Ethics Consult Trends Reveal the Best Targets for Education

By Stacey Kusterbeck

Many ethics consultation services now have databases to record various pieces of information — the type of professional that requested the consult, the topic of the consult, the unit the consult came from, the people involved, the actions taken, and the recommendations given.

"Once trends are identified, clinical ethicists can then offer educational sessions to the units or professionals that might benefit most," says **Joelle Marie Robertson-Preidler**, PhD, an assistant professor in the McGovern Center for Humanities and Ethics at the University of Texas Health Science Center at Houston. Armed with these data, ethicists can contact nurse managers or unit directors with an offer to provide a specific ethics education session. Recently, Robertson-Preidler and colleagues covered policies on death by neurological criteria, surrogate decision-making in the context of family conflicts, and identifying potentially futile treatment requests. Ethicists also can ask clinical leaders what educational sessions might be most useful from their perspective.

Ideally, ethicists allow a back-and-forth conversation with the healthcare team. "This can help ethicists understand the pressures, schedules, and roles that the medical team must balance as they navigate complex issues. It can also help ethicists gain insight into how their recommendations land amid the complex interplay of people and medicine," says Robertson-Preidler.

At the University of Rochester Medical Center's Strong Memorial Hospital, the clinical ethics program uses a Research Electronic Data Capture (REDCap) survey tool to capture key elements of each consultation. "Consult tracking provides valuable insight into recurring ethical themes and emerging areas for educational focus," says **Margie Hodges Shaw**, JD, MA, PhD, HEC-C, director of clinical bioethics.

Ethicists document the initiator of the request, the primary ethical issue, the patient's clinical service and location, the amount of time spent on the consult, and the ethics analysis and recommendations provided. Strong Memorial Hospital's ethicists use those data to shape multiple educational initiatives. For example, ethicists saw an increase in patients refusing recommended treatments, even when the likely outcome does not align with their stated goals. "This can lead to tragic outcomes. The trend to reject medical recommendations reflects broader societal distrust of science and medical expertise," observes Shaw. Another growing challenge involves family disagreements about what the patient would have wanted, including questioning the authority of surrogate decision-making.

The clinical ethics program maintains an online interface for non-urgent ethical questions. Any hospital or school community member can submit an inquiry. The questions and responses are shared without attribution, creating an open forum for institutional learning. "Advisory deans use these questions and answers for small group discussions with medical students," says Shaw.

Many hospital leaders expect that ethics programs are engaging in quality assurance-related practices. "This typically includes capturing information on ethics consultation topics and trends via an internal ethics database," says **Ann Munro Heesters**, MA, PhD senior director of clinical and organizational ethics

at University Health Network. This gives ethicists a way to identify areas where education is needed most. Heesters has found that data collected by other hospital areas can be helpful to ethicists, too. A patient relations program or quality and safety department dashboard, for instance, may track information that sheds light on ethics knowledge gaps. "We have collaborated on institutional approaches to capturing and addressing non-physical harm in the healthcare workplace. This can be cases involving name-calling, treatment refusal, and discriminatory requests for changes in healthcare providers based on provider characteristics," reports Heesters.

Researchers at Michigan Medicine recently analyzed ethics consultations (119 adult and 51 pediatric) involving surgical teams from 2014-2024 to identify ethical issues and contextual features.[1] "Our institution has a robust ethics department with a high volume of thoroughly documented cases, making it an ideal dataset for this type of analysis," says **Daniel Jenkins**, one of the study authors and a research fellow at Hospital for Special Surgery. The goal was to identify areas where surgical teams need targeted training to address ethical dilemmas. Some key findings:

- **Most ethics consults occurred during the preoperative period**. "Preoperative decision-making is where much of the moral deliberation of the practice of surgery occurs," observes **Janice Firn**, PhD, MSW, HEC-C, another of the study authors and a clinical ethicist at Michigan Medicine and Center for Bioethics and Social Sciences in Medicine. Many consults involved disagreements about whether to proceed with surgery. "If the surgeon determines that surgery cannot meet the intended goal, that the risks outweigh the benefits, or that the post-operative recovery requirements cannot be achieved, then the surgery isn't offered," Firn explains. An example would be a patient who cannot effectively participate in post-operative rehab and who would be exposed to the risks of the surgery without being able to achieve the benefits.

- **For pediatric consults, goals of care disagreements, treatment refusals, and surrogate decision-making were the most common ethical issues**. Conflicts between staff and family were the most common contextual features.

- **For adult consults, the patient's decision-making capacity, surrogate decision-making, and goals of care disagreements were the most common ethical issues**.

- **Miscommunication or unclear or competing goals between patients, families, and clinicians were primary drivers of ethical distress**. For example, in the context of a life-limiting illness, parents could have the goal of prolonging their child's life as long as possible, but accomplishing this goal requires continued intensive care unit admission when the parents desire to have the patient at home. In other consults, the healthcare team had concerns as to whether the physical burdens of interventions were ethically justifiable. "These findings highlight the ongoing need for training healthcare professionals in crucial conversation skills to better facilitate discussions where the stakes are high, opinions vary, and emotions run strong," says Firn.

Tracking ethics consult topics was more challenging than the researchers expected. "In our system, consults are stored as narrative writeups within a secure file-sharing system," Jenkins explains. Currently, there is no standardized field to classify the reason for the consult. This means that consults must be reviewed individually and manually categorized.

"Adding a checklist or searchable field to each consult note would make tracking much easier," suggests Jenkins. Ethicists could indicate the primary issue (such as decision-making capacity, goals of care, or informed consent) for each consult. This would allow for keyword searches and data aggregation, enabling institutions to identify trends more efficiently.

"At our institution, our colleagues from the department of learning health sciences have expertise in developing and promoting infrastructure to facilitate findability, accessibility, interoperability, and reusability of workflows. We recently began conversations with them about strategies for building infrastructure for ethics consultation within the electronic medical record that go beyond what is currently available in EPIC," reports Firn.

Although many ethics programs find benefits in tailoring educational efforts to the needs identified during consults, data entry and analysis requires significant resources. **Benjamin Krohmal**, JD, HEC-C, director of the John J. Lynch, MD Center for Ethics at Med Star Washington Hospital Center, is skeptical of the utility of systematically tracking ethics consult categories for purposes of targeting educational efforts.

"The inter-rater reliability of existing rubrics for categorizing consult topics is fairly low. It turns out that different ethicists often categorize the same consult differently. Other rubrics are in development in an effort to improve inter-rater reliability, but I'm withholding judgment until they're ready for primetime," says Krohmal.

It is not uncommon for a single ethics consult to involve multiple ethical issues. For instance, a single case might involve refusal of recommended treatment, decision-making capacity, decision-making for an unrepresented patient, and concerns about discharge safety. "Different consultants will often identify different issues as the primary ethics concern," adds Krohmal.

In Krohmal's experience, frequent ethics consults on a specific topic do not necessarily mean there is a big need for education on that topic. "Frequency data alone won't tell you whether there is a glut of consult requests about a particular issue because the issue is a source of confusion in need of greater education — or because clinicians are already educated and highly attuned to that issue," says Krohmal. If ethicists give a presentation about ethical concerns involving the use of restraints, for instance, more consult requests involving restraints are likely. "Those who attended the presentation are now more aware that this is an ethically complex issue that could benefit from the involvement of the ethics consult service," explains Krohmal.

In terms of the time and resources required to track consults, "there is an opportunity cost," says Krohmal. The Ethics Consult Service conducted trial runs of different tracking rubrics. The data confirmed what ethicists already knew about the most frequent consult topics. The top issues were identifying the appropriate surrogate, clarifying goals of care, potentially inappropriate or non-beneficial treatment, refusal of recommended treatment, decision-making capacity, and advance care planning.

Depending on the tracking tool, the data entry often takes an extra 10 minutes or so per consult. That adds up over the course of hundreds of consults, and data analysis requires additional time. In Krohmal's view, all that time is better spent doing ethics grand rounds or presenting at medical department meetings. "We ended up concluding that, for purposes of improving ethics education, the data juice wasn't worth the squeeze. We're better off saving time on data entry and analysis, and doing a few more educational sessions," says Krohmal.

Sometimes, an ethics consult does not reflect any larger trends but causes such a stir that providing targeted education to a clinical team is warranted. **Hilary Mabel**, JD, HEC-C, recently consulted on a case where a healthcare agent sought to override the patient's preferences as expressed in their advance directive. Ethics was called in fairly late, when prior discussions between the healthcare agent and the team already had resulted in conflict.

"[A colleague and I] ended up providing education to the unit on optimal communication practices with respect to honoring advance directives with the hope that the team would be able to better navigate the next case," says Mabel, core faculty and healthcare ethicist at Emory University Center for Ethics.

Stacey Kusterbeck is an award-winning contributing author for Relias. She has more than 20 years of medical journalism experience and greatly enjoys keeping on top of constant changes in the healthcare field.

Reference

1. Amin SC, Jenkins DC, Vercler CJ, Firn JI. Ethics consultations as a novel approach to needs assessments in surgical ethics curriculum development. *J Surg Educ*. 2025;82(10):103654.

