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The Failure of the Consult Model: Why "Mediation" Should Replace "Consultation"

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Abstract

Ellen Fox and her colleagues (Fox, Myers and Pearlman 2007) have generated a rich set of data about ethics consultations in US hospitals that raise serious concerns about this mode of conflict resolution. Using the data they have collected, I want to highlight several issues that question the ethical legitimacy of the ethics consult service (ECS) model, and I want to argue that it may be time to replace ethics consultation with ethics mediation.

Comments

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The Failure of the Consult Model: Why "Mediation" Should Replace "Consultation"

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Ellen Fox and her colleagues (Fox, Myers and Pearlman 2007) have generated a rich set of data about ethics consultations in US hospitals that raise serious concerns about this mode of conflict resolution. Using the data they have collected, I want to highlight several issues that question the ethical legitimacy of the ethics consult service (ECS) model, and I want to argue that it may be time to replace ethics consultation with ethics mediation.

The first concern raised by this study is the frequency with which the end result of the ethics consult is a recommendation. Fox et al. found that 65% of ECS always make a recommendation and the overwhelming majority (82% of ECS) make a recommendation in at least 80% of their cases (2007, X; Table 4). A *single* best course of action -- as opposed to a range of acceptable options -- is recommended in almost half (46%) of the cases (2007, X). What the data don't show is the percentage of ECS recommendations that are rejected by their respective hospitals, though if such rejections were common place, this issue would likely have surfaced in the study (as a data-point on the efficacy of ECS). This statistic about the rejection-rates is needed to determine whether "recommendation"—which merely implies "suggestion" or "advice"—is in practice more akin to "decision" or "rendered judgment." If the recommendations are always accepted and implemented by the hospital, then the force of the so-called

“recommendation” is actually that of a “mandate.” If ECSs possess this ultimate power to render decisions that dramatically affect other people’s lives, then a compelling case needs to be made—for each ECS—that it has a legitimate right to this power. For each ECS, the question must be asked: is this group qualified to mandate a course of action that will profoundly affect virtual strangers, who may have very different values and priorities from the members of the ECS?

This first concern about the status of the recommendations made by the ECS leads naturally into a second concern about the qualifications and expertise of the ECS. How are these decision-makers trained? What allows them to wield this power? It is unclear what type of training would actually qualify someone for this role, but no training is clearly inadequate. The Fox survey found that only 1 in 20 consultants had any formal ethics training, and less than half had an apprentice-based training through direct supervision by an “experienced” member on an ECS (2007, X). Additional data collected by Fox and her colleagues about the actual decision-procedures of the ECS were also worrisome. They found that is not unusual for ECSs to vote on these momentous decisions: 49% of ECSs voted in at least some cases, with 20% of ECSs voting “at least half of the time” (Fox, Myers and Pearlman 2007, X). If a case requires a vote as the decision-procedure, then there must be considerable disagreement, dissent and uncertainty surrounding the case, with some members of the ECS advocating one course of action and others advocating another. Such internal conflict indicates the absence of the kind of ethical confidence that might warrant the issuing of a recommendation, especially one that carries the weight of a

mandate. If a vote needs to be taken, a recommendation is surely not justified. At best, what the ECS comes up with in such cases is an ethical “best guess,” and that is not a good enough rationale to dictate the course of action for a patient or her family.

Perhaps the most striking finding of the Fox study is that ECSs are hardly being utilized: the median number of consults is a mere 3 per year, and 22% of ECSs did not perform any consults in the year of the study (2007, X). Even in the largest hospitals (≥ 500 beds), the median number of consults per year was only 15 (2007, X). If we reflect on how many ethically charged conflicts occur in hospitals each year, it is clear that there is a large, unmet need among patients and their families for help in navigating these conflicts: the ethics consultation system we have in place in the US is not working. The study does not provide clues to explain this under-utilization of the ECS, but perhaps it isn't used because it isn't properly conceived to meet the needs of the population it is intended to serve. In his commentary, Richard Zaner argues that the ECS misconstrues its proper role:

[T]he consultant's job is to help individuals whose situation it is think through their circumstances as thoroughly as possible, then help them understand what must be decided and what aftermaths can be expected (Zaner 2007, X).

But then what Zaner is really advocating is not the model of ethics consultation at all—at least not as it is now typically understood—but something closer to facilitation, or what I, and others, call “bioethics mediation.” Against a backdrop of the ethical uncertainty surrounding many hospital-based conflicts, and given the deep value disagreements that exist in the US at this time and the relative

infrequency of ethics consults, perhaps traditional ethics consultation should be replaced with bioethics mediation that will aid and support the legitimate decision-makers in these cases, namely, the patients and their families.

References

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