstrated.

Teach With Tact and Pragmatism

The integral educational responsibility of medical and ethics consultants unites the two, especially in the academic medical centers that host the most advanced specialty and ethics consultation services. Ethics consultants, on the one hand, can benefit from the example of their medical counterparts in striving to make education practical and definite. Medical consultants, on the other hand, can profit from the orientation of respect for all parties that is a characteristic of ethics consultation teaching at its best. Bates' description of the ideal consultant is thus as fitting for ethics consultants as it is for medical ones.⁴² The consultant "will render a report that informs without patronizing, educates without lecturing, directs without ordering, and solves the problem without making the referring physician appear to be stupid."⁴² Most important, instruction from the ethics consultant, both verbal and written, must avoid technical, abstract language and be accessible and helpful to medical practitioners. This pertains to analyses of ethical problems and the justification of how to prioritize the rights and obligations of those involved in the case.

Talk Is Essential

The vital place of communication is again underscored for all consultants. A study of 156 medical consultations found that in 22 the referring practitioner and the consultant disagreed on the reason for the consultation and the principal clinical issue.²⁸ **Clear and consistent** communication among the referring and consulting clinicians can prevent the patient from receiving inconsistent, critical, or confusing messages that undermine trust, participation, and informed consent. Disagreements among the consultant, clinician, and patient are inevitable, but it is discussion, not documentation of differences in unseemly "chart wars," that is the appropriate venue for resolution. The converse is also true; professional documentation is a hallmark of a mature ethics consultation service. More than perhaps any other element of consultation, referring clinicians anticipate and appreciate timely, articulate communication and documentation of the consultant's impression and recommendations. The medical record notes of ethics consultants, more than those of medical consultants, usually are made after a considerable amount of "talking," during which a consensus has been reached; in effect, the medical record note often reflects the results of an agreement that has been reached through team, patient, and family deliberations.

Follow-up

Providing follow-up is one of the best practices that makes medical consultation successful,⁴³ but it has not been suitably stressed in many ethics consultation models. Follow-up is also necessary to develop valid ethics consultation evaluation and quality improvement efforts.²⁶ Such efforts are essential if ethics consultation is to prove a worthy addition to the clinical care teams of the future.⁵ There are data that show positive clinical outcomes, such as improved patient, family, and physician satisfaction, reduced lengths of stay, and less inappropriate or unwanted use of life-sustaining treatment.^{44,45} Because of variability in ethics consultation training and performance and the methodologic weakness and small number of outcome studies, many health care executives are not fully persuaded that financial and political support of ethics consultation services is warranted.⁵ Not only are they not sure that ethics consultations can improve the quality of patient care, but also they are concerned about whether such consultations are worth the financial investment.⁴⁶

THE TRILATERAL RELATIONSHIP IN MEDICAL AND ETHICS CONSULTATION

This comparison of approaches to medical and ethics consultation highlights the relatively unexplored territory of the trilateral relationship, a concept described by Emanuel and Emanuel⁴⁷ in a widely quoted article. The consultant-patient relationship is a trilateral, deliberative model because of the 3-way, interactive association among the physician, patient or patient's surrogate, and consultant.^{43,47} The 3 parties communicate and agree on the goals of care and how to reach them as long as there are no perturbations in this collaborative homeostasis. There are at least 2 kinds of perturbations that can commonly occur: (1) a medical problem the referring physician cannot diagnose or treat or (2) an ethical dilemma that needs an outside voice to speak to it. Both convey alternative perspectives from the traditional dyadic physician-patient relationship. Medical consultation brings to bear additional scientific expertise, whereas ethics consultation conveys knowledge of professional standards and ethical principles, how they are applied to specific clinical cases, and the communication and interpersonal skills to implement them successfully. Both perspectives are intended to restore the physician-patient relationship to homeostasis so goals of care can be agreed on and pursued.

Both medical and ethics consultants should be aware of the potential for conflict with referring practitioners who do not believe in shared decision making or who view the resolution of con-

flicts with patients and families as their exclusive responsibility.^{6,48}

LESSONS LEARNED

Recognizing the Indications for an Ethics Consultation

It is crucial for attending physicians to be able to recognize the need not only for additional medical expertise but also for ethics expertise in the form of an ethics consultation. These indications arise when there is a value-laden conflict about matters such as the goals of care and how to define the best interests and achieve the best care of the patient. To reiterate, the expertise of the ethics consultant pertains to knowledge related to *procedural* norms and rules (ie, the rights and obligations of those involved) and to the skills to facilitate an acceptable consensus or outcome. In addition, the recommendations of ethics consultations are nonbinding.

Preventing the Need for an Ethics Consultation

The process of ethics consultation (ie, to bring into better focus patient preferences and values and relevant contextual features), as an effort to resolve a value-laden conflict, should serve as a reminder to physicians to pay adequate attention to these areas *before* such a conflict arises. As in providing medical care, the best way to deal with ethical conflict is often through prevention. This is not a new lesson for most physicians, but in the setting of contemporary medicine, there is a continual risk that these “low-tech” areas can get short shrift.

Viewing Ethics Consultants as Care Team Members

For an ethics consultant to be able to offer physicians helpful support, it is essential that individual ethics consultants have adequate medical and clinical knowledge. Ethics consultation is not an “armchair” academic endeavor. It is practical, and its recommendations affect outcomes and quality of care. Ethics consultants must view themselves, and should be viewed by the medical staff, as an essential part of the patient care team when needed.

Developing Broader Education in Physician Training

The best medical consultants are interested in the ethical conflicts that arise in caring for patients and wish to be informed and to collaborate in finding solutions. Research shows that physicians-in-training need, and want, more education on how to perform medical consultations.⁴⁹ Knowledge of the kinds of ethical conflicts that commonly arise in medical consultations and

the approach to them taken by the professional clinical ethics literature should be fully integrated into didactic and clinical instruction in each specialty area. This approach would lead to more constructive collaboration between medical and ethics consultants in providing sound recommendations to physicians about their patients.

IMPLICATIONS FOR MEDICAL EDUCATION

Mueller and Koenig,⁵⁰ in a 2006 *American Journal of Bioethics* article, proposed a systematic review of ethics consultation as a means of developing postgraduate medical education curriculum in ethics. Analysis of ethics consultation studies reveals that the most common reasons physicians and surgeons request ethics consultations are communication problems with patients, families, or other health care professionals.⁵¹ This finding supports a need for more attention to the development of communication and interpersonal skills for physicians and physicians-in-training. In recognition of this exigency, the Accreditation Council for Graduate Medical Education has identified this area as a core competency.⁵²

The study by DuVal et al¹⁸ examining triggers for ethics consultations found that the source of problems was more often highly emotional patient and family conflicts than questions related to ethical knowledge or reasoning. The need for ethics consultants to possess mediating skills is beginning to be stressed in the ethics consultation competency literature,⁵³ but conflict resolution is virtually ignored in the clinical training for medical students and residents. The renewed emphasis on professionalism across the career spectrum of medicine promotes the virtues of compassion, altruism, and integrity.⁵⁴ This is an important contribution, but to manage distressed and difficult human interactions positively, a wider range of emotional intelligence and relational abilities is required. Finset and Mjåland⁵⁵ conceptualized the medical consultation as a value chain model of 4 steps, including establishing rapport, patient disclosure of emotional cues and concerns, the physician’s expression of empathy, and positive reappraisal of concerns. Unfortunately, little space is given in most ethics and communications curricula to teaching the coordination of emotions and behaviors in the clinical interaction to achieve the goal of the consultation.

CONCLUSION

This comparison of medical and ethics consultation has, on balance, shown that medical and clinical ethics consultations offer complementary perspectives within the primary physician-patient relationship, reinforcing the wisdom of a clinical orientation

as essential to ethics consultation. From the finest examples of practice and practitioners in medical and ethics consultation, medical consultants and ethics consultants can learn valuable and mutual lessons from one another. Medical educators and scholars, especially physician-ethicists, have a rich and fallow field ready for cultivation as the basis for preparing future clinically astute ethics consultants and ethically attuned medical consultants.

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Abbreviations and Acronyms: CASES = clarify the consultant request; assemble the relevant information; synthesize the information; explain the synthesis; and support the consultation process

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