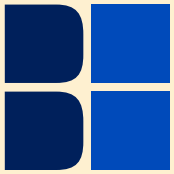

AMERICAN SOCIETY FOR
BIOETHICS + HUMANITIES

Resources for Developing Advanced Skills in Ethics Consultation

Clinical Ethics Consultation Affairs Committee
of the American Society for Bioethics and Humanities

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Background and Purpose

The American Society for Bioethics and Humanities (ASBH) and members of its Clinical Ethics Consultation Affairs (CECA) Committee have consistently worked to support the development and education of healthcare ethics consultants. In 1998, leaders in the field of healthcare ethics consultation (HCEC) identified core competencies for those working in the field, which ASBH published as *Core Competencies for Healthcare Ethics Consultation*; a second edition was published in 2011. In 2009, ASBH published *Improving Competencies in Clinical Ethics Consultation: An Education Guide,* designed to help individuals and groups master these core competencies; a second edition was published in 2015. The next step, in 2017, was the creation of *Addressing Patient-Centered Ethical Issues in Health Care: A Case-Based Study Guide,* which uses in-depth discussion of paradigmatic case consultations to complement *Improving Competencies in Clinical Ethics Consultation*.

During the development of these educational materials, ASBH and CECA members recognized that mastery of the core skills needed for healthcare ethics consultation requires substantial experience, sensitivity, and an understanding of nuance. In *Core Competencies for Healthcare Ethics Consultation,* the authors explicitly note that, although basic skills are necessary for one wishing to serve as member of an ethics consultation team and to perform a straightforward ethics consultation, more advanced skills are needed by those leading ethics consultations and conducting complex consultations. Yet little has been done by ASBH or others in the way of elaborating on the types of nuance and interpersonal skill required in conducting high-quality ethics consultations.

We hope that this resource will help fill that gap. As CECA Committee members, we know that ethics consultants must be approachable and must feel comfortable working with patients, families, and healthcare professionals alike. They must be empathetic and able to interpret and respond to others' verbal and nonverbal cues, yet remain objective and avoid partiality. They must be able to communicate with people who are not familiar with contemporary healthcare systems and must use language that is accessible to people from many backgrounds. Ethics consultants must also possess strong analytical and critical thinking skills and be able to think and respond promptly to situations that change incrementally over time. In crises, stakeholders' emotions change quickly, clinical statuses change abruptly, and courses of action must shift—all of which require very quick thinking and a deliberative frame of mind.

Dealing with such situations is not easy, and certainly none of these skills is easy to teach. Nonetheless, it is crucial that we teach interpersonal skills and varying approaches to conducting ethics consultations. In this resource, we build on the work of *Core Competencies for Healthcare Ethics Consultation* by describing how those skills might be used in consultative activities. For each of the consultative activities, we provide tips for executing each skill and conducting each activity. We note the pitfalls that may cause ethics consultants to fall short in conducting high-quality ethics consultation, and we highlight areas where we ourselves have made errors in our cases and where our experience may be instructive for others. We also correlate these notes with relevant sections of the cases presented in *Addressing Patient-Centered Ethical Issues in Health Care* (see column 4 in the table "Core Competencies for Healthcare Ethics Consultation: Pitfalls, Tips, and Resources," in the next section). We also include a resource for conducting family meetings—likely the most complex activity that ethics consultants engage in and one that requires a constellation of advanced skills. We set forth the elements of a family meeting and discuss phrases that can be helpful during these meetings, phrases and actions that should be avoided, and the rationale for these recommendations.

Finally, we include tips on doing a proper literature search to find more information on developing interpersonal skills for ethics consultation and provide a partial list of resources for finding bioethics knowledge.

In our work on this project, we sought to be as transparent, practical, and clinically based as possible, while also acknowledging that we could not be comprehensive. We know that developing the core ethics consultation skills, both basic and advanced, is a challenging and lifelong endeavor. As is true with many professional skills, one's development of interpersonal skills will be advanced by exposure to the experience of ethics consultants who have spent years individually conducting ethics consultations—through trial and error, success and failure, the sharing of hints and the recognition of pitfalls. It is hoped that this resource will supplement the development of the core skills achieved primarily through formal education and apprenticeship, enabling the sharing of real-world, hands-on experience—and wisdom. Like *Improving Competencies in Clinical Ethics Consultation* and *Addressing Patient-Centered Ethical Issues in Health Care,* this tool is primarily intended for individuals, groups, and organizations involved in the actual practice of healthcare ethics consultation, in varying roles and degrees. We hope you find it a valuable aid to your work in ethics consultation.

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Core Competencies for Healthcare Ethics Consultation: Pitfalls, Tips, and Resources

Activity	Pitfalls	Tips	Relevant Cases
Competency: Identify the nature of the value uncertainty or conflict that underlies the need for healthcare ethics consultation (HCEC).			
Information-gathering through conversations with the ethics consultation requestor, patients, families, and relevant healthcare professionals	Ethics consultants may be slightly "off" in recognizing the true ethical nature of the requestor's concern.	Consider asking the requestor or clinician to state the ethical issue in his or her own words. Ask the requestor if you are understanding the issue correctly. Watch cases longer than you might otherwise do. Share your chart notes with colleagues who can help you see or determine the issue and can help you make the issue(s) very salient within the note.	Case 2, Question 4 Case 3, Question 6 Case 11, Questions 5, 7
Misinterpreting the clinicians', patients', or family members' sense of uncertainty or conflict and formulating an incorrect or incomplete ethical question that fails to address the nature of the ethical conflict and the requestor's ethical concerns	Ethics consultants may expect other stakeholders to be able to create a well-formed ethical statement or question, or they may discount another's description that contains the ethics problem embedded within the description.	Be approachable, be accessible, and be patient. Expect that others may not be able to formulate an ethically precise question or statement. Expect that, if some discomfort or uncertainty exists, an ethical question may also be present. For that reason, consultants should avoid saying "there is no ethical question" or "I don't see the issue" during an initial phone call with someone requesting an ethics consultation. It may be important to gather some information first, including talking with other clinicians and reviewing the patient's chart, before determining that no ethical question exists. If, after you gather information and determine that the request does not involve "an ethics question," assist requestors to find the right organizational resource and follow up to ensure that the connection is made.	Case 5, Questions 8, 9 Case 9, Question 1
Reviewing the medical chart, including notes from medical, nursing, social work, chaplaincy, and allied health professionals	In fast-paced organizations, unintended short cuts may lead ethics consultants to overlook important data.	Articulate the roles of those on an ethics consultation service to ensure a delegation of responsibilities, and engage junior consultants or students to assist with chart reviews. For the chart review, focus on elements that will be critical to forming an ethical analysis. Important information that can be gleaned from the chart generally includes the prognosis or diagnoses, the interventions and options being considered, insights into patient-family dynamics, and the critical players involved in the case.	Case 3, Question 2
Observing the patient, watching for grimacing, moans, or other indications of suffering	Ethics consultants may lack awareness of when observation leads to bias or lack of objectivity.	It may be ethically justified for ethics consultants to avoid observing a patient. An example might be a case where the patient cannot purposefully interact and where the ethics consultant believes the patient's suffering might bias the consultant's ability to conduct a well-reasoned, objective ethical analysis.	Case 2, Question 3

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Activity	Pitfalls	Tips	Relevant Cases
Competency: Access relevant ethics literature, policies, guidelines, and standards.			
Discerning the presence or absence of ethical consensus and of justifications that might permit an exception to the ethical consensus	Ethics consultants may overestimate their familiarity with the ethics literature or with ethical issues in general.	Consider developing a specialty in ethics: actively follow and contribute to the ethics literature in that area. In areas outside your specialty, consider incorporating a step within your consultation process in which you conduct a literature review on that ethical issue or consult with an ethics colleague. Read professional guidance statements from top medical, nursing, and social work organizations every year. Read 3–5 articles every month on a selected topic.	Case 4, Question 6 Case 7, Question 4
Gaining knowledge of (1) case law, legislation, statutes, and regulations that are intrinsic to the work of most ethics consultation services, (2) professional guidance statements on issues that frequently surface during consultations (e.g., requests for medically inappropriate treatment); (3) empirical data that have contributed to defining ethically acceptable and recommended practices; and (4) hospital policies that have incorporated knowledge in the above areas	Ethics consultants who are not intimately familiar with the legal and ethics literature may make recommendations that (at best) are not practical or (at worst) are not ethically supportable.	Attend ethics conferences and deliberately attend sessions on ethical topics with which you lack familiarity. Establish baseline knowledge regarding case law, statutes, and regulations pertinent to the area of consultation; remain current on position statements from professional societies (e.g., those related to nursing and critical care); develop and maintain current documents that summarize key empirical findings that can support or, if necessary, refute recommendations (e.g., on topics like medically supplied nutrition and hydration in cases of patients with advanced dementia, effectiveness and ineffectiveness of cardiopulmonary resuscitation); and ensure that hospital policy is informed by current case law, regulations, statutes, empirical data, and professional position statements.	Case 1, Question 5 Case 4, Question 6 Case 5, Question 7 Case 7, Question 4
Competency: Establish HCEC expectations and determine whom to involve.			
Clearly communicating with the requestor about a timeline for the accomplishment of certain tasks and about the limits of what the ethics consultant can do (e.g., "I can facilitate a dialogue, but I cannot force the patient to do X, Y, or Z.)	Ethics consultants may give insufficient attention to (1) whether confidential requests are allowed; (2) whether the consultation will result in a consultation report in the patient's medical record; (3) whether the family will be notified of the consultation request; and (4) the limits of the consultation process (i.e., ethics consultation is not a disciplinary process).	To help align expectations between parties, remind healthcare professionals and other parties, when relevant, that (1) ethics consultants seek to facilitate sound ethical decision making but rarely, if ever, are able to prescriptively force an action; (2) ethics consultants seek to determine and articulate a range of ethically permissible options and that more than one permissible course of action may exist; and (3) ethics consultations are advisory but nevertheless carry substantial institutional force. Involvement of, or redirection to, other professionals may be needed in certain cases. An ethics consultant is encouraged to notify the requestor of an ethics consultation when an issue or case may need to be directed to another service (e.g., legal counsel, social workers, security professionals, pastoral care staff, administrators).	

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Activity	Pitfalls	Tips	Relevant Cases
Determining which parties are relevant to the information-gathering process	Ethics consultants may neglect talking to someone who might have a morally relevant perspective.	Ask all parties who else might be a key stakeholder with an ethically relevant perspective. This might include physicians and nurses; social workers; pastoral care staff; physical, respiratory and occupational therapists; and security staff.	Case 5
Determining who should attend family meetings and encouraging relevant stakeholders to provide their perspectives	Ethics consultants may allow one person to dominate the conversation. Ethics consultants may fail to include a relevant team member that other healthcare professionals or the family or patient views as essential.	Make clear at the beginning of a meeting that the ethics consultant may need to limit speaking time so that everyone's perspective may be heard. It may also be helpful to gently prompt and encourage reticent family members to voice their perspectives. Ask everyone to listen respectfully and patiently. Consider asking healthcare professionals and family members in advance of the meeting who they would like to be present and who they consider essential to the conversation. Then, invite people accordingly.	Case 11, Questions 8–10 Appendix, "Facilitating Family Meetings"
Competency: Use institutional structures and resources to facilitate the implementation of the chosen option.			
Ensuring that systems to address the recommendations given are in place, including the referral of certain aspects of a case to another service better positioned to address a recommendation	In the interest of completing a task or resolving a case, ethics consultants may act outside their scope. For instance, those with a background in law may be tempted to address legal issues, or those with a background in pain and symptom management may be tempted to address the patient's pain management.	Become familiar with other services of the hospital and their traditional scope of practice. Err on the side of bringing in other experts or services, to help ensure that ethics consultants do not exceed their scope. Hold routine meetings with directors of various units and services to help build rapport and to confirm that ethics consultants are acting within their traditional scope.	
Competency: Communicate and collaborate effectively with other responsible individuals, departments, or divisions within the institution.			
Building collaborative relationships with other individuals and services, while remaining objective in ethics consultations	Ethics consultants may, in an attempt to maintain positive relationships, feel compelled to agree with clinicians or hospital administrators in a case involving patient-clinician discordance or surrogate-clinician discordance, even when an alternative course of action might be ethically supportable or even preferable.	Ask this question: "Would I recommend this course of action regardless of my relationship with _____?" Underscore that the job of the ethics consultant is to remain objective and to make recommendations that accord with ethically supportable or preferable courses of action, regardless of the party that a particular course of action or actions would support. Work with others in the institution to establish a supportive atmosphere for collegial and respectful discourse among colleagues who may disagree.	Case 8 Case 9, Questions 8–15 Case 10, Questions 1–8

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Activity	Pitfalls	Tips	Relevant Cases
Competency: Facilitate formal meetings.			
Using conflict or dispute resolution techniques in facilitating family meetings, including knowledge in these areas: • The structure and elements of typical family meetings	Ethics consultants may lack the skill to facilitate (or lead) family meetings.	See section below, "The Family Meeting: Tips on Phrases to Use and Avoid, with Rationale" for tips on facilitating or leading family meetings.	Case 4, pages 32–33 Case 11, Questions 8, 9 Appendix Case 11, Question 8
• Potential *buckle points,* expected rough points in the meetings where the conversation may go off course, where questions will remain unanswered, and where next steps are not well-formulated. (Identifying buckle points is often considered part of the prebriefing or preplanning stage of a family meeting, in which healthcare professionals talk about the case without the patient or family present. The purpose of these meetings is to ensure that the medical team has achieved consensus about treatment options, prognosis, and plans for the family meeting.)	Family members and clinicians may spiral into debate about clinical details, often while holding different assumptions about what is relevant or meaningful.	Frame (or, if necessary, reframe) the discussion carefully around the patient as a person who has particular and relevant values and priorities. Remind clinicians to avoid diving deeply into medical specifics that may not be relevant.	Case 4, Question 5 Case 5, Questions 2, 9 Case 6, Questions 3, 4 Case 7, Question 8 Case 11, Questions 6, 8 Appendix
	One or more parties in a case may bring an attitude of dominance or control to a meeting, which prevents the parties from hearing one another and discussing solutions.	When planning meetings around value-laden issues, bring an attitude of openness and acceptance. Have a plan but not an agenda. Attempt to reduce the risk that participants will enter the meeting with a dominant attitude by reminding everyone that their opinions will be heard and are valued. Consider beginning the meeting by discussing common goals and purposes. Ensure that perspectives have been heard in proportion to the stake each voice has in the outcome of the discussion.	

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Activity	Pitfalls	Tips	Relevant Cases
Competency: Document and communicate HCEC activities.			
Documenting ethics consultations and other ethics activities so that ethics consultants can be accountable for the quality and scope of their work	The work of the ethics consultants cannot easily be accounted for or assessed for quality because it has not been documented in some way.	Document ethics consultations clearly and thoroughly in the health records of patients when the analysis and recommendations affect the patient's care. Consider documenting the following information: (1) at the nature of the ethical concern; (2) an assessment, which includes the work the ethics consultant performed to analyze the case; (3) an ethical analysis, tied to the facts of the case; (4) recommendations; and (5) a closure, including whether the consultant plans to follow the case or end his or her involvement. Consider documenting at these stages: (1) at the beginning of a case and the initiation of the ethics consultation, (2) at the middle of the case after certain substantive activities have been undertaken (e.g., a substantive patient interaction or family meeting); and (3) at the end of a case to close involvement. Document other ethics consultation activities in internal service records, such as a database. A database can be used to capture extraneous details that are not pivotal to the ethical analysis.	
Competency: Identify systems issues and delegate follow-up.			
Identifying systems issues that led to or contributed to the ethical concern and considering referral to quality improvement staff	Ethics consultants may find themselves repeatedly responding to concerns that are caused by a systems issue and may not recognize that the issue is indeed system-wide.	Review each consultation to determine whether a systems issue contributed to the ethical concern. Review consultations over time to determine whether a pattern emerges of systems issues that contribute to the ethical concerns being raised. Review monthly statistical reports to see whether issues are cropping up often in a certain unit or are repeatedly related to the same issue. Bring critical systems issues to the attention of the individual or group responsible for resolving these concerns for the organization. Consider using the bioethics committee to review systems issues and identify ways to follow up or to delegate tasks.	

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Activity	Pitfalls	Tips	Relevant Cases
Competency: Evaluate the HCEC and provide quality improvement.			
Participating in quality improvement activities, including formal assessment and seeking of feedback about quality improvement practices	Ethics consultants may perform consultations without systematically assessing them (i.e., comparing them to a set of explicit or implicit standards), which is inconsistent with expectations for the delivery of a healthcare service.	Remember that evaluation efforts need not be burdensome or costly. Consider the use of these quality improvement methods: • Use a process of reflection and self-assessment after a consultation has been completed. • Seek feedback about the consultation from the participants to identify areas for improvement in systems, processes, and outcomes (see *Ethics Consultation Feedback Tool,* in U.S. Department of Veterans Affairs, National Center for Ethics in Health Care, 2011). • Seek the assistance of experts in the organization (e.g., quality managers) to develop appropriate ways to assess quality, ensure that the measures used are valid, and ensure that data are collected and analyzed in a minimally burdensome fashion. • Do spot checks by having a member or several members of the ethics consultation service to randomly select cases to review. • Deconstruct cases as a team. Identify cases for deconstruction that did not go well or were very complicated.	
Competency: Effectively run an HCEC service.			
Integrating the ethics consultation service and oversight of its operation into the healthcare organization	The ethics consultation service is not integrated into the organization, or it lacks leadership support, expertise, staff, or resources, making it ineffective or unable to adequately address ethical concerns. The ethics consultation service does not ensure access, demonstrate accountability, demonstrate organizational learning, or evaluate its ethics consultants and consultations.	Ensure that the ethics consultation service is formally established in the organization and that expectations and standards for its performance are described in policies and other appropriate mechanisms. Consider the following guidelines: • The director of the service must have substantive experience in ethics and ethics consultation as well as strong collaboration skills. • The director of the service should have data on his or her own quality reviews in conducting ethics consultation. • The team (or at the least the director) should be willing to make rounds with the intensive care unit teams to demonstrate the value of ethics consultation and increase clinicians' awareness of ethics activities. • Members of the ethics consultation service should be well integrated into committees whose work has ethical dimensions, such as transplant committees or committees conducting reviews of long-stay cases.	

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Activity	Pitfalls	Tips	Relevant Cases
Competency: Listen well and communicate interest, respect, support, and empathy to involved parties.			
Purposefully listening to the verbal and nonverbal communication of all involved parties and giving respectful and empathetic responses	The consultant may (1) begin a conversation while partially distracted by other obligations, (2) fail to gather enough information and, as a result, misunderstand another person's perspective, or (3) fail to include key stakeholders in the discussion.	Consider allowing breaks between obligations. Deliberately set aside time for self-reflection, self-care, or disengagement. Consider setting a maximum number of family meetings that you will facilitate in a day or week. (One CECA member limits her participation to three family meetings a day, believing that by her fourth family meeting in a day, she is no longer actively listening in a way that is truly helpful for facilitating the meeting. She also requests time off the on-call schedule.) In the interest of including all relevant perspectives, consider postponing a family meeting if key members of a family are not present (see Koprowska, 2014; Stone, Patton, & Heen, 2010).	Case 2, Question 4 Case 4, Question 5 Case 8, Question 8 Appendix
Competency: Educate involved parties regarding the ethical dimensions of the consultation.			
Explaining in laypersons' language the ethical issues relevant to a case, distinguishing the ethical dimensions from overlapping areas (e.g., legal issues)	The ethics consultant may (1) fail to identify clearly the case's ethical issues or constructs, (2) talk about ethical issues using jargon that is not explained clearly, or (3) fail to distinguish the case's ethical issues from other overlapping dimensions.	Understand the ethical issues in each case and identify them before meetings. Refine the explanations as needed. Practice explaining an issue to a colleague or a friend who does not work in ethics to see if he or she understands it. Consult the literature on how to "pitch" communication at an appropriate level of education for different stakeholders.	Case 5, Question 1 Case 10, Question 2 Case 11, Questions 1–2
Competency: Elicit the moral views of the involved parties.			
Eliciting values preferences effectively, accurately, and consistently	Ethics consultants may ask very broad questions in an attempt to elicit values, but open-ended questions (e.g., "What are your goals?" or "What are the patient's values?") can frustrate efforts to advance the conversation and can lead to confusion.	Starting with broader questions may be initially useful in opening up the conversation (e.g., "What does your mother value and enjoy in life? What gives her life meaning?"). If these questions are rephrased as more specific ones (e.g., "What would you hope to see in 3 months for her recovery? How would your mother view this condition or level of recovery?"), families may be better able to discern what types of information would be helpful for the team and, in response, effectively answer questions. Ask follow-up questions in order to uncover or illuminate more specifics.	Case 4, Question 8 Case 9, Question 4 Case 11, Question 5

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Activity	Pitfalls	Tips	Relevant Cases
Competency: Represent the views of the involved parties to others.			
Facilitating representation of views among all participants	Ethics consultants may "institutionalize" their roles and fall into political traps.	Ethics consultations that involve team conflict (especially conflict between physicians who hold institutional power and patient-surrogates) pose challenges for the patient, surrogate, nurses, house officers, and allied health professionals. The ethics consultant's self-awareness and reflection on carrying out the role of ethics consultant are vital. Give attention to all stakeholders' views and motivations. Display moral courage. In politically complex cases, check in with, or request supervision from, other senior consultants.	Case 3, Question 3 Case 4, Question 5 Case 5, Question 3 Case 7, Question 6
Competency: Enable the involved parties to communicate effectively and be heard by other parties.			
Assessing whether and when a family meeting, team meeting, or one-to-one conversation is most appropriate for advancing a case	Ethics consultants may subconsciously judge the motives of surrogate decision makers who seem to be making "bad decisions" on behalf of patients.	Gather as much information as possible to help discern whether a meeting is appropriate and, if so, who should be included and what the meeting's purpose would be. Consider using a team meeting to facilitate difficult communication among clinician stakeholders; this format allows all stakeholders to hear the various perspectives. When facilitating a meeting, take special care to set up a discussion that fosters collegiality and mitigates tension (usually by keeping the well-being of the patient as the focus). Have a plan, but not a controlling "agenda"; if possible, begin the meeting by discussing the common goals or purposes of the meeting. Try to reduce the likelihood that participants will enter the meeting with a dominant attitude by reminding everyone that their opinions will be heard and are valued. Use one's own reflection to ensure that perspectives have been heard in proportion to the stake each voice has in the outcome of the discussion. Avoid promulgating gossip or triangulation about surrogate decision makers that may not be well-founded, and discourage other health-care professionals from doing so.	Case 1, Question 6 Case 5, Question 8 Case 7, Question 8 Case 9, Questions 7–9 Appendix, "One-on-One Encounters with Patients or Surrogate Decision Makers," Questions 1–2

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Activity	Pitfalls	Tips	Relevant Cases
Competency: Recognize and attend to various relational barriers to communication.			
Understanding how and for what reasons assessments of decision-making capacity are conducted	Ethics consultants may fail to recognize that some patients who do not meet the criteria for decision-making capacity may still be expressing a preference or manifesting signs and symptoms of pain or discomfort.	Avoid creating assumptions based on a single assessment of decision-making capacity by (1) visiting, observing, and interacting with the patient as part of the consultation process; (2) listening to nurses, who attend the patient 24/7, to assess even the "silent patient's" experience of illness; (3) seeking to understand familial factors or other factors that could influence a patient's ability or willingness to make decisions that are truly in keeping with his or her individual preferences.	Case 1, Questions 2, 9 Case 2, Questions 2, 3 Case 9, Question 15
Soliciting information related to the family's understanding of the patient's condition	Ethics consultants may rely on family members' responses to the question "Do you understand?"	Approach surrogate decision makers without judgment, allowing them to share their authentic perspectives. Use nuanced ways of eliciting family understanding that are more helpful and perhaps less demeaning than asking family members to repeat what someone has said or asking whether they understand. For example: "Does anything the doctors just said surprise you, or does it seem consistent with what you thought?" Or "Many doctors are involved in your loved one's care, and sometimes it can be hard to build an overall picture of how your loved one is doing. Can you tell me the gist of what you're hearing from the doctors?"	Case 3, Question 8 Case 6, Question 3 Case 9, Question 15

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The Family Meeting: Tips on Phrases to Use and Avoid, with Rationale

Subelements	Tips	Phrases for Possible Use	Phrases or Actions to Avoid, with Rationale
Meeting Element: Introduction and Openings			
Introducing meeting participants	• Describe who you are. • Identify your service or specialty. • Describe what that service does (because families may not remember the difference between, for example, the hepatology and pulmonary services). • Describe what you hope to contribute to the meeting (so families know that no extraneous individuals are present and that every clinician has a purpose and role in the meeting). • Allow others to introduce themselves.	"I am Dr. Garson from the pulmonary service. This means I monitor and treat Mr. Hill's lungs. During today's meeting, I hope to talk about our use of the ventilator and how we see his lung condition progressing."	"Hi. I'm Dr. Garson from the pulmonary service." • The statement does not specify what *pulmonary* means. • The statement does not specify what the physician hopes to contribute to the meeting and why that is important.
Describing the purpose of or intentions for the meeting	• Be specific about the purpose so that parties keep the meeting "on track." • If the purpose of the meeting is to encourage the family to shift to comfort care measures, simply use the statement "The purpose is to identify possible care pathways and which pathway we think you should take."	"The purpose of the meeting is to discuss what we have seen so far, what we expect moving forward, and what treatment options are available to Mr. Hill at this point." "The purpose is to identify possible care pathways and together decide the best path to take as we move forward."	"We are here to talk about the goals of care" or "We are here to talk about hospice care [or comfort care measures or palliative care]." • The statements use broad, ambiguous language. • The statements use language that is likely to be misunderstood or to generate alarm and anxiety.
Eliciting the family's agenda for the meeting	• Be specific and close-ended to ensure that you, as clinician, can talk about the agenda items you hope to address.	"That's our agenda for today's meeting. Is there anything else you'd like for us to address?"	"Please tell us what you are hoping to learn from the meeting." • The request is too open-ended. • The request shifts the leading responsibility from clinicians to the family.
Eliciting the family's understanding of the patient's condition	• Foster understanding by using clear and direct language.	"Many people are involved in Mr. Hill's care. It can be difficult for families and others to understand what is going on. Can you tell me your understanding of what is going on for him?"	"Tell us what you know about heart failure." "Repeat what we just told you about heart failure." "Do you understand?" • All these sentences can be perceived as demeaning and "testing." • These sentences do not help ensure that someone has actually comprehended what has been said.

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Subelements	Tips	Phrases for Possible Use	Phrases or Actions to Avoid, with Rationale
Reviewing the patient's condition	The presentation to the family is not the same as a presentation to the team during intensive care unit (ICU) rounds. Families are often not interested in the technical pathophysiological aspects of patient care, so more detail is not necessarily better. Keep the presentation short and avoid unnecessary detail. Focus on these questions: Where are we? What do we anticipate as we move forward?	"We see a few main things going on. His major problem is his heart failure, which is affecting the functioning of several organs, including his kidneys. What does it mean to have heart failure? Essentially, his heart …"	"Let me describe what has happened and how each organ is affected." • It is natural to want to repeat the patient's history and describe the scientific aspects of the patient's medical course, but this level of detail is often overwhelming to families.
Discussing prognosis for survival, expected trajectories, and timeframes, as well expected ability to engage in daily activities	Be clear when you make the transition from discussing the patient's medical condition to discussing the prognosis. Highlight the best-case scenario, worst-case scenario, and most likely scenario. This will help you, as clinician, synthesize the clinical information.	An example of a clear transition from medical condition to prognosis would be: "So what are the implications of what I just told you? What can we expect as we move forward? Well, …"	"The patient is not salvageable." "He will not do well." "He has a grim prognosis." "We do not expect a good outcome." "We will have decisions to make." • These frequently used phrases are ambiguous and too broad. Focus instead on what can be expected in the next month and the next 3–6 months.
Describing uncertainties, including timeframes for when more definitive information can be provided	If you do not have definitive information about certain elements, then say "We don't know yet" and provide a timeline for when you will know.	"We are not sure yet what Mr. Hill's brain function will be. But we should have a better idea in 3 days or so, after our clinical exams. We will be looking to see whether he can follow our verbal directions, and so on."	"We will never know." "We can't say for sure." We will have to wait and see." "I don't have a crystal ball." • These statements are used frequently, but they are not always helpful. There will always be uncertainties, and families know this. Try to provide as much information as possible, even given the uncertainties.
Meeting Element: Decisions			
Discussing options or treatment choices; making decisions	Be very clear when you are talking about options by discretely labeling them Option A, Option B, Option C. It can be helpful to use dry-erase boards to outline the benefits and drawbacks of options.	"One option is radiation. This would require you to come into the hospital 36 times over the next 3 months. The side-effects would include a little burning sensation and increased frequency of urination. The second option is surgery to remove the tumor. It is similar in effectiveness to radiation."	Discussing all the options (such as a do-not-resuscitate order, comfort care, and hospice care) together, moving back and forth between them, can be confusing. • Family members may conflate the options in their minds. • Discussing each option separately, first outlining the option, its benefits, and its drawbacks and then shifting to another option and its benefits and drawbacks, helps families distinguish among the options.

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Subelements	Tips	Phrases for Possible Use	Phrases or Actions to Avoid, with Rationale
Elucidating and adequately confirming patients' values, goals, and preferences	You may find it helpful to elicit values after discussing options in order to anchor the values decision. By doing this, you can contextualize the discussion of values within the options framework. On the other hand, many clinicians find it most useful to elicit values first and then use that information to guide options accordingly. Try both approaches and see what works best for you.	"Tell me what guides your medical decisions. What are you looking forward to, and what are you hoping for? Some prefer to take the most aggressive treatments possible, even when the doctors think there is not much chance that they will help and no matter how uncomfortable the treatments will be. Others prefer to focus on comfort and on being able to spend as much time as possible with their family. And some choose a course between those two. What kind of person is Mr. Hill? On what do you base your opinion about what he would want?" (It sometimes helps to draw a continuum on a dry-erase board or piece of paper and show the different clinical options along the continuum.)	"What are your values?" "What are your goals?" "What are you expecting?" • These statements are used frequently, usually with little success. The questions are too broad and are not likely to be helpful in reaching a treatment decision.
Meeting Element: Closings			
Summarizing or providing take-home points	Describe the main points of what was decided and what still needs to be decided.	"Today we have reached a decision to institute a do-not-resuscitate order. We talked about hospice care, and you'd like some time to think about that. Let's circle back in 3 days to see what you're thinking…"	Closing the meeting without recapping • You want to ensure that everyone is clear about what has been decided and what still needs to be decided.
Providing gratitude or acknowledgment or sympathy	Acknowledge the difficulty of what the family and the patient are going through and how valuable the family has been in supporting the patient. Try to avoid using the term *the patient* with the family, instead calling the patient Mr. or Ms. (with his or her last name).	"Thank you for working with us. We are so sorry these are the circumstances in which we met, but we have truly enjoyed working with you and your loved one. You are an incredible family, and we're thankful."	Failing to attend to emotions or failing to express gratitude
Discussing next steps	Discuss what still needs to be decided or determined and the ways in which the decisions or information will be sought.	"We will call you in 3 days to see how you are feeling about hospice care…"	Leaving without establishing a follow-up plan or timeframe

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Subelements	Tips	Phrases for Possible Use	Phrases or Actions to Avoid, with Rationale
Meeting Element: Communication			
Checking for family understanding throughout the meeting	Elicit understanding at three time points: after discussing the medical condition, after discussing treatment options, and at the meeting's close.		
Demonstrating active listening skills	To demonstrate active listening, first summarize what you think you heard a family member say, or validate a statement the family member has made.	"Am I right, then, in thinking you are feeling that no one is listening to your thoughts about the chemotherapy?" "You feel upset, which is understandable. I think I would feel upset, too, if I experienced X or Y."	Shifting to what you want to talk about without first acknowledging what the family said by summarizing or validating it
Transitioning at appropriate times	Most of the time during the meeting should be spent discussing options. If too much time is spent on any one element during a meeting, it is appropriate to redirect the meeting or speaker to the goals of the meeting.	"I'm so sorry. Just recognizing that we have only a few minutes in this room, we want to make sure we get to X, But before we do, I want to make sure we understand and heard you correctly."	"You are very focused on the previous hospitalization. We can't fix anything that happened before we took care of Mr. Hill. So let's focus on the here-and-now." • This statement is used frequently, but it can be construed as being dismissive. Instead, if you need to redirect, do so by apologizing, explaining why the redirection is necessary, and acknowledging what the person said to confirm that you are correctly understanding the speaker's sentiment. Then you are set up to shift the conversation.
Acknowledging and showing respect for the team	Allow team members to contribute to the meeting. Ask them specific questions during the meeting that are best addressed by them and within their domain of expertise. Invite other services and team members to meetings, even if their participation is not critical, so they can stay informed.	"My colleague, Dr. Rose, is from the palliative care service. She is probably best positioned to address how to alleviate Mr. Hill's physical pain and discomfort."	"I am the surgeon [or intensivist, or attending physician]. You will get a lot of mixed messages from the team members, but remember that I am the captain of the ship. Just ask me." • We've heard this statement used often, which is unfortunate. The statement invites the family to discount what any other team member has to say.

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Subelements	Tips	Phrases for Possible Use	Phrases or Actions to Avoid, with Rationale
Meeting Element: Emotional Support			
Responding to verbal and nonverbal expressions of emotion by acknowledging and validating emotion	If you are unsure whether you are reading a cue correctly, simply ask family members what they are thinking. Allow yourself to test hypotheses. By testing hypotheses, you can enhance the efficiency of the meeting.	"I am noticing that you are quiet, Jennifer. We want to hear from you. Does your quietness suggest that you disagree? Tell us what you are thinking." "You look at each other and nod when we mention option A. Am I right that you are leaning toward option A?"	Giving family members tissues at the first sign of tears • This can signal that the tears are unwanted. Instead, when you see tears, first move closer to the crying family member, pause, acknowledge that tears are normal, and then hand the person tissues.
Providing support for hopes and reassurances about comfort, or finding necessary support through other support staff	Always remind families that you will do everything possible to ensure the patient's comfort, no matter what they decide.	"Even when we move toward comfort care measures and the patient is in the passing process—actually, most especially when patients are dying—we pour ourselves into taking good care of patients, and we will do everything we can to minimize pain or discomfort. We are there the whole time."	Failing to remind families that healthcare professionals attend to patient suffering and distress at all times and will never abandon the patient

Note. Adapted from "Developing and Testing a Comprehensive Tool to Assess Family Meetings: Empirical Distinctions Between High- and Low-Quality Meetings," by C. Bruce, A. D. Newell, J. H. Brewer, D. O. Timme, E. Cherry, J. Moore, … D. S. Zhukovsky, 2017, *Journal of Critical Care 42,* Table 1. Copyright 2017 by Elsevier Inc. Used with permission.

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How to Conduct an Internet Search*

Ethics consultants can enrich every ethics consultation and improve the final result by conducting a literature search for the best thinking about ethical standards and practices and incorporating the findings into the consultation process. Even a quick search can provide valuable information relevant to the consultation at hand.

The following steps are useful in conducting an internet search for ethics knowledge:

1. **Begin with the ethics question.**
   - ❏ The question should identify the specific values that are uncertain or in conflict and the contextual information that will help to focus the consultation process.
2. **Choose terms.**
   - ❏ Pick out several search terms that are specific to the topic of the consultation.
   - ❏ Think of synonyms for these terms.
   - ❏ Try searching for different combinations of the terms.
   - ❏ Add *ethics* to the beginning or end of the list of search terms.
3. **Review the list of results for relevant items.**
   - ❏ Quickly review the first 1–2 pages of the list.
   - ❏ Read titles and skim excerpts.
   - ❏ Notice the source of each item; determine which are from authoritative sources that may be the most useful (versus blogs, advertisements, etc.) Authoritative sources often end in *edu* or *org*.
   - ❏ Notice whether the item has been cited in other publications, and follow that lead as appropriate.
   - ❏ Notice whether promising items use terms that you might include in a future search.
   - ❏ If the results are not promising, try again using different search terms.
   - ❏ Remember to bookmark those sites you find most useful for ease in conducting future searches.
4. **Drill down on items that show promise.**
   - ❏ Click on the most promising items.
   - ❏ Determine whether they are worth pursuing. If not, move on.
   - ❏ Follow only promising leads or links.
5. **Obtain and review resources.**
   - ❏ Try to find full-text articles.
   - ❏ Print out or download full-text articles (or request them from your library).
   - ❏ Review references in articles to look for other leads.

*Adapted from work of the U.S. Department of Veterans Affairs, National Center for Ethics in Health Care

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Resources for Finding Bioethics Knowledge*

Internet Resources	
American Medical Association (AMA) PolicyFinder	https://www.ama-assn.org/about-us/policyfinder
EthicShare	www.ethicshare.org/
Georgetown University, Kennedy Institute of Ethics, National Reference Center for Bioethics Literature	https://bioethics.georgetown.edu/
Google Scholar	http://scholar.google.com
Palliative Care Network of Wisconsin—Fast Facts and Concepts	https://www.mypcnow.org
U.S. Department of Veterans Affairs National Center for Ethics in Health Care	https://www.ethics.va.gov
U.S. National Library of Medicine (includes PubMed, NLM Catalog, and more)	https://www.nlm.nih.gov/bsd/bioethics.html
Bioethics Journals	
AMA Journal of Ethics	http://journalofethics.ama-assn.org/
American Journal of Bioethics	www.bioethics.net
BMC Medical Ethics	www.biomedcentral.com/bmcmedethics/
Hastings Center Report	www.thehastingscenter.org
IRB: Ethics & Human Research	www.thehastingscenter.org/publications-resources/irb-ethics-human-research/
Journal of Clinical Ethics	www.clinicalethics.com/
Journal of Empirical Research on Human Research Ethics (JERHRE)	https://us.sagepub.com/en-us/nam/journal-of-empirical-research-on-human-research-ethics/journal202321
Journal of Law, Medicine and Ethics	http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1748-720X
Other Journals	
JAMA—Journal of the American Medical Association	http://jama.jamanetwork.com/journal.aspx
The Lancet	www.thelancet.com/
New England Journal of Medicine (NEJM)	www.nejm.org/

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