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THE JOHN J. LYNCH MD CENTER FOR ETHICS AT MEDSTAR WASHINGTON HOSPITAL CENTER

Proceedings of the 15th Annual International Conference for Clinical Ethics and Consultation: It's the Organization! Clinical Ethics and Consultation at the Intersection of Institutional Practice (ICCEC 2019)

Hosted by the the Austrian Province of the Hospitaller Order of St. John of God

MedStar Washington Hospital Center

mission

The mission of the *Journal of Hospital Ethics* is to enhance bioethical discussion and to assist in the development of skills associated with recognizing, understanding, and managing moral uncertainties and ethical complexities in hospital practice.

The mission of the John J. Lynch, MD Center for Ethics at MedStar Washington Hospital Center is to help clinicians and other hospital professionals meet a standard of excellence in the care of our patients through education, training, consultation, policy development, and research in clinical ethics. Additionally, when appropriate, we address the ethical concerns of our patients and families directly. The MedStar Washington Hospital Center's bioethics program began in 1982. The John J. Lynch, MD Center for Ethics, subsequently established, is involved in over 300 clinical ethics consultations a year, as well as the development of internationally recognized bioethics conferences and education programming.

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A Note from the Editor-in-Chief

Dear All,

Welcome to the fourth of the *Journal of Hospital Ethics's* published proceedings of the International Conference for Clinical Ethics and Consultation (ICCEC). We are very pleased to continue to be the sponsoring journal for the proceedings of this excellent meeting. ICCEC does such an excellent job of bringing together those practicing and those interested in the practice of clinical ethics consultation, and the Vienna 2019 meeting was no different. True to form, the conference materials were well designed and presented. The conference organizers did an excellent job of keeping everything moving smoothly throughout. And the presentations were, as usual, at a high level of intellectual and pedagogical excellence.

Another important aspect of the ICCEC conferences is the ability they provide for all of us to catch up with our colleagues from around the world. During that process, attendees get to meet new international counterparts, many of whom go on to become new colleagues. That tradition was continued in 2019. Many of us were thrilled to meet attendees we had not previously met and to discuss the presentations while enjoying the beautiful city of Vienna. As usual, not only do we want to thank the Vienna onsite organizers, but also those who created this super conference system. So thanks, as usual, to George Agich and Stella Reiter-Theil for their unwavering support of these meetings and their assistance to us in the continued publication of these proceedings.

We hope you find this fourth proceedings another useful resource and reminder of the excellent presentations at another excellent ICCEC. As we have been doing each meeting, a copy of these proceedings will be provided to each attendee in South Africa for ICCEC 2020, as well as to our institutional and individual subscribers. I look forward to hearing from as many of you as possible. Have a wonderful and exciting meeting in Cape Town.

Sincerely,

Evan G. DeRenzo, PhD
Assistant Director
John J. Lynch MD Center for Ethics
Editor-in-Chief
Journal of Hospital Ethics
MedStar Washington Hospital Center
Washington, DC

Faculty of ICCEC 2019

The Names of Presenters at ICCEC 2019, with Abstract Numbers

Author/co-author/ presenter — **Abstract number** — *** Indicates presenting author**

Poster presenter/ co-presenter — **Poster abstract number * Indicates poster presenter**

Conference Program

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Authors and Abstracts

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1001

Healthcare Organizations, Quality Improvement, and Clinical Ethics

George Agich

Drawing on earlier work, this presentation will begin with an argument to the effect that healthcare organizations (HCOs), in addition to health professionals, have a responsibility to improve the quality of the healthcare delivered. That said, the focus of this presentation will be the question, "What, if any, role should clinical ethics programs play in these quality improvement efforts?" Working from examples, I will show that clinical ethics programs have a definite role to play, not only in pursuing quality improvement of their own activities, but also that clinical ethics programs have a role to play in addressing the challenges and problems that affect the delivery of patient services in the HCOs in which they function.

In terms of improving the quality of clinical ethics services, I will first discuss a series of projects that address one of the central problems that ethics consultation services face in many hospitals, namely the paucity of requests for consultation and/or perceived impediments to requesting an ethics consultation by healthcare professionals, patients, and families.

In terms of improving the delivery of healthcare services, I will discuss a set of challenges or problems that arise in patterns of referral and use of services such as critical care, cardiopulmonary resuscitation, and emergency room admissions.

These examples of quality improvement are within the capacity of most ethics committees or clinical ethics services. They certainly do require effort, but not as much as many committee members and ethics consultants fear. I will conclude this presentation by arguing that clinical ethics' commitment to quality improvement can have benefits by highlighting its contribution to the overall function of the healthcare organization. Rather than being a cost center, clinical ethics can be viewed as a distinctive asset for the healthcare organization.

1002

So, Do We Really Need Doctors Anyway?

Giuliana Antolovich, Kate Milner, Zoe McCallum, Clare Delany

Increasingly, clinical ethics case consultations at our center involve situations in which parents take the lead in clinical decision making, requesting the doctor's support in accessing new, often unproven treatments. The universal and unfiltered access to information has changed the traditional clinical relationship, granting parents a more powerful role. The emergence of the "parent as expert" has implications for clinical ethics deliberation and advice.

This presentation will use the case study of a child with a rare and well described genetic condition. The case highlights the personal challenge in this situation for doctors, who are trained to be expert careproviders, and feel undermined in their clinical authority, trust, sense of purpose, and clinical confidence. This also produces cognitive dissonance for doctors, who are trained to base decisions on available evidence but who have little or no training in how to balance patients' and families' perspectives on treatment. The clinical ethics consultation process needs to take account

of these factors, in addition to addressing the "standard" or "obvious" ethical issue of the best interests of the child.

In these circumstances, doctors can feel professionally and personally threatened if a family exerts pressure to ensure a particular clinical outcome. This can be exacerbated if doctors feel the institution will not back their clinical judgement. This again raises questions about clinical ethicists' role in addressing these concerns, and in supporting doctors to do what they think is right, as employees of the healthcare institution. What is the role of the clinical ethics service in encouraging the institution to support doctors' expert opinions?

The "parent as expert" produces an ethical challenge for doctors, for the clinical ethics team, and for the institution. Using this case as an example, we will explore the issues and suggest some responses.

1003

Patient Autonomy: A Human Right with Moral Implications

Marianne Klungland Bahus, Pål Friis, Terje Mesel

A young woman, mother of a newborn baby and a toddler, was diagnosed with possible sepsis. If sepsis was ascertained, it had an increasing mortality risk of 7 percent per hour and a huge risk of severe injury without treatment. The condition was easily treated with an antibiotic if it was given in an early phase. Unfortunately, it was not possible to wait until the diagnose was verified, since, at the point of verification, it would normally be impossible to avoid severe consequences, including the death of the patient. Treatment therefore needed to start on the suspicion of sepsis. Nevertheless, the woman chose to deny the recommended treatment with antibiotics, despite repeated information on the consequences from involved doctors. She was convinced that her body would heal naturally and without medical intervention.

Medical treatment without an informed consent from the patient is illegal according to the European Convention on Human Rights Article 8, which is incorporated in Norwegian national law by the Human Rights Act Section 2, and it is also illegal according to the Norwegian Patient's and User's Rights Act Section 4-1. The principle of patient autonomy is a legal and an ethical principle. Sometimes patients with the necessary capacity to consent refuse medical treatment, despite the patients' best interest, based on the wrong premises, objectively speaking, and despite thorough and repeated information about the diagnosis from involved doctors.

We use legal methods and ethical theory concerning relational versus individual autonomy to discuss how to "balance" the principles of biomedical ethics when patients' decisions to deny medical treatment are in conflict with their best interest and cause severe consequences for their closest family members.

1004

How Can the Immediate Management of the Organization Influence the Ethical Climate?

Cecilia Bartholdson, Margareta af Sandeberg, Pernilla Pergert

Objective: To investigate and present the ethical climate in pediatric oncology, perceived by healthcare personnel (HCP).

Methods: HCP at all six pediatric oncology centres (POC) in Sweden were invited to participate in this study by completing the Swedish version of the shortened Hospital Ethical Climate Survey (HECS-S). Data were analyzed using descriptive statistics, and differences in distribution between groups were tested using the Mann-Whitney U test. When the respondents returned the survey, assumptions of informed consent were made.

Results: Almost 300 HCP answered the questionnaire resulting in a high response rate (> 89 percent). Low/high values on items regarding the HCP's manager were not related to low/high values on other items, like, for example, support from coworkers, apart from the item about conflicts being openly dealt with. No relation was found between HCP's perceptions of an immediate manager and the ethical climate at the workplace. HCPs with the lowest perception of the possibility of practicing ethically good care also reported the most negative ethical climate at the POC.

Conclusions: The possibility of talking about burdensome patient care situations with an immediate manager is not important for the perception of an ethical climate, but rather the manager's capability to provide conditions for an open dialogue within the healthcare team, which is of major importance to attain a positive ethical climate. Supporting inter-professional collaboration and providing ethics support is essential because HCP at the POC with the poorest ethical climate found that they could not practice care as it should be practiced.

1005

Impact of International Patient Programs on U.S. PICUs: Conflicting Organizational Duties?

Emily Berkman, Jonna Clark, Douglas Diekema, Mithya Lewis-Newby

Increasing numbers of international pediatric patients are seeking medical care in the U.S. at specialized pediatric centers, often for potentially lifesaving therapies not available in their home countries. There is a paucity of ethical analyses looking at the impact of these programs on both patients and U.S. institutions. With the growth of these international pediatric programs, the need for an ethical framework is clear. Several initial questions must be explored: (1) With limited and highly specialized resources, does a regional pediatric institution have a duty to all children or to children of the local community? (2) Who pays for costs that exceed those anticipated—the family or the institution? (3) If only families with access to financial resources can afford these programs, are they fair? (4) When cultural differences result in requests for care that are considered contraindicated by the medical team, how should institutions approach resolution? These questions are particularly relevant in pediatric intensive care units, given the highly specialized care provided.

In order to investigate the ethical challenges associated with the implementation of these international programs, we conducted an exploratory pilot study using mixed methods. Seven medical directors and/or division chiefs of large academic U.S. PICUs (= 24 beds) completed surveys and semi-structured interviews. Three themes of potential importance were identified, echoing the aforementioned questions : (1) concern about potential negative impact on the care of local/domestic patient populations, (2) cultural differences can lead to barriers in providing optimal care to international patients, and (3) lack of transparency regarding institutional finances: if there is revenue, where is it reinvested? Although preliminary, these findings suggest a need for a transparent patient selection process and organizational policy that encompasses ethical issues and ensures just treatment for all children.

1006

Implementing Clinical Ethics: Expectations and Realities

Cordula Brand, Uta Müller, Christiane Burmeister, Robert Ranisch

Expectations towards clinical ethics and consultation are diverse and sometimes contradictory. On the one side, it is frequently expected that "ethics" can provide clear answers in challenging situations and that it advocates all kinds of interests of patients, as well as of the medical staff, on various levels of the organization. On the other side, clinical ethics is often deemed as patronizing, notoriously vague, time-consuming, and just not made for the highly rationalized and economized practice in medical institutions.

Both views point towards incorrect expectations, which can hinder the successful realization of clinical ethics. Acceptance and understanding of its scope, potentials, and limitations is pivotal for a sustainable implementation in healthcare organizations

Based on two projects we conducted—an ethics management system in a maximum-care hospital and in a non-profit healthcare organization—we propose insights for further reflection on how to organize clinical ethics. First, we argue that during the course of implementation, sound communication with all relevant stakeholders is crucial to set expectations regarding clinical ethics appropriately. Second, the realization of clinical ethics is essentially shaped by the organizational framework of the institution involved. Applied clinical ethics must learn from theories of organizational change and consider insights from organizational ethics. Third, to gain leverage, instruments of ethics management must be implemented and aligned with different levels of the organization. While clinical ethics needs strong support from the management level as well as backing from the ward, its processes need to be separated from the clinical institution to guarantee independence. Fourth, agile and flexible institutions help to achieve sustainable implementation of clinical ethics. To adapt to changing demands, efforts such as ethics consultation require ongoing stakeholder involvement, evaluation, and retrospective review.

1007

Intuition in Ethical Decision-Making Processes

Cordula Brand

[No abstract available.]

1008

Duty of Care Versus Duty of Confidence in Genetics: A Legal and Moral Tension

Hannah Cagney, Jeremy Wickins

Background: The legal and ethical boundaries of medical confidentiality are ambiguous, particularly the disclosure of information against patients' wishes. Genetic information is particularly relevant, being pertinent to a specific and limited number of individuals beyond the patients themselves, and associated with real and serious harms if not disclosed.

Objective of the research: Our objective was to review the legal basis of the ethical principle of confidentiality of medical information, and previous attempts to construct an acceptable ethic of disclosure in genetic disease (Foster's joint account model, Parker's *prima facie* moral obligations, and Weaver's ethic of care), focusing on the U.K. National Health Service.

Methods: We reference *ABC v. St. George's NHS Trust,* in which an individual was denied, and then given, leave to sue the health providers of her relative for not disclosing the relative's genetic diagnosis.

Results: The ethical basis of medical confidentiality as a consequentialist beneficence and as an expression of patient privacy and autonomy.

However, the legal principles of medical confidentiality are not determined by a single instrument, and instead arise from a complex web of statute (particularly data protection legislation), the duty of confidence in common law, guidance from professional bodies, and human rights law, often without ethical justification. There is particular tension between the duty of care of health-care organizations to individuals and the public, and the human right of privacy. Any "fundamental principle" of medical confidentiality is undermined by the arbitrary nature of discretionary and mandatory disclosure permitted in law. The *ABC* case could impose on healthcare organizations a further "duty to disclose" confidential information to third parties for genetic and other medical information.

Conclusion: The legal basis of disclosure of confidential information is contested. Healthcare organizations and ethics committees face a complex task to determine disclosure policies that are legal, clear, and fair.

1009

Relational Leadership in Healthcare Organizations

Louise Campbell

Organization ethics examines the ethical issues that arise in the governance and management of healthcare organizations. Healthcare organizations have responsibilities to multiple stakeholders in the provision of care and must be accountable in balancing these responsibilities. Because healthcare organizations are committed to pursuing a public good, it is important for them to ensure that the values they espouse are in alignment with their organizational practices. Like many other organizations, the operation of healthcare organizations often reveals a dissonance between the values they espouse and the realities of their daily operations, but in the healthcare context this results in inequitable working conditions and inconsistency in the quality of care.

Leadership—understood as a relationship of influence between leader and followers—is a central concept in the analysis of organizational behaviors and activities. Recent feminist scholarship has drawn attention to conceptualisations of leadership which challenge received definitions (Werhane and Painter-Morland, 2011). The purpose of this presentation is to enquire whether clinical ethics support services might draw on a relational conception of leadership —non-hierarchical, communication-focussed and distributed rather than concentrated—to consolidate their positions within the organizations they serve by helping these organizations to address the issue of the alignment between their practices and their stated values.

1010

One Too Many: Is Fetal Reduction the Same as Abortion?

Mei Yoke Chan, Kumudhini Rajasegaran

With improvement in assisted reproductive technologies to treat infertility, multifetal pregnancies are becoming more common. Fetal reduction has emerged as a morally and ethically controversial way to manage this iatrogenic problem.

Singapore law allows termination of pregnancy before 24 weeks of gestation, for any reason. However the law is not clear on fetal reduction. The following two cases illustrate the difficulties faced by an ethics committee caused by this ambiguity.

A woman, 12 weeks pregnant with twins after in vitro fertilization, requested to reduce the preg-

nancy to a singleton, for social and financial reasons. Another woman was pregnant with triplets after ovarian stimulation, and had fetal reduction to twins at 11 weeks' gestation to improve the outcome of the pregnancy. At 20 weeks, she requested reduction to a singleton for social reasons. In both cases, both twins were normal and progressing well in the pregnancy.

Referral to the ethics committee was made, as the attending doctors could not justify the procedure for medical reasons. Ethical deliberation on these two cases included a morass of emotional and moral undercurrents. If the law allowed for abortion for any reason, and if fetal reduction is a form of abortion (albeit selective abortion), then a woman should be allowed to do so as long as she gives informed consent. But is fetal reduction the same as abortion (or termination of pregnancy), since the pregnancy is not, technically, terminated? Since this is an iatrogenic complication, are we morally obliged to "fix" it? What about natural multifetal pregnancies? There is also a reluctance to sanction "killing one to benefit another," even though, before 24 weeks' gestation, the fetus has no legal rights in Singapore.

Ultimately both women went elsewhere for fetal reduction, as the majority of the ethics committee were unwilling to support fetal reduction without medical justification, even though the law allowed the abortion of normal fetuses.

1011

Ethical Challenges in Telecare: Reviewing Moral and Legal Frameworks for Remote Clinical Care

Lukas Chandler

Telemedicine changes what it means to be "seen" in a medical context by holding the clinical consultation via videoconferencing. This challenges our traditional understanding of careprovider-patient relationships. Videoconferencing in telecare equips healthcare providers to reach underserved populations for specialty, episodic, and continuous care. I demonstrate how telecare unveils a new angle to the timeworn questions of privacy and confidentiality in bioethics. I focus the challenge of privacy and confidentiality at the locus of the biomedical data exchange during the remote clinical encounter via videoconferencing. The normative and legal distinctions between privacy and confidentiality need to be detangled to elucidate the ethics of clinical care at a distance.

I analyze the context of home-based telecare in which the careprovider and patient are no longer singular actors with interests in clinical encounters. This context reveals that telecare may be morally required in some instances, but that consideration does not imply that its use will always be ethical. I introduce a balancing approach that examines the justifications for using telecare technologies to evaluate the moral weight of telecare's utility for distributive justice and cost savings as motivating factors for its widespread use. I present two arguments, first a cautionary vantage of using telecare technologies for which the motivation of cost savings neglects the nuances of the healing relationship. Second, there are cases when it is unethical to not employ telecare technologies. I introduce comparative ethical frameworks from bioethics that can inform how telecare can ethically innovate while stimulating technical and clinical progress. I conclude with remarks pointing to the possibility that conflating the concepts of confidentiality and privacy may impair the process of informed consent, in the legal and normative senses, due to gaps in relevant information sharing between patient and careprovider.

1012

Between a Rock and a Hard Place: Medical Repatriation of a Critically Ill Tourist

Eunice Chua

Mr. Mehta is a 75-year-old Indian man from Mumbai, India. He suffered a PEA collapse [pulseless electrical activity—cardiac arrest] as a tourist to Singapore. He was brought to hospital and intubated for type 2 respiratory failure. He had severe community acquired pneumonia with acute respiratory distress (ARDS), non-ST elevated myocardial infarction (NSTEMI), and acute kidney injury. He required inotropes, antibiotics, and hemodialysis. Mr. Mehta had hypertension, hyperlipidemia, diabetes, gout, and a single kidney since birth. He did not have an advance directive or living will. His niece wanted resuscitaton to stop, as the family were unable to pay the medical bills. The primary care team was informed by the hospital administration to minimize treatment. The ethics committee was consulted, and resuscitation was continued in patient's best interest. Mr. Mehta improved and was successfully extubated. He developed functional decline and delirium, suspicious of stroke. The primary care team was pressured not to investigate and facilitate medical repatriation. It was uncertain that the patient could tolerate a flight home. The availability of appropriate medical care in Mumbai was uncertain.

Medical repatriation is fraught with ethical dilemmas. It is driven by economic factors, as the patient is not a resident of the country and has no claim to the medical benefits reserved for residents. Doctors will feel limited in their ability to act in the patient's best interest. These factors were exacerbated by the administration of the hospital who were concerned about incurring bad debts for the hospital. Mr. Mehta's poor fitness for travel and the uncertainty regarding appropriate follow-up care increased conflict about repatriation. Patients who become ill outside their home country are vulnerable due to an unfamiliar language, lack of social support, and lack of knowledge of the rights or resources available to them.

1013

Gender Assignment/Reassignment by Proxy: Special Ethical Considerations for Shared Decision Making and Substituted Judgment in Transgender Healthcare

Cynthia Coleman, David Mann, Laura Webster

Four case studies will be presented that highlight the challenges of incorporating substituted judgment from surrogates of gender assigned/reassigned patients.

In the absence of a multidisciplinary team, sex-assignment decisions for newborns with ambiguous genitalia are typically made in a paternalistic fashion, and they might not adequately respect the physician's oath of "do no harm." After a sex assignment, later interventions require ethical and psychological support for the patients' families. Who has the right to make those decisions? Parents must be adequately informed, and team decisions ought to include the child, in a developmentally appropriate fashion, as a stakeholder. What about a teen/preteen who voices a gender identity that is different than gender at birth, and yet continues to be dependent upon parents for medical consent? What happens when clinicians declare an elderly transgender woman (who has not gone through surgery, but has lived as a woman for years) incapacitated, but her surrogate refuses to acknowledge her transgender identity?

Globally, we grasp a heightened awareness of the unique medical needs of transgender persons who enter the healthcare system. A growing number of healthcare professionals receive special training regarding respectful, inclusive treatment of transgender individuals. Yet disparities exist on how to respectfully engage patients and their surrogates. Political considerations continue to sway regulations, which causes more confusion. This panel will discuss these challenges and analyze solutions using an ethical framework for decision making.

1014

Emotive Forces and Moral Distress: Can a Discussion about Medical Futility Save the Day?

Philip Crowell

The role of emotions in both a pediatric setting and the adult cancer center is very evident in clinical ethics consultations. The most difficult and tragic clinical cases almost inevitably engage ethics services, and these scenarios are emotionally charged with concomitant "moral distress." Utilizing an ethics framework document generates a consistent, standardized, and structured attempt to treat "like cases alike," as well as a flexibility that attains to the nuances of each individual case. Our objective is to identify the trends emerging in terms of emotional/moral distress and the psychological dynamics at work. Defense mechanisms, denial strategies, trauma disorders, complex grief, and moral residue may be more manifest in patients and careproviders in these situations of emotional distress.

It is important to unpack the emotive elements in such questions as, "have we gone too far with potentially futile interventions?" or "are we on a slippery slope?" in accommodating medically inappropriate treatment due to threatening emotive forces. Questions regarding the accommodation of patients' requests can move in a different direction when limited services are available to terminally ill adult cancer patients who choose MAiD [medical aid in dying] because they are unable to get home services. Ethics committees can be emotively charged and polarized by a "quality of life" debate: that a life of irremediable pain and suffering for a child should not be prolonged, against an argument that the sanctity of life and the potentiality of a child require every heroic effort imaginable. A brief summary of this latter type of case illustrates these tensions and trends. In conclusion, careful application of "best interests" arguments and the "harm principle" bypass futile debates about futility, and are an essential mode of discourse in these tumultuous situations, to shape emotive forces in a positive direction.

1015

Revising the Euro-MCD Instrument for Evaluating Outcomes of Moral Case Deliberation: Normative Reflections on Empirical Findings

Janine de Snoo-Trimp, Mia Svantesson, Henrica de Vet, Bert Molewijk

Background: Evaluation of clinical ethics support services like moral case deliberation (MCD) are gaining increasing attention, as MCD becomes more and more common, while its actual effect is largely unknown. This gap of knowledge is due not only to a lack of research, but also to the complex nature of ethics support as an "intervention," and because there is yet no clear consensus on the aims of MCD.

In 2014, the European Moral Case Deliberation Outcomes Instrument (Euro-MCD) was developed.[1] Since then, several Euro-MCD studies[2] have been conducted that provided valuable insights into the structure and validation of the items of the instrument. Based on both empirical findings and normative reflections by experts and experienced participants, the time has come to revise the instrument.

Aim: To present and discuss a preliminary version of the revised Euro-MCD Instrument for measuring outcomes of MCD.

Methods: Both empirical findings from field studies within the Euro-MCD project as well as reflections upon these findings by the research team were combined through in-depth and structured dialogues.

Results: As the revision is a work-in-progress at the time of writing this abstract, a proposal for the revised Euro-MCD Instrument (including the methodology behind this revision work) will be presented at the 2019 ICCEC.

Implications: The revision of the Euro-MCD Instrument will lead to the presentation of a valid and feasible tool to use in research, education, and clinical practice in order to evaluate and improve clinical ethics support services.

References:

1. Svantesson, M., Karlsson, J., Boitte, P., Schildman, J., Dauwerse, L., Widdershoven, G., Pedersen R., Huisman M. & Molewijk, B. (2014). Outcomes of Moral Case Deliberation-the development of an evaluation instrument for clinical ethics support (the Euro-MCD). BMC Medical Ethics, 15(1), 30.

2. See an overview of studies on Researchgate: https://www.researchgate.net/project/Euro-MCD-Project-Measuring-Outcomes-of-Moral-Case-Deliberation.

1016

Translating Clinical Ethics into Caring Practices in an Institution for the Intellectually Disabled: Empirical and Methodological Insights

Janine de Snoo-Trimp, Jelle van Gurp, Karen Schipper, Bert Molewijk

Background: In a Dutch healthcare organization for people with intellectual disabilities or acquired brain injury, clinical ethics support in the form of moral case deliberation is organized in various settings. It is, however, unknown to what extent this support actually contributes to meaningful changes in care practices within this organization. In the literature, several claims have been made about the impact of moral case deliberation, but the path from moral case deliberations to actual changes in care practices is still mainly hypothetical. Therefore, this study aimed to gain insight into the concrete impact of moral case deliberation on care practices and healthcare professionals. Secondly, we explored how to empirically study and conceptualize "impact" due to ethics support by an innovative qualitative approach.

Methods: This multiple-case study included observations of moral case deliberations and interviews with relevant stakeholders afterwards. Fieldnotes and memos of observations and interviews were analyzed using thematic content analysis. Throughout the study, constant comparison analyses were performed within each moral case deliberation and between sessions.

Findings: Final results will be presented at the 2019 ICCEC. Preliminary findings are that observed moral case deliberations mainly contribute to the development of personal skills in identifying and reflecting on moral cases and personal viewpoints/opinions, and reflecting on team collaboration in specific cases. When communication with family was part of the moral issue, contact with family was improved in the period after the session. Interviewees differed in opinions about eventual impact on concrete care practices.

Implications: By providing insight into what happens after a moral case deliberation session, our study contributes to the debate about the important question whether, and how, clinical ethics support improves the quality of care for patients, and how empirical research following a multiple-case study approach might provide important evidence for realizing this.

1017

"You Can Give Them Wings to Fly": A Qualitative Study on Values-Based Leadership in Healthcare

Yvonne Denier, Lieve Dhaene, Chris Gastmans

Background: Within contemporary healthcare, many of the decisions affecting the health and well-being of patients are not being made by clinicians, but by those involved in healthcare management. The existing literature on organizational ethics provides insight into the various structures and strategies—such as mission statement, ethics committees, ethical rounds, etc.—that exist to create an organizational climate that fosters ethical practices and decision making. It does not, however, decribe how healthcare managers experience their job as being intrinsically ethical in itself.

Objective: We present the way in which ethical values (can) shape the lived experiences and daily practices of healthcare management.

Method: We carried out a qualitative study (using a grounded theory approach) to explore the essence of values-based leadership in healthcare (elderly care, hospital care, and mental healthcare) in the various regions of Flanders, Belgium.

Results: Six predominant themes, presented as metaphors, illustrate the essence of values-based leadership in healthcare management. These are: (1) values-based healthcare management as managing a large garden, (2) learning and using a foreign language, (3) going trekking with an ethical compass, (4) embodying integrity and authenticity in a credible encounter with everyone, (5) being a present and trustworthy leader during sun and storm, and (6) contributing to human flourishing by giving people wings to fly.

Conclusions: Notwithstanding the importance of a good ethics infrastructure, values-based leadership in healthcare entails much more than that, namely, the co-creation of an integrated ethical climate of which community-model thinking and authentic leadership are essential components. As a never-ending process, the six metaphors can help leaders to take substantive pro-active steps to shape the desired ethical climate within healthcare organizations.

1018

To Include or Not to Include Patient Perspectives in Case Consultation Practices: Organizational Preference or Necessity?

Marleen Eijkholt

Background: The question about whether or not to include patients' perspectives in clinical case consultation seems mostly a European discussion at this time. In Europe, models of case consultation are, with some organizational differences, focused on careproviders. Patients are often not directly involved, and exploration of patients' views is left to immediate clinical careproviders. In the U.S., discussion about incorporating patients' perspectives seems to have been settled a while ago, and favors the exploration of patients' perspectives by an ethics consultant.

Objective of the research: In this presentation I will seek to highlight the reasons for and against these consultation practices. I will ask whether excluding patients' involvement in consultation can be justified, and whether this decision can be left to organizational preference.

Methods: By exploring several cases I will illustrate how patients' perspectives may reconfigure the morally relevant facts. By means of this illustration, I will highlight how patients' perspectives should ideally be explored directly by a trained (ethics) consultant.

Results: It has been suggested that all ethics consultation in the U.S. eventually pivots on the question: Who should be the decision maker, and whether this decision maker is governed by the doctrine of autonomy, versus the question: What constitutes good clinical care in European settings. My presentation submits that excluding patients' perspectives is ethically suboptimal for arguments that go beyond the issue of patients' autonomy.

Conclusion: We have come to understand that multidisciplinary input and reflection are necessary in consultations with careproviders, to create a holistic picture of morally relevant clinical and professional facts. Hence, for organizations that focus on good clinical care, it seems an omission to exclude patients' perspectives from ethics consultation practices. European systems of case consultation should include patients' perspectives directly, not as an organizational preference, but as a necessity.

1019

Doing Clinical Ethics Collaboration Differently: A Working Event to Innovate Clinical Ethics Consultation

Margot Eves, Jane Jankowski, Hilary Mabel, Paul Ford, Marleen Eijkholt

Expanding on the traditional concept of a working group meeting, and in the spirit of collaborating to address shared challenges across the field, the authors' institution hosted an event for 95 professional clinical ethicists from 62 institu-

tions to exchange best practices and develop new, implementable solutions to existing challenges. Attendees collaborated on institutional and program development aspects of clinical ethics consultation, including how to cultivate institutional buy-in among key stakeholders, optimize systems design of clinical ethics services within the pressures of healthcare organizations, expand clinical ethics services to reach underserved areas, and standardize expectations of meaningful quality improvement measures.

This presentation will discuss lessons learned from applying processes intended to disrupt and extend ethics working meetings, including (1) key insights regarding organizational issues in clinical ethics; (2) reflections on the nontraditional session formats utilized, especially as they relate to future working group meetings; and (3) the results of post-event surveys administered to attendees one week and six months after the event, including the concrete organizational innovations that attendees are now implementing at their home institutions.

Given that ethics consultation is a skills-based endeavor that is embedded within complex organizations, an adaptive format for convening clinical ethicists provides substantial opportunity to develop new ways to structure clinical ethics programs and respond to the emerging ethics needs of healthcare providers, patients, families, and communities.

1020

The Elephant in the Room for Clinical Ethics Training Programs: What Makes a Program Worthwhile?

Margot Eves, Cristie Horsburgh, Joshua Crites, Kathryn Weise

Over the past 12 years in the U.S., there has been an explosion of new formal fellowship training programs and intensive courses in clinical ethics. Despite this proliferation of educational opportunities, there remains a lack of transparency and consensus around learning objectives, content, and associated standards for successful completion. The presenter will facilitate an interactive discussion exploring critical questions such as: (1) what accounts for the proliferation of programs and are they all needed; (2) what are the different purposes served by these programs; (3) what priorities and objectives are appropriate for different audiences (training a clinical ethicist versus enhancing clinical ethics knowledge);and (4) what factors distinguish a good program from an adequate (or bad) program?

To ground this discussion and establish a starting point for dissecting and critiquing varying approaches, the presenter will describe two educational programs offered at the same healthcare system: a robust, full-time fellowship and a three-day intensive plus two-week immersion program. Using these two programs as examples fosters exploration of what educational needs each program meets (or fails to meet) and how each contributes (or fails to contribute) to the field and the organizations the field serves. The final objective of the session will be to synthesize descriptive elements of these programs with feedback from attendees to elucidate initial standard criteria for what constitutes a program that is justified in its existence and substantially contributes to the field of clinical ethics.

1021

Navigating Internal and External Goods: Who Is Responsible for His Care?

Joseph Fanning

An 18-year-old man suffered a devastating traumatic brain injury in a motor vehicle collision and presented to a tertiary hospital. The patient and his mother live in the U.S. as undocumented immigrants who have limited social support with no resources for post-acute care. The primary care team recommended an exclusively palliative approach given the patient's severe brain injuries and minimal improvement after a month, but the mother did not accept this recommendation. Efforts were made to develop a home care plan involving nutrition and hydration, suctioning, and turning the patient, but the mother could not demonstrate the ability to deliver this care. The case discussion arose in a weekly meeting in which a clinical ethicist deliberates alongside clinicians and hospital administrators about challenging discharges. Administrators raised morally salient concerns about the locus of responsibility for ongoing care. What were the hospital's ethical obligations to provide adequate care to this patient for the indefinite future?

Doing clinical ethics in this case involved critical awareness of several theoretical distinctions appropriated from the work of Alasdair MacIntyre. In this presentation, an account will be given of the relationship between healthcare practices and healthcare institutions and their respective responsibilities toward the goods internal and external to the practice of healthcare. Because the goods involved in care practices are vulnerable to compromise by institutional interests, the need for

three virtues—justice, truthfulness, and courage—will be articulated. Justice considerations will be explicated in terms of balancing the short and long-term interests of this patient/family, the clinicians and the healthcare institution. Systemic obstacles to financial transparency will be highlighted as a challenge to truthfulness in evaluating allocation options. Finally, courage is elucidated to provide an increased understanding of the pressures ethicists face when participating in routine meetings with administrators/clinicians about resource allocation for patients such as this one who face obstacles to hospital discharge.

1022

Comparing and Contrasting Clinical Ethics Support and Clinical Ethics Consultation: Engaging Responsibility via Institutional Roles and Clinical Activities

Stuart Finder, Mark Bliton, Bert Molewijk, Jochen Vollmann

As an essentially "American" enterprise, "ethics consultation" (as clinical ethics work is typically called in North America) places emphasis on individual clinical case consultation between ethicists and those who are directly involved in specific patient situations. In this way, ethics consultation serves as the primary institutional means to address clinically generated ethical issues. Ethics consultation, moreover, is often, or primarily, done in the real time of a specific situation. "Ethics support services," on the other hand, as clinical ethics work is widely known in Europe, places emphasis on moral case deliberation. Ethicists utilize moral case deliberation to engage with healthcare professionals in a variety of educational and administrative contexts. The institutional goal of such engagement is to develop and improve moral competencies for healthcare professionals. Those professionals are then encouraged to utilize those competencies in at least two ways: in future specific healthcare situations and as part of sustained reflective follow up that aims toward improving the overall ethical climate of the institution. By appearances, then, ethics consultation and moral case deliberation represent different responses to institutional need for addressing clinical ethical issues.

This panel is designed to examine the presupposed similarities and differences of ethics consultation and moral case deliberation. For instance, there may be philosophical standpoints and moral orientations that are shared, while at the same time the activities engaged by these different practices may aim toward different institutional goals. Speaker One will introduce the topic to be addressed and sets the frame for what will follow. Speaker Two will outline tensions between institutional role (including expectations regarding the results of ethics consultation) and actual activities of doing clinical ethics consultation work and serving as a clinical ethics consultant. Speaker Three will describe the core elements of doing ethics support service work, including the institutional role and expectations that accompany moral case deliberation, and then briefly highlights presupposed similarities and differences between ethics consultation and moral case deliberation. Speaker Four will identify critical aspects of each of these standard models of "doing" clinical ethics work, both in terms of institutional role and clinical activity. Speaker One will then suggest some reframing questions, in light of which the panel will engage each other and the audience about strengths and weaknesses of these two different approaches to address ethical matters in clinical contexts, with an eye towards how they compliment each other—but may not both work in the other's context.

1023

This Is How *We* Do It: New Roles, New Rules, and Knowledge Transfer for New Ethics Consultants

Stuart Finder, Andy Kondrat, Laura Webster, Jürgen Wallner, Virginia Bartlett

Even as robust efforts are developing to "professionalize"—and hence standardize—ethics consultation (this effort is currently most prominently displayed in the U.S. by the ASBH certification process), "clinical ethics consultation" remains a term (along with "ethics") that encompasses a variety of meanings, values, and practices across institutions, training and educational programs, regions, and countries. As a result, complexity unfolds when an ethicist enters a new context of practice. This is in no small part due to differing (even if compatible) understandings, commitments, and orientations regarding clinical ethics work of the newly hired ethicist and of the institution (including, if such exists, the already existing clinical ethics support service peer group the new ethicist is joining). More significantly, the new institution likely holds an interest in (and perhaps even a method for) acclimating new colleagues to the values, practices, and expectations of this

institution while, at the same time, new ethicists arrive with their own knowledge base—their own education, experiences, expectations—and thus may also possess an interest in (and perhaps even a method for) discerning what of their knowledge base pertains to their new environment or not. Thus, a crucial challenge for practice exists within a particular clinical ethics program in how such interests, knowledge bases, and processes of knowledge transfer are (and should be) articulated, discussed, and governed to support and maintain a consultation service over time.

To illustrate these challenges, our panel will provide a moderated discussion in which each panelist brings a different perspective on his or her transition and process of settling into a new service. Each panelist transitioned roles and institutions to serve as an ethics consultant: (1) one moved from an acute rehabilitation hospital to a large quaternary care hospital; (2) one trained at a North American ethics program then was hired at a Central European law school and hospital ethics program; and (3) one shifted from serving as a long-time emergency room nurse to a trained ethics consultant within the same healthcare system. The moderator, who trained at a major academic, university-based medical center and then was hired at a community/academic hybrid hospital, will pose a series of questions to panelists that prompt dialogue and reflection about several key considerations: finding a good "fit" between one's training and experience and a new institution; making use of relational and organizational knowledge (institutional memories; political awareness of "who's who" and "how do things *really* work"); expanding networks of professional development and support from one institution to the next; and clarifying roles and expectations in one's new position in relation to long-standing institutional practice and experience. The moderator will also elicit questions and comments from the audience to further explore how previous experiences prepare one for learning about ethics and practicing in sometimes radically different contexts, even while "still" doing clinical ethics consultation.

1024

Ethics Consultation in U.S. Hospitals: Current Practices and Perspectives of EC Practitioners

Ellen Fox, Marie-Eve Bouthillier, Ralf J. Jox

This multi-national panel session will begin with a 20-minute presentation describing the results of a new national study on ethics consultation (EC) in U.S. hospitals. The data presentation will be followed by two 10-minute commentaries about the study's implications for the future of clinical ethics, leaving 20 minutes for audience questions and discussion. A 2007 study by Fox et al., published in the *American Journal of Bioethics,* raised serious concerns about the quality of EC services in U.S. hospitals and served as a "wake-up call" to the field. In this panel, Dr. Fox will introduce the results of a follow-on study addressing these research questions: How has EC in the U.S. changed since 2000? How do current practices compare with American Society for Bioethics and Humanities (ASBH) standards? What are EC practitioners' views on EC quality and quality improvement?

Methods: This study replicated many of the prior study's methods. A random sample of 600 hospitals was surveyed (13 percent of general U.S. hospitals). "Best informants" about EC were identified and confirmed using a telephone protocol, then invited to complete a survey on the internet. The web-based survey consisted of 86 questions. Of these, 15 were from the prior survey, allowing direct comparison with previous findings (e.g., prevalence of EC, consult volume, EC practitioners' background/training). There were 13 questions on specific EC practices that allowed comparisons with ASBH standards (e.g., written policies, use of formal meetings, patient visits, documentation, formal evaluation). Other questions addressed EC practitioners' views on EC in general (e.g., the need for EC, the value of EC); on their own EC service (e.g., satisfaction with the service, perceived quality, problems); on ASBH standards (e.g., awareness, relevance, barriers to implementation); and on various strategies to improve HEC (e.g., training, certification, credentialing, practice guidelines).

Results: Data collection was recently completed and data analysis is currently underway. Among the 600 hospitals in our study, one hospital was closed; we were unable to confirm a "best informant" in 79 (13 percent); and an additional 58 (10 percent) opted out. A total of 462 hospitals (77 percent) responded to at least one study question. Detailed results will be presented at ICCEC 2019, but we will describe one example. Respondents were asked, "To what extent do you think the following would be useful to promote high quality ethics consultation at [hospital]?" Among 11 listed strategies (e.g., validated tools to assess EC quality, detailed practice guidelines, external expert review and feedback, specialized EC software), the strategy that was rated least useful was "an

external certification process for individuals who perform ethics consultation."

Panelist Commentaries: Panelists will review study findings in advance and present prepared remarks emphasizing practical implications for the field. Dr. Bouthillier, who has experience in Canada and recently Spain, will comment on EC practitioner training and competence, while Dr. Jox, who has experience in Germany and Switzerland, will comment on EC quality standards and evaluation.

Funding: This work was funded by a grant from the Greenwall Foundation and supported by Altarum, a non-profit health systems research organization.

1025

Clinical Ethics Informatics

John Frye

ASBH and other organizations recommend that ethics services keep a log of their ethics consultation activities both in a patient's chart and in internal service records, such as a database. The database can capture features of how cases are handled that are not pivotal to the ethical analysis of an individual case. Dozens of publications from different institutions have indicated a wide variety of approaches for categorizing and analyzing the cases in their respective databases. General categories such as "end-of-life" are coded inconsistently across different institutions, and data that some may deem relevant (such as who initiates the consults, the frequency of particular interventions, types of case resolution, etc.) are not consistently reported. Such variety significantly complicates any attempt to apply lessons based on another institution's records to one's own ethics service. There is a tension between such databases' responsibility to the needs of an institution, and their potential contribution to large-scale analysis and understanding of a still-emerging professional service.

This project proposes a survey of a subset of American hospitals to understand how ethics cases are recorded at different institutions, what data and analysis they deem important, and whether even minimal standardization is desirous or possible. Initial findings from early respondents will be reported as available.

1026

A Needle in an Ethical Haystack: A Virtue Ethics Analysis

Ann Gallagher

This presentation is based on an anonymized case discussed at a clinical ethics committee in the U.K. The case involved uncertainty following a clinician receiving a needle-stick injury. The patient ("Laura") was dying and unresponsive and was known to be HIV positive. Her hepatitis status was unknown. One of Laura's family ("Paul") was aware of her HIV status, but other family members were not aware. A clinician wanted to know Laura's hepatitis status and requested that blood be taken from the patient for testing. Legal and professional guidance on this issue pointed in different directions. What should the team do? Should the family be asked to leave the patient so that blood can be taken? Should the situation be explained to Paul? What policies did, and should, the organization have in place to respond to such an eventuality? The case will be analysed using the ETHICS deliberative framework and a virtue ethics approach.

1027

Adding Ethics to the Ethics Policy

Colleen Gallagher

Background: Most organizations have an ethics policy. These generally address ways to hold people responsible for decisions and behaviors surrounding things such as conflicts of interest, accepting gifts, sponsored travel, and other things that need to comply with governmental laws and regulations. These are different than a code of conduct or code of ethics.

Objective: This presentation will describe what happened when a clinical ethicist and others were added to an organizational ethics policy review committee that was led by compliance experts, that led to adding an ethical principle to the policy that helps staff think about these situations and decisions before they act, and some of the resulting changes.

Method: Increasing the membership of the review committee for ethics policies brings to the fore emerging concerns and new ideas. This review involved adding reviewers from ethics, internal auditing, administrative, business, faculty, human resources, and other areas of the organization.

Results: Discussion from the larger group added new questions, provided new processes,

and led to adding an ethical principle to the policy itself. This means that, when addressing compliance or the legal elements of behavior, staff at all levels have been given a tool to assist them in the process of shared decision making, rather than a "rule-based" process.

1028

The Ethical Obligation to Find Family of the So-Called "Unrepresented" Patient

Monica Gerrek, Oliver Schirokauer, Steven Radwany, Jane Penttila

An incapacitated patient without a surrogate poses a special problem for medical institutions. Such a patient is unable to participate in healthcare decision making and does not have a loved one to assist the healthcare team with this responsibility. This frequently means that the team, which is likely made up of complete strangers to the patient, is charged with making major healthcare decisions for the patient, including those pertaining to the end of life. It is understandable that significant attention has been given to how such decisions should be made and who should participate in decision making for these patients. While these discussions are necessary and important, perhaps even more compelling are the ethical obligations medical institutions have to provide appropriate resources to find the family members of these patients.

One study reports that up to 27 percent of patients who died in an intensive care unit (ICU) did not have decision-making capacity, a surrogate, or an advance directive that delineated end-of-life treatment preferences. Another study reports that 16 percent of patients admitted to an ICU did not have decision-making capacity or a surrogate during their entire stay. The same study reports that these incapacitated, unrepresented patients were in the ICU twice as long as, and received more life-sustaining treatments than, other ICU patients. This observation is concerning, as extended and aggressive treatment at the end of life often results in dysthanasia (a bad death). Additionally, in a third study, patients ranked the following as very important at the end of life:

- 90 percent: say goodbye to important people
- 86 percent: resolve unfinished business with family or friends
- 85 percent: share time with close friends
- 85 percent: believe family is prepared for one's death
- 81 percent: presence of family
- 75 percent: not die alone.

This information indicates that patients believe having loved ones, and family in particular, at the bedside is integral to a good death.

In this session, we will argue that the principles of nonmaleficence and beneficence require that medical institutions provide the necessary resources to find the family of patients in order to avoid dysthanasia, allow for orthothanasia (a normal or natural death), and support the kind of death patients want. While this may seem like an enormous undertaking, in actuality, finding estranged family members often takes less than two hours using free services over the internet.

The panel will consist of a clinical ethicist, a lawyer who is a member of a hospital ethics committee, and a palliative care physician who is the former chair of an ethics committee. Each will discuss their perspectives on the obligations that a medical institution has to allocate resources to finding the families of incapacitated, unrepresented patients. They will also share some of the more memorable cases of patients whose family members they have found.

1029

Aggressive Behavior by Parents to Healthcare Staff: Is "Zero Tolerance" the Answer?

Lynn Gillam, Anusha Hingalagoda, Clare Delany

Aggressive parental behavior towards clinical staff has been a key issue in a number of referrals to the clinical ethics service in our pediatric hospital. This presentation describes the value of an ethical perspective on an issue that is often seen as a workplace safety matter. The policy response of healthcare organizations to aggressive behavior commonly draws on the concept of "zero tolerance," which features in some government policies in the U.K. and Australia. However, these policies also discuss managing and minimising risk to staff, which seems inconsistent with zero tolerance. Additionally, the organization's responsibility to provide a safe workplace for clinical staff can be in tension with health professionals' ethical instinct to tolerate aggressive behavior from parents in order to provide family-centred care for the child, thus acting in the child's best interests.

In our experience, these inconsistencies and tensions create moral uncertainty and distress for staff. This is heightened in the multi-disciplinary team environment, where individuals have different levels of tolerance towards parental aggression. Also, some clinical departments or wards have a culture of tolerating a higher level of aggressive parental behavior than others.

Taking a clinical ethics perspective, we suggest that there is an underlying ethical question that is not explicitly addressed in policies and organizational responses: how much personal risk from a parent's aggressive/threatening behavior ought clinicians tolerate when providing healthcare to a child? It is not self-evident that the answer is zero. By addressing this question directly, we have identified a number of factors to take into account in making an ethically sound decision about how much aggressive behavior to tolerate in a specific situation, and conversely when it would be ethically appropriate to exclude the parent. Based on this, we suggest some practical tools and strategies that a clinical ethics service can offer for this purpose.

1030

The Pope Francis Formula—For Healthy and Ethical Leadership!

Erny Gillen

Just as an unhealthy lifestyle can lead to disease, so, too, can a poorly managed hospital lead to unhealthy outcomes. Leading a life and leading a hospital both have practical consequences and carry moral weight. Ethics, understood as a critical reflection of human and technically prolonged behavior, especially in the age of artificial intelligence, can't be separated from leadership.

Looking for healthy leadership models, Erny Gillen will unfold a specific and comprehensive formula able to create a semantic field of dialogue bringing patients, medical doctors, caregivers, and social and pastoral workers together. The elements for the formula derive from Francis Bergoglio's professional life and work as a young Jesuit in sinister contexts and as a pope leading a heavily damaged institution with hope and spiritual uprightness.

The first parts of this handy formula address tensions within people and encourage them to keep going by addressing time and unity as pacemakers in blocked positions and conflict situations. The second parts of the method address the inner tensions within therapeutic or organizational approaches and encourage an honest culture of trial and error by accepting realities and the whole as pacemakers, when ideas or parts prevail.

Systematically implemented, the formula supports people and hospitals crossing long established borders and discovering new land. Connecting our past and our future is an urgent humanitarian challenge in an induced ambience of disruptive technics and of the permanent present tense. The Francis Formula is a great remedy against isolation and faintheartedness, as it accepts the open future as a normal challenge for our freedom, responsibility, and history. It offers a breakthrough method for healthy and ethical leadership—personally and institutionally! Erny Gillen's unique translation of the Francis Formula into his copyrighted Ethical Leadership Octahedron brings a smart pedagogical tool at the bedside of patients, as well as at the hands of hospital managers and ethicists.

1031

Defining the Role of Clinical Ethics Consultation in Pre-Transplant Recipient Assessment Practices

Alessandra Agnese Grossi, Federico Nicoli, Mario Picozzi

The registration of potential transplant recipients on waiting lists is a critical moment in the transplant process. To determine patients' "capacity to benefit," there is general agreement that pre-transplant evaluation will benefit from data that exceeds standard clinical criteria. However, nonclinical transplant criteria data lack standardization across international guidelines, and current pre-transplant assessment practices are generally limited in content. This challenges the duty to balance core ethical principles in clinical practice. Therefore, nonclinical issues are often grounds for moral uncertainty during pre-transplant multidisciplinary evaluations relative to successful transplant outcomes. This is especially true when vulnerable subjects are involved, given the variety of psychosocial and sociocultural characteristics in this patient population. The ethics of the patient-physician relationship are a major concern when vulnerable patients are affected; clinical ethics consultation (CEC) may be a valuable resource to address the ethical issues involved in the individual and contextual features of this subgroup of patients. This presentation seeks to provide a scientific reflection on the value of CEC during pre-transplant evaluations. CECs performed by our clinical ethics team at this time of the transplant process will be presented. These cases will serve to support theoretical and practical arguments in favor of CEC in pre-transplant recipient assessments.

1032

The Art of Being Directive without Being Directive: Requirements and Demands on Ethical Expertise in Psychiatric Clinical Ethics Consultation: Preliminary Results

Joschka Haltaufderheide, Jakov Gather, Jan Schildmann, Georg Juckel, Jochen Vollmann

Background: Recent data indicate high implementation rates of clinical ethics support services (CESS) in psychiatry in Germany. One of the core elements is the claim of ethical expertise, that is, to be able to identify, analyze, or contribute to solutions of ethical issues more accurately than oth-ers. However, concepts of expertise within the context of CESS are numerous and often vague. This presentation will explore dimensions of ethical problems and concepts of ethical expertise in CESS in mental healthcare professionals and members of CESS, to reconstruct challenges in providing ethical advice in psychiatry.

Methods: Interviews with mental healthcare professionals and ethics consultants were triangulated with nonparticipant observation of decision making by CESS. Data are analyzed according to the principles of grounded theory and discussed from a normative perspective.

Results: Preliminary analysis of eight interviews and two observation sessions reveals three different dimensions of the ethical problems that professionals in psychiatry want to refer to CESS. However, CESS members largely focus on two dimensions, while the third remains unnoticed. Regarding their role, CESS members recognize a strong inner tension perceived as double-bind dilemma. On the grounds of their self-perception as ethically trained persons, they reject the idea that their judgments have expert status. However, they feel that professionals reach out to them to obtain guidance, and that it is their responsibility to offer it. They describe their role as mastering the art of being directive without being directive.

Discussion: Unnoticed types of ethical problems contain the risk of misunderstandings and misconceptions and may affect the quality of CESS. Different options need to be discussed: either to restrict scope of CESS to certain problems or to adapt concepts of problem solving to practitioners' needs. Insecurities in regard to the role of being an ethical expert need to be overcome. Theo-retical clarification of ethical expertise and conceptual implementation in training is needed.

1033

The Challenges of Educating Healthcare Ethics Consultants: Setting the Bar and Shooting for the Stars

George E. Hardardt

The field of healthcare ethics consultants (HCEC) continues to evolve and mature as a professional discipline, but the road has not always been straight. The driving forces for professionalization have included: to maintain and improve the quality of ethics consultation, to elevate the status of HCEC in the healthcare community and institutions through widely accepted certification standards, and to justify financial support of HCEC. Despite the limitations associated with basing certification on a multiple-choice examination, this is the current path chosen by the American Society for Bioethics and Humanities. Time will tell if this approach to HCEC certification achieves widespread acceptance and utilization, but this approach certainly presents educators with critical challenges.

As academic leaders and organizations strive to establish clear standards for minimum competency, there is also a recognition that we need to continue to support and nurture the rich, multifaceted and nuanced practice skills needed to excel in the field. There have been challenges along the way: how to continue to recognize and honor the diversity of our multidisciplinary field with origins in law, medicine, pastoral care, philosophy and more; how to avoid the pitfalls of "teaching to the test"; how to manage the financial costs of both certification and education in an environment in which HCEC are often not paid for their services; and how to truly foster excellence in the field, for new trainees as well as for experienced consultants.

In this presentation, we will discuss the path that has brought us where we are, the challenges that professionalization poses for educators, and potential strategies for our academic community and organizations to engage in achieving our goals.

1034

Apples to Oranges: Why Share Data in Healthcare Ethics Consultation

Kelly Harris, Thomas Cunningham, D. Micah Hester, Joseph Fanning, Ahra Kim

Background: Studies across the healthcare spectrum consistently report that sharing and comparing data across institutions improves the

quality of patient care. Whether comparing data about the activities of clinical ethics consultation services (CECS) would similarly improve the quality of services is unknown because no published studies have reported on CECS data sharing and comparison. One reason for this is that systems of data collection differ across institutions, complicating direct comparison of recorded activities.

Objective: This presentation describes an approach to overcome the barriers found in comparing CECS activities across institutions.

Methods: We analyzed data from two academic medical centers in the Central Southern United States that employ a shared, robust coding system ($N = 703$ cases over 2.5 years, 575 at one institution and 128 at the other) using variable clustering, correlation matrices, and binary logistic regression.

Results: We identified the top 10 most common content domains of ethics consultations at both institutions (out of 138 possible), and determined that, within them, eight topics out of 10 (80 percent) were shared. The top two shared content domains were goals of care and determining appropriate decision maker, accounting for 12 percent and 9 percent of consults, respectively, across both institutions. The two differing codes among the top 10 topics included (1) lack of a decision maker or unbefriended patient and (2) vulnerable person at one institution, and (1) futility/inappropriate or non-beneficial treatment and (2) clinical candidacy or risk/benefit analysis at the other institution. We will also explore other statistical relationships that were identified in our analysis.

Conclusion: With these variations identified, interesting questions follow, such as: Why does a CECS from one medical center have three times as many consults about unrepresented patients as a similarly active CECS of another medical center? We believe that posing and answering these questions using the methods we describe will ultimately advance the conversation about best practices in clinical ethics consultation.

1035

Mission and Method: Clinical and Organizational Ethics from a Multi-Institutional Perspective

Charlotte Harrison, James Sabin

Since 2014, ethics leaders from more than a dozen healthcare institutions have participated in a citywide consortium to share issues, cases and methods in organizational ethics (OE). Anchored by clinical ethicists from careprovider organizations, the group has also comprised academics and individuals from professional societies, health plans, and a research organization. This presentation describes strategies and concerns from the group's experience to date, featuring three themes.

Supporting and re-visioning organizational mission: Mission commitments are a natural OE reference point. How can these values translate into action? Methods reported include (1) forming a stakeholder advisory group to help interpret mission in relation to resource allocation and other policy issues, following principles of accountability for reasonableness; (2) designating a vice president of mission, with an initial focus on the experience of traditionally marginalized patients; (3) exploring finance and ethics in hospitals' efforts to expand interventions targeting social determinants of health.

Responding to evolving norms, internal dissent and public criticism: To be effective, organizations must be trusted by their immediate stakeholders and the public. How should they respond when their norms and policies are challenged? For issues ranging from medical aid in dying to assessments of politicians' mental health, strategies have included (1) developing a mindset for facing criticism; (2) building internal consensus, while giving voice to dissenting views; (3) "mythbusting" and relationship building with key initial critics.

Tackling hybrid policy issues in clinical ethics committees (CECs): Organizational policies may be driven by concerns for resource allocation or cost savings as well as individual patient care needs. How can this range of factors be approached by CECs? Methods comprise (1) augmented fact finding and deliberations; (2) community consultation; (3) tracking of policy impacts, including research on effects of policy-driven ethics consultations.

A multi-institutional consortium can facilitate shared learning, agenda setting, and capacity-building in OE.

1036

How Can Clinical Ethics Support Contribute to Just Culture in Healthcare Organizations?

Laura Hartman, Iris Wallenburg, Roland Bal, Guy Widdershoven

A just culture is defined in the literature as a culture of trust in which professionals feel free to be open about insecurity and fallibility. An important aspect is fairness towards persons involved in situations with unwanted outcomes and a willingness to learn from these occurrences (for professionals as well as organizations). A culture

of openness and cooperation can provide room for improving patients' safety and quality of care. Patients and clients benefit from healthcare providers who recognize, discuss, and repair unsafe situations in healthcare. But how can an organization foster a just culture?

Methods: Five healthcare organizations in the Netherlands have started an experiment trying to foster a just culture in their organizations. The researchers follow this process through observations and interviews.

Results: Based on our preliminary findings, we suggest that just culture is a relational and layered concept, that is fragile and hard to achieve within the power dynamics both within an organization and outside the organization (for instance, in the relationship with the health inspectorate). Within the current healthcare system and accompanying time pressure, there is often little time to reflect, question, or address systemic causes of incidents and mistakes. Ethics support may help learning from incidents or mistakes in a constructive way, by encouraging reflection on and discussion about values, principles, norms, routines, or (implicit) rules that may have been taken for granted up until then.

Conclusion: Just culture is a promising concept to foster quality of care, by encouraging learning from mistakes instead of blaming. Fostering a just culture is, however, difficult for healthcare organizations because of power dynamics within and outside the organizations. Ethics support may help to foster a just culture.

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1037

Ethical Lessons in Assisted Dying: Navigating a Non-Binary Path

Anita Ho, Soodabeh Joolaee, Kim Jameson, David Kirchhoffer

As legislation regarding medically assisted dying develops and evolves in many jurisdictions, including Canada and Australia, clinical ethicists and ethics committees are being called upon not only to address ethical dilemmas arising in individual cases, but also to help establish organizational guidelines and processes that can anticipate and resolve ethical issues. This presentation will focus on findings from our qualitative content analysis of semi-structured interviews with 40 interprofessional palliative and hospice care providers (PHCPs) in Vancouver and Toronto. The interviews elicited PHCPs' experiences caring for patients who inquired about or requested assisted dying. The interviews focused on PHCPs' views of what is working well when engaging in end-of-life (EOL) discussions and providing EOL care since the legalization of assisted dying, challenges and dilemmas PHCPs have encountered or foresee, and what other resources or support may be helpful to enhance their ability to manage various challenges and provide high-quality care within the new legislative environment. Despite common binary assumptions regarding careproviders' and institutions' moral stance for or against assisted death, we will argue that the reality of caring for patients who consider or desire assisted dying is ethically complex. This is especially so for PHCPs, who are trained to treat the physical, spiritual, psychological, and social pain of life-limiting conditions holistically without hastening or postponing death. They may encounter additional moral distress and professional challenges in advising and caring for EOL patients with the legalization of assisted dying. Informed by our interview data and a scoping review of the relevant literature, this presentation will explore how personal, professional, organizational, and societal factors intersect as PHCPs and institutions interpret assisted-dying legislation. Findings will inform pathways that can help careproviders and organizations to respect the relevant laws and stay true to their professional and organizational mission and values.

1038

Governance of Automated Image Analysis and Related Artificial Intelligence Applications in Healthcare

Calvin W.L. Ho, Peter Novitzky, Derek Soon, Gabriel Hong Zhe Wong

Artificial intelligence, particularly machine learning, enables a computer to optimize its performance by learning from past experience. In healthcare, machine learning is already applied within controlled settings in image analysis systems to detect conditions like diabetic retinopathy. Conceivably, this technology could profoundly impact the way that screening is done, particularly in low-resource settings. Unlike comparatively straightforward data mining algorithms however, a machine learning program is able to change its behavior through a human-like learning process. Owing to the lack of clarity over how this learning process actually takes place and what the outcomes could be, regulatory concerns have limited broad

deployment of this capability. Most immediately, a sufficiently robust governance framework needs to be established to support the considerable research that is needed to train, test, and validate machine learning algorithms. In this presentation, I analyse the regulatory policies of the U.S. Food and Drug Administration and the EU's European Medicines Agency in order to explicate the nature and character of an emergent governmentality, with focus on the application of artificial intelligence in automated image analysis. It is argued that progress in artificial intelligence will depend as much on regulatory advancement as on information and communications technology (ICT) innovation.

1039

Methods for Collective Success and Resolutions: A Standardized Ethical Assessment Model to Facilitate the Consultation Process

Donald Hoepfer, Geraldine Hider

The goal of clinical ethics consultation is to enhance collective moral agency in which the stakeholders are aware of the options available, the clinical and moral impact of each option, and the nature of responsibility for these choices to the group and its individuals. When the consultation process works, there is collective success in moral decision making. When the process does not work, there is collective failure.

The authors propose a multi-leveled ethical assessment model that, when utilized in the ethics consultation process, can promote critical thinking, collaboration, and collective success in decision making. Collective ethical decision making addresses rights and respect, analysis of potential outcomes, and the interpersonal needs of stakeholders. This ethical assessment model translates from the deskside to the bedside by combining moral theory (deontology, utilitarianism, and ethics of care and ethics of compassion) with clinical experience and observation. Ethical decision making is a process. This assessment model facilitates that process by identifying the issue and the perspectives taken by those who are directly impacted by the decision. Collective moral agency is enhanced by bringing to light the different vantages of those involved. Appropriate decisions are facilitated by bringing this group together with nuanced attention to the complexity of the ethical issue.

1040

It Takes an Institution: Examining the Institution as Surrogate Decision Maker for the "Patient Alone"

Adira Hulkower

Globally, our population is aging, with nearly 962 million people over the age of 60 as of 2017. The aging population has increased health concerns, many of which affect cognitive functioning and decisional capacity. As this population has grown, so has the cohort of patients who are alone: patients who lack capacity and have neither clear advanced directives nor an identifiable surrogate. Decision making for these patients has increasingly become the subject of bioethics consultation and bioethics scholarship. Attention has been given to the variability of laws, nationally and internationally, guiding decision making for this population, and thus how expediency and the quality of care provided to these patients can vary dramatically based on locale. It is not solely the laws that effect quality of care, but also how those laws are translated into hospital policy and actualized within individual ethics consultations.

I will present the case of Mr. E, an 82-year-old nursing home resident with metastatic cancer, without capacity and completely alone, who was refusing biopsy and surgery. His clinical team sought bioethics support in addressing this refusal and determining goals of care. The ethics consultation process that ensued involved the primary team, psychiatry, palliative care team, orthopedics, oncology, the office of the medical director, social work, and the nursing home team. Reaching a patient-centered, respectful, values-based outcome demanded the participation, commitment, and presence of all of these specialties, as well as cross-institutional collaboration. As a team, we explored questions of best clinical practice, as well as what constitutes a real "value," and how to best honor this man whom we could not know. Together we shared the responsibility and accepted the honor of deciding on his behalf. It took an institution.

1041

When Does the "Why" Matter? Considering "Intent" in Clinical Ethics Consultation

Adira Hulkower

When surrogate decision makers agree with clinical recommendations, we rarely ask them why they agree or question their intent. Clinical ethics services are rarely consulted when clinical options

and a family's choices are aligned. Care marches on. What happens when surrogates choose to forego treatment, an ethically and clinically justifiable option given the patient's health status, but for reasons that just don't feel right? Is there a role for ethics when it is intention that is causing the tension?

I will present the case of Amahle, a five-month-old boy with Trisome 21 and advanced cirrhosis who was desperately in need of liver transplant. Without the transplant, Amahle faced imminent death. Amahle's parents refused the transplant. They had not expected to have a child with Down syndrome and they were not prepared to care for Amahle, given his underlying condition and the rigorous demands of post-transplant care. Bioethics was consulted.

Through an exploration of the ensuing consultation, attendees will grapple with the implications of Amahle's parents' choice for Amahle, their family, as well as well as the treatment teams. Should the parents be allowed to refuse the transplant? How much weight should cultural differences and financial considerations be given, when the refusal would result in certain death? If Amahle's parents had presented an alternative reason for refusal, one based on the risk/benefits profile of the surgery, how different would (or should) that analysis be? Ultimately, we will ask, what role, if any, should intent play in reaching ethically sound recommendations.

1042

Complicity in Clinical Ethics? The Role of Clinical Ethicists in a Hospital Committee on the Uninsured

Samia A. Hurst, Anne Dalle Ave, Marion Fischer, Ralf J. Jox

The primary mission of public hospitals is to provide high-quality healthcare to those in need. This mission is a challenge in the context of financial pressure, particularly when trying to ensure fair access for vulnerable populations, in particular refugees, the uninsured, and undocumented immigrants.

In 2007, a multi-disciplinary permanent working group was created at a university hospital, under a mandate of the public health department, to deal with such cases when hospital treatment coverage for an individual patient would be a problem.

As the ethicists among hospital administrators and clinicians in this working group, we were confronted with difficult questions: What should be our contribution within this group? Should we be advocates of the patients or the institution? How can we ensure independence of speech and thought? When do we become complicit in potential wrongdoing, and what would this mean for our role in the working group?

We will answer those questions by discussing illustrative examples of our daily practice, with a focus on the question of complicity in wrongdoing, and potentially exacerbating and excusing factors. We use the distinctions proposed by Chiara Lepora and Robert Goodin to disentangle co-operation, collaboration, collusion, connivance, condoning, and complicity.

In dealing with challenging conflicts of interests, one strategy ethicists can develop to protect their independence and values is to keep a critical distance from the decision-making process while remaining at the disposal of the working group as ethics consultants.

1043

To Err Is Human: Mistakes in Clinical Ethics Consultation

James Hynds, Joseph Raho

Errors abound in medical, surgical, and nursing practice. Some of these errors—preventable adverse events—result in direct harm to the patient.

Error is not limited, however, to the actions or omissions of physicians, surgeons, and nurses. Mistakes may also occur during the process of clinical ethics consultation itself—perhaps most notably in an ethicist's recommendations. The issue of error in clinical ethics consultation has not received much scholarly attention, with the notable exception of several chapters in a book edited by Rubin and Zoloth (2000). This is surprising, since the consequences of the clinical ethicist being mistaken are often significant for all of the relevant stakeholders. Moreover, it is only by learning from one's mistakes that the quality of ethics consultation can be improved as a professional endeavor (conference sub-theme 5: practicing clinical ethics as consultation). The purpose of this presentation is to clarify what constitutes error in clinical ethics consultation. To this end, a definition and typology of error will be offered, followed by practical strategies to reduce mistakes during consultation. Concluding remarks will consider the implications of serious error among "ethics amateurs" in light of recent efforts to credential

hospital-based ethicists in the United States. **Reference**

Rubin, S.B. and Zoloth, L. (eds.), *Margin of Error: The Ethics of Mistakes in the Practice of Medicine* (University Publishing Group, Hagerstown, MD: 2000).

1044

Metrics of Ethics: Translating the Narrative of Healthcare Ethics Consultation the C-Suite

Michael Ieong

Ethically challenging dilemmas in the hospital at-large are common daily events. Health professional societies have articulated the importance of engaging expert ethics consultation as a means of addressing such dilemmas to improve patient care and resource utilization, and to avoid unnecessary miscommunications with patients. The establishment and sustaining of this expertise is difficult in part because it is hard to represent and account for the work of these services. We hypothesized that restructuring our clinical ethics consult service with the following format would result in improved understanding and increased support by hospital administration for not only the consult service, but also for the hospital ethics committee to address hot spot ethics topics.

The key three components were: (1) standardization of the ethics consultation process patterned after the ASBH's ethics consult core competencies and skills, (2) development and use of an evaluative tool through which utilizing staff could provide feedback, and (3) implementation of the Armstrong Clinical Ethics Coding System (ACECS) to clearly measure and accurately reflect the work of our ethics consult services. We report that through this approach and set of tools we were able to increase the number of ethics consults steadily between the years 2014 and 2018, as well as provide annual reports of these data to the Medical Executive Committee and hospital C-suite administrators, during which we made requests for increasing resource support. Implementation of a structured and strategic approach to ethics consultation allowed us to track hospital ethics consult service work and provide easily understood and accurate metrics of the demand for this expertise. Representing and describing the character of this demand resulted in the increased allocation of hospital resources towards this potentially preventative consult service.

1045

Ethical Duties toward the Patient's Family: A Theoretical Framework and the Contribution of Clinical Ethics Consultation

Ralf J. Jox, Anne Dalle Ave, Marion Fischer, Samia A. Hurst

Bioethical theory has largely focused on the interests and rights of patients, but rather neglected those of their relatives. This approach is reinforced by medical law's narrow concept of patient autonomy. Yet, clinical ethics very often has to deal with situations when the interests of patients' family members come into play. Here, the question arises whether healthcare professionals have ethical duties toward patients' family caregivers and whether they trump their duties toward patients. In this presentation we will offer a literature-based theoretical framework to analyze this question, drawing from examples of clinical ethics consultation. First, we argue that healthcare as a systemic activity aims at the health-related well-being of all those in need, individually and collectively, taking into account the social dependence of well-being. Therefore, healthcare professionals have a range of ethical duties toward patients' relatives. Second, we present examples of how family-related duties may outweigh patient-related duties. This is the case if four criteria are present: minimal risk to the patient, significant and probable benefit to the relatives, a mutually close relationship between the patient and relative, and the expressed or convincingly presumed consent of the patient. In our clinical ethics activity, we generally involve the patient's family in the deliberative process, based on the patient's or surrogate's consent, because, in our experience, this enables a much richer account of the patient's and family's needs, interests, and preferences. Hence, we argue that clinical ethics can help overcome the reductionist focus of traditional bioethics and medical law and facilitate a discussion on ethical duties toward patients' families.

1046

Which Language Should Clinical Ethics Use? Reflecting on the Interaction of Ethics with Institutional and Professional Culture

Ralf J. Jox

Clinical ethics is essentially an activity of communication. Therefore, it is astonishing that research and reflection have rarely considered the question of language in clinical ethics activities. It is well known that each healthcare profession,

as well as institutional hospital contexts, have developed their specific linguistic jargons. Clinical ethics, as a young profession of people often socialized beyond the healthcare context, finds itself confronted with the question: Which form of professional language and terminology should clinical ethicists use in their consulting activities? On the one hand, a strong argument can be put forward in favor of using clinical terminology, because clinical ethics is a practical endeavor with the purpose of application in healthcare and with healthcare professionals as the main recipients. On the other hand, clinical lingo is sometimes part of the problem, as it may obfuscate an ethical analysis (as in the terms "futility" or "medical indication") or it may implicitly convey problematic moral connotations that impede a balanced ethical analysis (e.g., "compliance," "do-not-resuscitate order," "passive euthanasia"). Some jargon may be so disrespectful that the question arises whether the clinical ethicist should intervene when such an expression is being used in a conversation (e.g., "the patient hits the floor"). Moreover, clinical ethicists often have to bridge the world of healthcare professionals and that of patients or family caregivers, and a thorough translation of information in both directions is an indispensable element of problem solving in clinical ethics. In summary, clinical ethicists should be skilled in three linguistic areas: healthcare jargon, ethical terminology, and lay language. Training and certification of clinical ethicists should therefore also increase linguistic awareness and competency.

1047

Establishing a Clinical Ethics Service in an Australian Tertiary Hospital: Opportunities and Challenges Created by the Introduction of Voluntary Assisted Dying

Danielle Ko, Rosalind McDougall

In November 2017, Victoria became the first state in Australia to pass legislation allowing adult patients with life-limiting illness, who meet strict eligibility criteria, access to voluntary assisted dying. This is a significant policy and clinical shift that has created many ethical and practical challenges for healthcare institutions and their staff, who hold a range of views on the ethical validity of voluntary assisted dying.

This presentation will discuss the opportunities and challenges created by voluntary assisted dying in establishing a clinical ethics service in one tertiary referral hospital in Melbourne, Victoria. Like most Australian healthcare institutions, this hospital did not have a formal clinical ethics service or a paid staff ethicist prior to the assisted dying legislation. The need to implement the new voluntary assisted dying legislation created a unique opportunity for establishing clinical ethics within the organization.

However, linking clinical ethics with voluntary assisted dying created substantial complexity. Whilst voluntary assisted dying created great opportunities to raise the profile of clinical ethics and to demonstrate its utility to hospital leadership, the need to finely balance this with gaining the trust of all of the clinical staff, an essential pre-requisite to the success of any new clinical service, created unique strategic dilemmas.

1048

Organizational Ethics and Assisted Dying: Helping Hospitals to Implement Morally Controversial Legislation

Danielle Ko, Rosalind McDougall, Barbara Hayes, Bridget Pratt

From June 2019, residents of the state of Victoria (Australia) who are at the end of life and meet strict eligibility criteria are able to request access to voluntary assisted dying (VAD). They can request physicians to prescribe a lethal substance for oral self-administration or, in limited circumstances, ask physicians to administer a lethal substance. The legislation also allows healthcare professionals to conscientiously object to participating in any, or all, of the VAD processes.

Between the passage of the legislation and the starting date for accessing VAD, there has been much uncertainty and significant anxiety amongst healthcare staff. In preparing for this significant policy and practice shift, hospital management recognized the importance of engaging and consulting with staff. This was thought to be essential, given the substantial ethical challenges raised by VAD and the wide range of views held by staff regarding the acceptability of VAD as a medical intervention.

This presentation reports findings from a study, led by the clinical ethics team, to assist in developing a local organizational approach to VAD. Using a mixed methods approach, all clinical staff at two major metropolitan health services were invited to participate in an online survey. The aim was to gain an understanding of the ethical views of staff regarding VAD, what level of participation (if any) staff would be willing to engage in, and what institutional supports they anticipated

they might need. The findings fed into the hospitals' formulation of their local organizational approaches to VAD. These approaches aim to be respectful of both the ethical views of all staff and those patients who wish to access legally available VAD.

1049

Why Ethics Consultants Should Break the Law

Peter Koch

Clinical ethics consultation services (CECS) are often consulted when a law or policy fails to capture the morally salient features of a patient's care. This means that, at times, an ethics consultant provides a recommendation that is contrary to a legal or institutional requirement, which gives rise to important questions about when, if ever, it is permissible to break the law. In this presentation I argue that (1) clinical ethics consultants ought to be willing to break the law and (2) they may even have a unique obligation to assume the risks of breaking the law. I support this argument by first differentiating between legal and moral frameworks, demonstrating that a CECS must be directed towards moral, rather than legal, goods. I then argue that breaking the law is not intrinsically immoral; on the contrary, violating the law is often grounds for moral praise. The primary reasons that ethics consultants ought to give weight to legal and institutional norms are (1) the norms are already moral or (2) the consequences of breaking the law harm the agent, and so must be accounted for in moral reasoning. If the former, then morality, and not the law, is the primary motivating reason for action; legal and institutional norms carry no additional weight in moral reasoning. If the latter, then such harms must be weighted just like any other relevant harms. Thus, it is the consultant's responsibility to determine whether a legal or institutional directive is ethical in the first place and, if so, whether and how it applies to a particular patient's care. Finally, I conclude that the clinical ethics consultants' unique role implies that they must be especially willing to assume the risks of violating laws and policies, as well as be prepared to recommend that others assume that risk.

1050

Towards a Virtuous Clinic? The Dynamics of Character and Ethical Climate within the Clinical Organization

Jos J. Kole

My hospital wants to express hospitality towards its patients. Hospitality is a virtue. Can a clinic, as organization, be virtuous? If so, in which (nontrivial) sense? And why does it matter?

The leading interrelated questions of this plenary session are:

- Can virtue ethics contribute to clinical ethics?
- If so, how?
- How does the cultivation of virtues (character) of diverse members of the clinical community (patients, physicians, nurses, managers) relate to the ethical climate of the clinic as organization and institution?
- Can and should an organization be virtuous in order to create a climate that enables members of the clinical community to flourish?
- If so, how?

The goal of trying to answer these questions is to explore how virtue ethics can contribute to the *quality of care* within the clinic and the *well-being and flourishing* of the diverse members of the clinical community—not only of patients, but also of healthcare professionals who may suffer from moral distress, compassion fatigue, heavy work load, loss of job satisfaction, and risk of burn out. Quality of care and the well-being and flourishing of the members of the clinical community may be either undermined or stimulated by how the clinic is organized. Thus, an organization that focuses one-sidedly on managing (quality of) care through protocols, evidence-based guidelines, and procedures runs the risk of thwarting patient-centered care while neglecting the practical wisdom of healthcare professionals. An organization that focuses on commercial, cost-effective management through output measures and performance indicators may undermine the intrinsic motivation of its professionals, that enables them to provide compassionate care. Perhaps a "virtuous clinic" is able to stimulate person-centered, compassionate care for patients, while its professionals stay healthy and "happy"? Such a clinic would foster a positive clinical ethical climate and assist its patients and professionals to cultivate virtues and character. This session will not take the usual form of a lecture. The audience is invited to join in an interactive exploration of this new theme.

1051

Behind the Numbers: Understanding Ethics Consultation Requests for Unrepresented Patients

Andy Kondrat, Virginia Bartlett

At many institutions, increases in ethics consultation requests are often interpreted as a key measure of ethics consultation services' (ECS) "success," to be utilized to justify continued (or even increased) administrative support. However, looking at numbers alone can miss critical insights about how an ECS is actually understood and utilized, and so can miss opportunities for an ECS to evaluate its practices and identify opportunities for improving outreach, education, and support. As a specific example, we will present data about one subset of requests for consultation: those concerning "unrepresented" patients.

In our medical center, "unrepresented" patients are defined as patients who have no decision-making capacity, surrogate, or advance directive. By policy, decisions concerning major interventions, withholding/withdrawal of life support, and code status changes require ethics consultation. Since this policy went into effect, requests for ethics consultations for unrepresented patients have steadily increased, from five requests in 2011 to 74 requests in 2017. Requests for consultation regarding unrepresented patients are now the largest single category for our ECS, yet, in exploring our data, we discovered that a significant percentage of consultation requests for these patients were not driven by policy requirements: practical and experiential ethical challenges—questions of clinician responsibility—spurred a significant number of these requests, rather than simply fulfillling a policy requirement.

These data illustrate how understanding what is not captured by the numbers may actually be more important to understand the ethical climate of the institution and awareness of ethics resources for clinicians. What is not in the numbers may also be more important to understand and evaluate the effectiveness of the CECS, and hence indicate opportunities for further education, outreach, and support for clinicians. We conclude by considering what it might mean to offer such evidence of moral engagement (rather than measurable evidence of performance) to institutions and healthcare management stakeholders.

1052

A Person-Centered Point-of-Care Tool for Clinical Ethics Consultations

Lalit Kumar Radha Krishna, Ying Pin Toh

Clinicians are often called upon to make decisions on behalf of patients who lack mental capacity. In such situations, the "best interest" principal is relied upon. However, the processes of arriving at "best interest" decisions are complex, subjective, and not clearly delineated. Best interest requires that one takes into account the patient's needs and social and welfare preferences and an objective evaluation of what the patient's "reasonable preference would be," in the event that the patient's views are not known. Extant literature lacks an effective clinical tool that considers the personal, relational, cultural, and societal context in which the patient's illness story unfolds. Moreover, non-Western cultures are predominantly community-centric rather than person-centric. Decision making in these societies takes into greater account the relationships and societal expectations that surround an incapacitated patient. Existing personhood models are predominantly person-centric and fail to address the cultural overlay that is intricately woven into non-Western cultures. The ring theory personhood tool was developed to encompass the community-centric values that shape non-Western communities. It was developed to address the needs of Asian communities and has been validated in an Asian setting. The ring theory personhood tool consists broadly of four parts. The first component is the innate ring, which anchors the entire framework. The innate ring assumes that each individual, merely by being alive, is valuable regardless of other personal characteristics. The second component of the tool is the individual ring, which encompasses one's beliefs, values, and personal characteristics. The third component of the personhood tool is the relational ring, which envelopes all close personal relationships, which are determined by the individual. Lastly, there is the societal ring, which is distinguished by familial and societal expectations, religious mores, and standards set out by national and international bodies. In this study, we put forth the use of the ring theory personhood tool as a bedside point-of-care tool to facilitate clinical ethics consults in "best interest" decision making.

1053

Reconciling Business and Healthcare Ethics in Practice: The Case of For-Profit and Non-Profit Nursing Homes

Florien Kruse, Stef Groenewoud, Patrick Jeurissen

Background. Like many healthcare systems, the Netherlands has enhanced market incentives in the long-term care (LTC) sector to curb costs. This Dutch LTC reform resulted in a growing for-profit sector, which triggers the question of how business principles, beliefs, and values are manifested in the LTC market.

Objective. There is a rich body of literature questioning the moral limits of markets (MLM), but this study contributes to this literature with an empirical study in the LTC sector. This presentation identifies the motives, objectives, rules, and values of the carers, care-recipients, and managers, whereby, *inter alia,* the levels of commodification and objectification are assessed. The central questions are: (1) How do for-profit-oriented and non-profit nursing homes define their care relationship, their mission and vision, and their role in the healthcare system; and does this differ between the types of homes? (2) Are the motives, objectives, rules, and values consistent with the actual care provided?

Methods. We adopted a qualitative phenomenological approach and utilized a triangulation of data,to answer these questions. Two non-profit and two for-profit nursing homes were used as case studies. This research consists of three components. (1) Semi-structured interviews were conducted, with clients, carers, and managers to define the care relationship between the client and the caregiver. (2) The mission and vision of the organization were analyzed, using their mission statements, newsletters, and other public documents. (3) Through participatory research, the possible discrepancy between the defined care-relationship and the mission statements with daily practice were identified. Data analysis was codified by two independent researchers and embedded in the rich theoretical MLM frameworks.

Results/conclusion. The results and conclusions of this study are presented at the conference.

1054

Moral Distress in Hospital Health Personnel: A Topic for Clinical Ethics Consultation Services?

Katja Kuehlmeyer

There is a considerable body of literature in medical and bioethical journals about moral distress in healthcare personnel. What exactly defines moral distress has not yet been conclusively established. It is essentially a term for human reactions (especially psychological reactions) to certain moral challenges. Personal and professionally shared moral values, the healthcare setting, and the healthcare system in which health personnel operate play a role in its onset. The majority of articles deal with the description of its widespread occurrence, with the concept itself, with psychological tests to measure its extent, and with its possible mid-term and long-term effects, amongst them burnout and a change of occupation. Interventions that are designed to mitigate moral distress or to improve the coping with moral distress (e.g., through the approach of empowerment) have received considerably little attention.

In this presentation, I will argue that moral distress is a significant phenomenon that should be explicitly addressed. I will then analyze its importance for clinical ethics consultation services.

First, I will describe the concept of "moral distress" and point out its significance for the individual and the hospital system. Then, I will investigate moral distress in the context of clinical ethics consultation. I will argue that moral distress is not automatically addressed by clinical ethics consultation when its focus is on an ethically justified decision. Third, I will illustrate to what extent the concept of moral distress could fill a void in the field of clinical ethics consultation. I conclude with a proposal for further research to initiate the development of components that promote an appropriate handling of healthcare personnel's moral distress, not only on an individual, but also on a systemic level.

1055

Strengthening Organizational Ethical Culture from the Ground Up: Tailored Preventive Ethics Rounds in a Quaternary Children's Hospital

Naomi Laventhal, Salomeh Salari, Katherine Feder, Janice Firn

Preventive ethics (PE) has gained traction as a model for building an ethical culture and integrating a clinical consultation service into a hospital system. This approach emphasizes building contextually relevant ethics knowledge within an existing clinical group, often with an emphasis on interprofessional education, case discussion, and debriefing. PE rounds have the potential to proactively address recurring clinical ethics issues, constructively identify cases in need of formal consultation, build a framework for shared language

and understanding, and identify and mitigate moral distress among healthcare providers. However, no single model for PE rounds can account for the diversity of structure and identity reflected by different clinical groups within a hospital. We describe multi-faceted efforts to develop and sustain interprofessional PE rounds in a quaternary U.S. children's hospital, with case studies describing the design, successes, and challenges in three distinct units: the neonatal intensive care unit (NICU), the pediatric hematology-oncology service (heme-onc), and a home ventilator program. We identify and explore specific micro-organizational cultural features of these different clinical groups, with attention to their impact on the successes and challenges, and highlight the importance of an individualized and contextually appropriate approach to PE rounds. In the NICU, we describe challenges in working with a very large group, constrained by real-time clinical demands, 24-hour staffing, and diverse professional backgrounds. For heme-onc, we explore the impact of "outsider" facilitators, and consider approaches to building trust and continuity between and within professional groups. For the home ventilator program, we examine the impact of previously established strong interprofessional team work, and the role of integrating PE rounds into an existing meeting time and place. For all settings, we also describe approaches and challenges to identifying and addressing unmet needs of the organization. Finally, we consider the resources needed for clinical ethics consultation services to develop and maintain PE rounds for multiple service lines.

1056

Why Ethics? The Cost and Confusion of Employing Traditional Ethics in a Healthcare Organization

Hugh Lee, Hellen Ransom

Most organizations have adopted ethical norms that provide operational standards for healthcare organizations, and those norms may be inconsistently stringent and/or specific, leaving questions about how these standards impact patients. These operational standards often embrace traditional ethical norms. But patients often do not rely on nor even have knowledge of these organizational ethics. Instead, patients are increasingly dependent on industry or professional guidelines or laws to establish the societal norms that address their medical needs and protect them as moral agents. Malpractice standards, HIPPA (the U.S. Health Insurance Portability and Accountability Act) regulations, and licensing standards also reflect the ethical expectations of patients and society through regulatory regimes. These standards, rules, and regulations may be described as society's expression of its ethical expectations for medicine.

Do these regulatory regimes provide an acceptable framework for organizational ethics? These regulations are often described as merely "adequate." So one might ask whether these regulations present an unacceptably marred set of ethical expectations or a more accurate sense of society's ethical expectations.

This presentation will explore the unintended (or intended?) consequences of organizational ethics grounded in healthcare regulation—the creation of a sub-ethical best case scenario. Does the healthcare regulatory regime provide a better basis for a set of organizational ethics—one grounded upon society's actual expectations about performance? An organization's commitment to a higher ethical practice may create unintended costs, may result in potentially higher levels of moral distress, and may decrease access to medical care and resources. Arguments for the implementation and support of traditional ethical principles (in addition to regulatory compliance) include meeting traditional ethical expectations of the profession, supporting the mission of a healthcare organization, enhancing the patient-physician relationship, and improving societal perception of the healthcare industry. Arguments for and against adopting current regulatory regimes as society's ethical norms will also be addressed in this presentation.

1057

The Relationship between Ethics and Law: The Importance of Values

Axel Liégeois

Background: Legal thinking is dominant in healthcare because it has a mandatory character, while ethical thinking relies on voluntary action. Consequently, ethics always risks being subordinate to law.

Objective: Ethics has an important contribution to make to law: a constructive function in the creation of law, a critical function in relation to existing law, and a complementary function to what is not or insufficiently regulated by law. How can we design a clinical ethics model that can realize these three functions?

Method: Based on fundamental ethical literature and practice of clinical ethics, we have developed a clinical ethics model focusing on ethical analysis, virtues, values, and dialogue. (A. Liégeois, *Values in Dialogue: Ethics in Care,* Leuven: Peeters, 2016).

Results: Ethics can realize these three functions by responding from its uniqueness, namely its focus on values. Because values are often unclear and people may have blind spots, we have built up a pattern of 10 fundamental values in care. The justification of this pattern lies in the historical development of care paradigms: support and inviolability (traditional paradigm); autonomy, well-being, and privacy (emancipation paradigm); participation, justice, and sustainability (societal paradigm); and trust and solidarity (relational paradigm). In the face of the tensions and conflicts between those values, those involved in care enter into dialogue, inspired by their virtues. After ethical analysis, those involved in providing care try to realize each of the values as much as possible, to violate each of them as little as possible, and to strive for a reasonable proportion between the values that are enhanced and that are violated. For this purpose, we have developed a practical tool for scoring and assessing values.

Conclusion: A proportional evaluation of values is really useful in the practice of clinical ethics and has a constructive, critical, and complementary function to a legal approach.

1058

Moral Deliberation in Bioethics: Method and Virtues

David Lorenzo, Jose J. Ordoñez

When solving ethical issues in clinical practice, ethics committees or ethics consultants can be an important and helpful tool. At the core of that process is "moral deliberation." Moral deliberation is a process based both on intuition and rational reflection, but tries to be a rational process. Moral decision methods are useful tools for deliberation in order to follow "rational" steps. During the last decades, reflection on methods decision making has increased in bioethics.

These methods help an individual to make decisions because they help the agent to select the relevant facts, the goods or principles related to the situation, to argue rightly, etc. However, a good method, by itself, does not ensure a right moral decision. The use and application of a method depends on the qualities of the individual (or individuals) who apply it, that is, its virtues. This presentation, based on a philosophical approach/methodology, aims to show the importance of virtues in applying a method in decision making.

1059

Engaging Tomorrow's and Current U.K. Healthcare Practitioners in Clinical Ethics Education

Laura Machin, Lorraine Corfield, Anglea Smith, Julia Parkhouse

Clinical ethics can be viewed as a practical discipline that provides a structured approach to assist healthcare practitioners in identifying, analyzing, and resolving ethical issues that arise in practice. Clinical ethics typically involves the provision of expert ethics input into clinical education, policy development, and the care of individual patients. Clinical ethics is intended to promote ethically sound clinical and organizational practices and decision making, thereby contributing to health organization and system quality improvement. For these reasons, we have opted to design and deliver clinical ethics educational activities within our ethics, law, and professionalism undergraduate curricula. In this presentation, we will describe a range of educational activities that draw on elements of clinical ethics. These include:

- Using ethical frameworks to analyze cases
- Running interprofessional clinical ethics fora
- An on-line interprofessional ethics case discussion
- Providing guidance to colleagues when facing ethical uncertainty

We will draw on our experiences and student feedback, collected over the last three to five years, to identify the appeal of these approaches to students and to outline the range of benefits offered to tomorrow's healthcare practitioners' by training in clinical ethics. In particular, we consider the benefits to healthcare organizations and medical schools, such as enhancing and developing decision-making skills, working as a member of a team, and improving practitioners' ethical sensitivity and awareness in clinical placement and in practice.

We will briefly reflect on how including clinical ethics within tomorrow's healthcare practitioners' curriculum can secure and continue future engagement in clinical ethics support services in the U.K., as well as consider the dangers of prepar-

ing practitioners for organizational cultures that might not (yet) exist.

1060

Making the (Business) Case for Clinical Ethics Support Services: Selling Ethics or Selling Out?

Laura Machin

This presentation provides a series of reflections of an academic socio-ethicist's experiences in making the case for the introduction of clinical ethics support services (CESS) within an NHS Trust. At the time of writing, no CESS are available within the local region for hospital- and community-based practitioners, despite extensive support from healthcare professionals across the NHS Trust for the introduction of CESS. This presentation will outline the journey of the academic socio-ethicist who was approached by clinical colleagues to consider setting up a CESS at the NHS Trust, who worked collaboratively with clinical colleagues to draft a business case, and submitted a business case to the NHS Trust Executive Board. These reflections will focus on the drivers and agendas underpinning the aspiration to establish a CESS, and the emotions and reactions generated by composing a business case for the NHS Trust. In turn, the complexities that resulted from working across and within two organizational cultures—a university and the NHS—are highlighted. The presentation will reference aspects of the hospital's NHS Trust's business case template and how this was "translated" and "interpreted" when composing a proposal for CESS. This presentation provides key considerations for those building a (business) case for CESS within NHS Trusts.

1061

Ethics from the Back Seat: Managing Conflict Between Ethical Action and Organizational Interests

Janet Malek

In most cases, organizational interests align with ethical action. Institutions have both intrinsic and instrumental reasons to encourage their healthcare teams to offer care in accordance with ethical norms and values. As a result, clinical ethics consultants (CECs) can typically offer sound ethical recommendations with the expectation that they will be supported and facilitated by their institution's administration. But what if they are not?

In this talk, the presenter will describe a case in which ethical considerations were given a back seat. Questions raised by this case will then be identified and discussed, including: Should institutions ever prioritize other considerations over ethical ones? If so, are some competing priorities more legitimate than others? How should clinical ethics consultants respond when their ethical recommendations are not supported by an institution's administration? What should they do if they are intentionally excluded from decision-making processes?

To help answer these questions, the presenter will offer a brief analysis of the role that ethical considerations about clinical cases should play in organizational decision making. A thorough understanding of this issue also requires recognition of the extent and limits of CECs' authority, influence, and scope of practice. Finally, the appropriate role of a CEC's legitimate self-interest will be explored. Using these key concepts, guidance about how CECs should manage conflicts between ethical action and organizational interests will be proposed.

1062

Conflict on the Technology Cutting Edge: ECMO, CentriMagsTM and the Definition of Death, Organizational Policy on End-of-Life Conflicts, and Moral Distress

Norine McGrath, Evan DeRenzo, Nimesh Shah, Karen Jerome

This panel presentation, consisting of the director and the assistant director of the John J. Lynch, MD Center for Ethics; the chief of the Cardiovascular Program; the vice president of Quality, Safety, Risk Management, and the chief quality officer will discuss how patients on ECMO (extracorporeal membrane oxygenation) or a Centri MagTM (acute circulatory support system with Full MagLevTM flow technology) take patients beyond the point of being able to be declared dead by standard cardiopulmonary and/or neurologic criteria. After explaining what these technologies are and in what patient populations they would be applied, examples of patients in these conditions will be presented to bring clarity to the use of these cutting-edge technologies.

The panel will also focus on demonstrating how clinical ethicists interact with C-level executives and others in the organization, including the legal department of the hospital or healthcare system and bedside clinical teams, in developing policies on how to declare a patient dead and how to prevent, manage, and resolve conflicts that can arise between patients' surrogates and the clini-

cal team at the end of patients' lives. This session will include a brief presentation of the literature on what the relevant medical professional associations have advanced for defining death during application of these technologies. Next will be presented organizational processes to create and sustain a group of hospital C-level individuals, clinicians, ethicists and others, working together to develop a definition of death for patients who are utilizing similar technologies. This part of the panel session will include a presentation of the kinds of policy responses that can be developed to assist the clinical teams to establish criteria of death. Also included will be a discussion of a newly completed policy at our hospital designed to assist in the prevention, management, and resolution of end-of-life conflicts, and how this policy could be applied to patient care of patients on ECMOTM or with a CentriMagTM.

Finally, the panel will address the moral distress that is likely to surface when clinicians are taking care of patients who die on these technologies. Included in this section will be a discussion of the kinds of responses that can be utilized to reduce such moral distress.

1063

Law, Policy and the Role of Clinical Ethics Committees

Lisa Mitchell, Giuliana Fuscaldo

In November 2017, the Victorian Parliament of Australia passed the Voluntary Assisted Dying (VAD) Act. This law came into effect in June 2019 and, under strict eligibility criteria, allows that a terminally ill person can access medication prescribed by a doctor to hasten death. This presentation explores the role of our clinical ethics committee in light of diverse views and staff concerns about the implementation of VAD at our health service.

We surveyed staff at our health service to determine their views about the legalization of VAD and the possible barriers to and enablers of the implementation of VAD at our hospital. The survey found that more than 90 percent of participating staff (n = 1,670) agreed with the legalization of VAD and were willing to be involved in VAD in some capacity. However, many staff also indicated concerns about how VAD would be implemented, monitored, and controlled. Some staff suggested that ethics education or support would be helpful in the implementation of VAD. Several staff reported that they would prefer not to be involved in some or all aspects of VAD, and a small number of staff (6 percent) disagreed that VAD should be legal. A few staff stated that if VAD became available at our health service, they would resign their positions.

How should our clinical ethics committee (CEC) respond to this new law and to the views of our staff? Should, and how, could our CEC support the staff that are conflicted about or refuse to be involved in VAD? How can the CEC reconcile providing support to staff who may conscientiously object with the need to support the law? Should the work of the CEC include educating staff to align with institutional policies? In order to be relevant, the CEC needs to clarify that its role is in the face of contested laws and policies.

1064

Ethics Support Regarding Ethical Challenges When Allocating Hospital Beds: Insights from Daily Allocation Meetings in a Dutch Hospital

Bert Molewijk, Janine de Snoo Trimp, Laura Hartman

Background: Every hospital has to deal with the distribution of patients throughout the hospital in order to prevent congested wards and create enough free beds for new patients. This distribution is an ethically challenging exercise, as it requires a balance between conflicting values such as protection of the workload of teams, solidarity between wards, and guaranteeing quality of care. E.g., "Can we postpone the planned admission for this elected surgery again because we need this bed for an acute patient?" In order to allocate all beds in a transparent way, a Dutch hospital started daily "allocation-of-beds meetings" with representatives from all wards. The chairs of these meetings asked for ethics support.

Aim: The aim of this pilot study is (1) to map the core ethical challenges experienced and observed during the allocation of beds, and (2) jointly co-create normative guidance (e.g., via guidelines) for dealing with these ethical challenges.

Methods: A qualitative study was performed with observations of the allocation meetings and 13 individual interviews with chairs and representatives on ethical challenges, the need for normative guidance, and the content of the normative guidance.

Results: Preliminary findings (of October 2018) revealed ethical challenges regarding (the limits of) solidarity, bed availability versus quality of care, shared responsibilities, the disadvantages of

actually using decisional power, and (dis)trusting the information presented by colleagues about the condition of patients or availability of personnel.

Conclusion: Awareness and openness about these ethical challenges with the help of neutral ethics support was a first step towards creating shared ownership and dealing appropriately with these challenges. A second step would be to jointly develop normative guidance in dealing with these ethical challenges. Future research should study the use and effectivity of the developed normative guidance.

1065

Fostering Quality of Ethics Support: NEON (A National Network on Ethics Support) as a Vehicle for Mutual Learning about CES Quality

Bert Molewijk, Laura Hartman, Eva van Baarle

Clinical ethics services (CES) activities and practices are increasingly used to foster critical reflection and decision making within healthcare organizations. There appears to be an increasing awareness of the importance of research on the quality of CES, resulting in a variety of research approaches for assessing this quality. The American Society for Bioethics and Humanities, for example, recently published the *Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants.* In the Netherlands another approach has been developed: a qualitative and responsive way of assessing the quality of CES.

In this panel session we would like to discuss the merits of and the problems with such an alternative way to assess the quality of CES. In the Netherlands, the National Network on Ethics Support (NEON) has developed a set of quality characteristics together with the NEON participants. Subsequently, these quality characteristics were used as input for CES practitioners to responsively evaluate each other's practices. We welcome a broad discussion about determining quality of CES, quality (peer) assessment, and the improvement of our own practices.

1. Fostering the quality of ethics support through a responsive methodology: This presentation describes the aim to foster the quality of CES in the Netherlands through a responsive evaluation methodology. This means that instead of determining quality criteria beforehand or providing research input from an outsider's expert-perspective, the evaluation of both CES practices and the quality characteristics for CES takes place together with the stakeholders, jointly evaluating and improving CES practice and CES quality characteristics. Responsive evaluation implies a cyclical process, in which a variety of stakeholders (CES providers, managers, caregivers, ethicists, researchers) are actively involved in the evaluation of the CES practices and the quality characteristics.

2. Analysis of quality and quality characteristics of CES with the NEON assessments. A critical appraisal: During the session we will present the quality characteristics and the planned structure and scope of the quality assessments. Then we will present systematic analyses of the assessments reports. We will reflect upon how the quality characteristics functioned, and what kind of feedback the assessors gave regarding these characteristics.

3. Lessons learned from responsively evaluating clinical ethics support in Dutch healthcare: This study presents a qualitative evaluation of the Dutch quality assessment program based on responsive evaluation by CES practitioners themselves. The first goal of this particular study is to evaluate the responsive quality assessment project on the quality of CES in Dutch healthcare organizations. Second, we aim to appraise and, if worthy of further application, improve this particular way of evaluating the quality of CES. To examine and evaluate the perceived outcomes of the responsive quality assessments, we focus on the experiences and lessons learned from CES practitioners who participated in these responsive quality assessments.

1066

Novel and Innovative Treatments: Who Approves, REC or CEC?

Keymanthri Moodley, Sharon Kling

Organizational issues often complicate decision making when novel and innovative treatments are concerned. These tensions are evident in the case below.

A plastic surgeon, Dr. A, is employed in a public hospital in a resource-constrained setting. After years of treating patients with severe burns, he develops a technique to culture the patients' own skin cells in an incubator. He then transplants these cells onto the patients to improve healing. Prior to using this procedure in October 2014, he sought approval from the institutional Research Ethics Committee (REC). The committee indicated that they only review and approve research. Their request to the doctor was that he provide feedback on the clinical outcome and that he submit his publication on the procedure to them for review.

The REC subsequently approved the first case for publication in March 2015. The recommendation was that the hospital approve subsequent cases. Hospital management requested that the Clinical Ethics Committee (CEC) review the plastic surgeon's request for urgent approval to perform the procedure on two subsequent patients in whom he considered it to be potentially life-saving. The CEC was prepared to approve the procedure for the first patient, but recommended that subsequent cases only be approved if they formed part of a research project that had been submitted to the REC for review. As soon as the media reported on this new treatment, Dr. B at another hospital claimed that he had discovered this technique first. However, he had not published any data on his technique. The conflict inherent in this case was escalated when Dr. A filed for a patent on the technique he developed.

The complex organizational, legal, and ethics issues will be elaborated, discussed, and debated in the context of resource constraints, legislation, and guidelines.

1067

"Are We Still Talking about Charlie Gard?": Exploring Organizational Responses to Ethical and Cultural Fallout

Bryanna Moore, John Lantos

This presentation analyzes cases in which disagreements between doctors and parents lead parents to take their story to digital media. We argue that, when that happens, the nature of the debate changes in important ways. Before parents "go public," the issues are the familiar, ongoing controversies about medical futility. Once they go public, and especially when they go viral, the focus may shift from the clinical issues to the implications of the case for larger political and culture wars.

Healthcare organizations have been reluctant to engage in online discourse about these cases. There are good reasons for this. Clinicians and hospitals are bound by privacy and confidentiality laws. They may also want to avoid antagonizing parents by appearing adversarial in public forums. But when negative publicity is unavoidable, and when a case sparks public interest, healthcare institutions may have an obligation to educate the public about the issues that are at the center of debates. Refusing to comment on a case, or offering only vague public statements, does little to foster good relations with the community or to fulfilll this obligation to educate the public.

There are responsible and thoughtful ways for healthcare organizations to directly engage with these cases once they cross a certain threshold of public interest. Hospitals should seek an alliance with parents around the goal of public discussion, and utilize web-based platforms and provide the public with information about medical conditions, experimental treatments, and how clinical ethics deliberation in hospitals works. Approached with care, such cases could become "teachable moments" for society. A test of public scrutiny might also be a useful prompt in clinical ethics deliberation, and encourage increased self-reflection on the part of clinicians and hospital administrators.

1068

Leveraging an Institutional Project Management Process to Optimize Breadth and Impact of Clinical Ethics

Georgina Morley, Cristie Horsburgh

A common challenge of ethics programs is how to empower non-ethicist colleagues to lead or substantially contribute to projects that address organizational ethics challenges. The ethical practice of medicine is not the sole purview of the ethicist, but a shared responsibility among everyone who works in the clinical setting. Theoretically, the ethicist's role is to provide the content expertise to optimize the ethical dimensions of patient care, including organizational processes and policies. In practice though, the presence of professionally trained ethicists can unintentionally disincentivize colleagues' engagement in ethics-related work, particularly on an organizational level. A potential root cause of this lack of engagement may be feeling overwhelmed by organizational ethics challenges and naturally deferring to the "expert" to solve the problem. However, relying only on the ethicist (or ethicists) to carry all ethics-related projects substantially limits the effectiveness, breadth, and impact of an ethics program.

This presentation will describe a case study that lasted approximately one year, in which non-ethicist professionals leveraged a project management tool commonly used by nursing to advance ethics programming in a community hospital within a larger healthcare system. The presenter will discuss how utilizing a familiar structure to tackle an organizational ethics issue, i.e., systemically managing moral distress, transformed the issue from overwhelming to manageable,

thereby enhancing engagement and, ultimately, sustainability. In this particular case, the ethicist was unfamiliar with the project management tool, which further empowered others to take the lead and allowed the ethicist to focus on providing content expertise about moral distress (e.g., definition, etiology, impact, and interventions) and connecting the group to resources within the system. Additionally, the structure included accountability mechanisms and required leadership sponsorship, which enhanced visibility and leadership buy in. The presentation will conclude with a description of the program's current status, including engagement, and implications for long-term sustainability.

1069

Ethical Justification for Strike by Doctors in Kenya

Stephen Ombok Muhudhia, Ames Dhai, Yolande Giudozzi

The problem: Doctors serving in public health services in Kenya under the employment of the government went on strike in December 2011 and September 2012. The strikes were national, and doctors withdrew all their services, including attending to emergencies in hospitals. The reasons for the strikes were poor salaries, poor working conditions, and the poor state of public health services.

Objective: The aim of this research was to analyze ethical aspects of the strikes by doctors in Kenya and to determine any ethical justification or lack thereof. The second objective was to explore ways to minimize harm to patients and society.

Methodology: The research was a normative study based on desktop and library material. It examined the circumstances and contexts of the strike to enable an understanding of the status of health services and the nature of the demands by doctors. The obligations of the medical profession and ethical codes and rules of conduct for doctors were discussed in relation to the strike. Ethical theories of deontology, consequentialism, and virtue ethics were applied to establish moral justification or lack thereof.

Key findings: Analysis of the reasons for the strikes and the status of public health services revealed that there were compelling reasons and circumstances for the strike action by doctors. It was acknowledged that harm and benefits resulted from the strikes. Some grounds for moral justification of the strikes were discussed and found valid.

Conclusion: Comprehensive justification of the strikes was difficult, considering the professional and ethical obligations of doctors to society and to patients. In particular the withdrawal of emergency services made it difficult to find moral justification for the doctors' strikes. Failure to provide emergency services expunged any moral justification for the strike action.

1070

Institutional and Individual Responsibility in Healthcare Organizations: Ethical and Legal Aspects

Uta Müller

There is a tension between individual responsibility and institutional responsibility, which may lead to important ethical and legal questions concerning decisions in healthcare organizations. It is widely recognized that individual adult persons are responsible for their actions against the background of certain values or norms—not only ethical, but also professional, legal, economic, or other conventional norms. However, opinions differ on the question whether organizations are capable to act and are therefore responsible for decisions. Assuming that organizations like clinics have responsibilities, one may ask: Can individual agents be relieved from their responsibility if an organization, e.g, the clinic, made the decision? On the other hand, one can imagine that organizations want to be absolved of their responsibility for questionable actions and try to attribute responsibility to individual persons who acted in a certain way.

Some ethical problems are generated by unclarified tension between singular personal responsibility—e.g., the conscience of an individual medical doctor—and institutional responsibility—e.g., for the economic success of an institution. In this presentation, I want to reconsider and further discuss the conception of institutional responsibility of healthcare organizations related to the basic definition of responsibility, and against the background of the mutual recriminations mentioned above. In German law, the concept of corporate responsibility is regarded with great skepticism. But in complex professional situations, like in healthcare, the consequences of actions can rarely be attributed unambiguously to a single responsible person or party. The more diffuse the ascription of responsibility is, the more difficult it is to judge who should assume responsibility. The results of these deliberations on an ethical and legal level may lead to a clearer view of certain problems in

clinics and other healthcare organizations and may prevent serious conflicts between individuals and the institution.

1071

To Block or Not to Block? The Role of Puberty Blockers in a Young Person with a Non-Binary Gender Identity

Ken Pang, Michelle Telfer, Lauren Notini, Rosalind McDougall

Referrals of transgender children and adolescents to gender clinics worldwide have grown exponentially in the past decade, as societal awareness of gender diversity has increased and relevant clinical services have become available. A key motivation in the establishment of such services has been the desire to improve the mental health of transgender youth, who struggle not only with gender dysphoria, but also extremely high rates of depression, anxiety, self-harm, and attempted suicide. At the same time, the proportion of transgender young people identifying as non-binary—that is, having a gender identity that does not conform to the typical binary options of male or female—is also on the rise.

Here, we present a case study of a 13-year-old individual with gender dysphoria who was assigned male at birth but identified as non-binary for many years. They recently commenced puberty and strongly wish to permanently avoid developing either the male or female sexual physical characteristics that typically arise during puberty.

While this goal can readily be achieved by using GnRH analogue medication—often referred to as "puberty blockers"—in the absence of any hormonal replacement therapy, such an approach is associated with long-term physical health risks, such as osteoporosis and infertility, as well as likely cognitive and social consequences. Thus, while it could be argued that the gender dysphoria and mental health needs of this young person would be best served by long-term puberty blocker treatment, the risks of doing so are significant.

In presenting this case—which is likely to become an increasingly common scenario in gender clinics in future years—we will explore whether it is ethically permissible to keep a body paused in early puberty to help individuals fulfill their non-binary gender identity.

1072

Parents' Request for Therapeutic Amputation of Their Child's Foot: An Oral Case Study Presentation in Divergent Views and Organizational Influences on Clinical Ethics Case Consultation

Anne Preisz, Lynn Gillam

This case study relates to a one-year-old child with a delayed diagnosis of fibula hemimelia, a congenital shortening of the fibula. A clinical ethics consultation was requested at a crucial point when parents were urging for the therapeutic amputation of their child's foot, and the surgeons were either opposed or deeply ambivalent. Standard treatment for this condition in this hospital is a series of limb-lengthening surgical procedures over a number of years, which preserves the limb but can be painful to the child and onerous for the family. The treating surgeon was morally conflicted about the idea of amputating a salvageable limb, however the child's parents had done a considerable amount of information gathering about treatment options and outcomes, and felt strongly that amputation was in their child's best interests.

As the ethics consultation processes unfolded, it emerged that the divergent opinions had arisen in part from some normative organizational procedures and processes, including the structures and practices around the family's attendance and review at outpatient clinics. It also became evident that the tacit ethos of the orthopedic department in relation to limb salvage was a factor. The usual format for ethics consultation in this hospital is a clinical ethics response group meeting, organized and run by the clinical ethics team in a neutral location in the hospital. In this instance, in order to best address the organizational factors, the treating surgeon requested that the consultation occur as part of a multi-disciplinary education meeting of the full clinical department, which three members of the clinical ethics response group would attend. Previously the orthopedics department had had minimal engagement with the clinical ethics team.

This case study will address both the substantive ethical issues at stake as well as the organizational factors and influences in this context.

1073

Ethics Consults in Pediatric Intensive Care Units (PICU): Who, What, Where, When, and Why?

Rebecca Propper, Kelly Harris, Jessica Turnbull, Joseph Fanning, Ahra Kim

Background: Repeated studies report that the care of children in the PICU is fraught with ethical challenges. Use of clinical ethics consult services has not been widely studied in this population.

Objective of the research: The primary aim of this study was to establish common ethical concerns identified in the PICU. Secondary aims of the study included comparing the relative frequency of requested pediatric consults in the PICU, compared to other locations, and identifying the individuals who were most likely to request a consult.

Methods: We retrospectively reviewed 66 ethics consults for patients in the PICU from January 2014 to September 2018 at a 267-bed pediatric tertiary academic hospital in the U.S. Data collection included information on demographics, consultation process, and description of ethics consultation activities.

Results: 47 percent of all pediatric ethics consults occurred in the PICU. The majority of PICU consults regarded treatment decision making, specifically related to goals of care. The next three most common topics identified were (1) moral distress, (2) clinical candidacy or risk/benefit analysis, and (3) futility/inappropriate or nonbeneficial treatment. Physicians were the most likely to request an ethics consult, followed by case managers and bedside nurses. An ethics consult was requested for less than 1 percent of admitted PICU patients.

Conclusion: These data are congruent with what likely causes moral distress in the PICU. Given the high-pressure environment, an ethics consult was requested for only a small number of PICU patients, perhaps indicating underutilization of a valuable resource. Recently, Au et al. (2018) found, for adult patients, that ethics consultation was associated with decreased length of stay in an intensive care unit, and the increased satisfaction of both family and healthcare providers. Similarly, ethics consults in the PICU are a valuable tool and can help navigate issues found to be ethically challenging.

1074

A Seat at the Table: Exploring the Intersection of Race and Profession in Clinical Ethics Consultation

Hellen Ransom

The founding of the discipline of bioethics was based on the formation of principles, moral thought, and policies that influenced provisions used to help those mistreated by medical institutions. From the Tuskegee Study to the Nuremberg Code, bioethics has long sought to remedy society's treatment of vulnerable patient populations. However, much of the popularized works in bioethics are often an examination, rather than a collaborative or biographical voice of these vulnerable and often minority populations. Unfortunately, the continuation of this divide has resulted in a void in the availability of minority bioethicists. While much can be said about the lack of minorities entering the field of bioethics, this presentation will examine racial identity and the role of a clinical ethics consultant.

As a clinical ethicist who identifies as a black female, I am aware of the missed opportunity to incorporate lived experiences with the intersection of race and profession. Moreover, many clinical ethics consults are connected to patients' social and cultural context, and these social issues do cross the paths of bioethicists on a consistent basis.

The question that I want to explore in this presentation is, "Why am I being called for this clinical ethics consult?" While routine calls from medical staff and peers who are seeking an ethics consult are not of concern, a problem lies with pleas from persons who request my presence at a "difficult" family meeting. Am I being called because (1) of my expertise, (2) of my race as a black female, or (3) of my lived experience as a black female who happens to be a clinical ethicist? In answering these questions, I will explore the intersection of professional and personal responses.

1075

What Can We Offer with the Resources Available for Clinical Ethics Support? Insight from Four Services in Europe

Stella Reiter-Theil, Renzo Pegoraro, Anne Slowther, Jürgen Wallner

While it is generally acknowledged that the available resources for doing clinical ethics support (CES) are of great importance for successful work, the range, distribution, and management of

these resources have been widely neglected in the clinical ethics literature.

The goal of this panel is to give insight into four established and functioning CES services in (Western, Southern and Central) Europe. The relationship between their strengths and weaknesses, opportunities, and threats shall be compared (SWOT analysis). An overall aim is to draw conclusions and make suggestion for the development and consolidation of CES services, especially at the onset of their implementation.

The panel includes four clinical ethics support services (CESS) representatives, from Padova, Italy; Warwick, U.K.; Vienna, Austria; and Basel, Switzerland. The following list of questions will serve to structure the exchange between the respective services. (1) What resources are available for performing CESS in one's institution/location (especially staff—qualification levels, FTE/full-time equivalents; other)? (2) How far can CESS benefit from existing organizational infrastructures (e.g., for organizing events, paying fees)? (3) Which opportunities can be accessed to benefit from personal, collegial, or professional support (in one's own institution or through external relations such as the European Clinical Ethics Consultation Network/ECEN etc.)? (4) How flexibly can working time be handled and adjusted to CESS needs (i.e., scheduling ethics activities with priority above other obligations)? (5) What are the challenges regarding the consolidation/development of each CESS (e.g., when organizational management expectations generate value conflicts with the role of CES)?

The speakers will take turns in responding to all questions in succession providing a rich overview on each topic. In ECEN we have observed since its foundation (2005) that some CES services have flourished. Often, major medical centers, trusts, churches, or universities have played a key role in financing these services. Other colleagues have reported difficulties in getting started or maintaining function. However, one general feature seems to be that dedicated individuals invest personal resources, at least during sensitive periods, to compensate insufficient infrastructure and resources.

What are the recommended strategies for European countries where CESS has not yet been successfully implemented? Can a minimum or optimum level of resources necessary to initiate and maintain a CESS be articulated? Questions such as these will be discussed, including the audience.

Conclusions and suggestions following from this panel will be submitted to ECEN for discussion, agreement, and possible publication to enhance the development of successful CESS implementation and maintenance.

1076

Jail Care Ethics

Oliver Schirokauer, Monica Gerrek

As is well known, the U.S. has a mass incarceration problem that comes with profound, large-scale, and high-profile ethical issues related to a variety of population health concerns. Less discussed are the ethical challenges that arise in the clinical setting when treating incarcerated patients. In this workshop, we will consider bedside clinical ethics in a jail.

Jails in the U.S. are facilities that hold people who are either awaiting trial or sentencing, or whose sentences are less than a year. These individuals are generally not confined for a long time and are often on an unpredictable legal course. Nevertheless, in many cases the charges against them and their immediate legal status are known to the clinicians in the jail. These circumstances have an enormous impact on ethical questions related to treatment, including what interventions to offer, and to patient advocacy, including whether the medical team should request judicial leniency for a patient on medical grounds. The first part of our workshop will be devoted to an overview of our local jail, with a focus on healthcare delivery and the relationships that providers have with other professionals who might influence medical treatment (e.g., judges, corrections officers). During the remainder of the workshop, attendees will work in small groups to formulate recommendations for the following three cases.

Case 1: A 45-year-old female came to the hospital from the jail because of slurred speech and weakness and was subsequently diagnosed with a brainstem tumor. A clinical ethics consult was requested by the medical providers at the jail because they felt the patient should be released from incarceration due to her condition and the need for skilled nursing care. However, the judge was opposed, indicating that the patient "did the crime and has to do the time."

Case 2: A 50-year-old female was incarcerated nine days after being diagnosed with cervical cancer. Surgery had been scheduled to take place soon after her arrival at the jail. A clinical ethics consult was requested by the jail's medical direc-

tor because, while government insurance would pay for the surgery, the jail would have to pay for corrections officers to accompany the prisoner during treatment and rehabilitation. The director was, therefore, hesitant to send her, especially since she might be released on bond.

Case 3: The patient was a 35-year-old male with repeated hospital admissions for intentional ingestion of a foreign body. In a five-week period, he had been sent from the jail to the emergency department six times for ingestions, each resulting in endoscopy. Concerned about the risks and burdens of the endoscopies, careproviders at the jail and hospital requested a clinical ethics consultation to help with developing a care plan for the patient. They agreed that the best option was prevention, but they were not in a position to influence the corrections officers tasked with surveillance of the patient when he was in jail.

1077

Ethics Rounds and Clinical Ethics Consultation: Two of a Kind?

Dagmar Schmitz, Alexander Kersten

Background: Clinical ethics support is often implemented as a clinical ethics consultation (CEC) service that provides consultation and advice on request. The expectations regarding the acceptance and integration of traditional CEC into clinical processes and the healthcare organizations, however, are seldom met.

Newer clinical ethics support services like ethics rounds, when healthcare professionals (with the support from a clinical ethicist) are themselves engaging in identifying, preventing, or resolving ethical conflicts, might provide an opportunity to address both deficits. They are typically implemented as a complement to traditional clinical ethics counselling.

Objective: We aimed to examine how both types of clinical support services are interacting if implemented in the same healthcare organization.

Methods: We analyzed the possible inconsistencies of both approaches from a theoretical point of view and described the practical experiences of a traditional clinical ethics consultation service and ethics rounds in two intensive care units in a large, maximum-care university hospital in Germany.

Result: From a theoretical point of view, both types of clinical ethics support may be in conflict. They differ significantly with regard to the perspective (bottom-up or top-down), with regard to moral neutrality, and the specific expertise of clinical ethicists.

In practice, we experienced an initial strong increase in requests for clinical ethics consultation after the implementation of ethics rounds and a shift in the type of consultation that was requested by the clinicians. After the implementation of ethics rounds, the majority of requests were for a moderation or mediation of family meetings or interdisciplinary case discussions by the clinical ethicist instead of traditional clinical ethics consultations.

Conclusion: Traditional clinical ethics consultation and ethics rounds are potentially interacting and conflicting types of clinical ethics support services. Further research is needed to verify our single-center experiences and clarify possible causes and consequences.

1078

It's the System!—What Preventive Ethics Can Contribute to the Quality of a Healthcare Organization

Jan Schürmann, Stella Reiter-Theil

Background and aim: Preventive ethics (PE) is an approach in clinical ethics (CE) that aims to improve quality in healthcare by identifying and addressing ethical issues in a pro-active, systematic way. It analyzes risk factors and indicators for ethical problems and provides interventions to prevent them. If feasible, it offers a link between day-to-day level ethics consultation (EC) and strategic level organizational ethics.

This study examines existing PE approaches, identifies ethical risk factors at two university hospitals in Basel, Switzerland, and suggests an integrative PE framework.

Methods: Systematic literature search; review of EC records ($n = 150$); conceptual analysis; framework building.

Results: Different PE frameworks exist, pioneered in the 1990s in the U.S. Core elements are: definitions, process model, parameters (risk factors etc.), interventions, and evaluation. Ethical risk factors on the part of patients, families, healthcare practitioners, and the organization were found, e.g., diminished capacity, missing surrogates, treatment goal conflicts, lack of policies. Suggested interventions are assessment surveys, pro-active EC, ethics rounds, screenings, decision support, policies, education etc. Evaluation research, however, is still rare. An integrative framework of

PE based on parameters relevant for the involved hospitals will be presented.

Conclusions: PE services are not (yet) widespread—especially in Europe. They add an important systemic perspective to day-to-day clinical and organizational CE practices helping to improve both the performance of clinical care and ethics support.

1079

Dignity and Decency: Personal Integrity and Decent Institutions

Clemens Sedmak

The talk outlines (1) a profile of decent institutions with a special emphasis on the clinical context and on hospitals, (2) a nuanced understanding of personal integrity in an institutional context, (3) a number of examples that shed light on the question of how to conceive of the interaction of person and institution. The main concern of the contribution is a thick and robust understanding of human dignity within a clinical setting: Which are the minimum standards that must not be undercut? Which are appropriate guidelines to safeguard human dignity?

1080

Impact of Collusion in the Implementation of "Terminal Discharges" from an Acute Hospital and the Role of Welfare Model to Achieve Transparency of Care

Sushma Shivananda, Yung Ying Tan, Lalit Kumar Radha Krishna, Ying Pin Toh

Collusion—circumnavigation of direct patient involvement in care determinations and familial determination—infringe on patients' autonomy and informed consent and is particularly evident in Asian societies. Drawn from Confucian beliefs, end-of-life discussions, prognosis, advanced care planning, determination of care goals, and places of death are rarely discussed as a result of the belief that "bad news" will precipitate despair, a loss of "hope," and hasten the patient's death. Unsurprisingly, few terminally ill patients in Singapore are aware of their prognosis at the end of their life. The impact of these practices is particularly concerning in the context of "terminal discharges" (TDs). TDs are rapid, unanticipated discharges from an acute hospital to a patient's desired place of terminal care that are implemented at the request of the imminently dying patient or family members. Yet because patients are not often aware of their condition, and care is often suboptimal at home, there are concerns that TDs may compromise care and be harmful to patients.

To better protect the interests of patients, the welfare model (WM) has been proposed. The WM recommends that requests for TDs that are based on compromised data that may potentially cause harm to patients should be approved by a multidisciplinary palliative care team, rather than simply being a function of respect for a patient's autonomy. Informed with holistic evaluations of the case, it is the multi-disciplinary palliative care team that has the task of approving TDs. Drawn from the principle of beneficence that is also strongly rooted in traditional Chinese medical ethics, the WM aims to maintain transparency and accountability in care determinations without endangering quality of life or hastening death. WM can be applied in many family-centric societies when there is reason to doubt a patient's grasp of her or his condition.

1081

Facilitating Decision Making When the Patient's Autonomy is Compromised

Kurt Smidt-Jernstrom

Ethics consultation helps to ensure that patient-centered medical care is provided when challenging ethical problems arise in the medical decision-making process. A necessary component of the process is the patient's preference regarding medical treatment. However, determining the patient's medical treatment preference can be complicated when the patient's autonomy is compromised. A case from practice is presented that highlights the complexity of compromised autonomy when it stems from family coercion. Cultural concerns are also considered. Relational autonomy is explored as it is applied in this case, and a strategy for working with and advocating for patients with compromised autonomy in the context of family coercion will be discussed.

1082

The Relationship of Lawyers and Bioethicists in the Hospital Setting

David Sontag, Charlotte Harrison, Joshua Abrams, Michael Ieong

It is common for hospital lawyers to serve as members of hospital ethics committees in varying capacities. Legal expertise can be of great value in bioethical deliberations; however, the question of a hospital lawyers' potential conflicts in obligation can be a concern.

Common questions include:

- Whom do attorneys represent when participating in ethics activities, and how does that affect their role?
- What kind of independence should ethics committees have from organizational concerns that do not pertain to ethics, and how can this independence be maintained while allowing ethicists and lawyers to benefit from each other's involvement in various ethics committee undertakings?
- How do attorneys meaningfully play a role in ethics discussions without overwhelming the discussion with legal considerations and concerns?

Particularly in the activity of ethics consultation, a number of objections have been raised: (1) The hospital's attorney has a responsibility to protect the institution from liability, which may not be the priority of the ethics consultant(s). (2) Including the institution's attorney may have "a chilling effect" upon the patient/family and/or staff. (3) Ethics consult team members or care team members may defer to the attorney. (4) Ethics consult team members or care team members may assume (often incorrectly) that the law in an area is settled and look to the attorney for a definitive answer.

The existing literature is limited in its guidance. How real and significant are these concerns? Are they applicable in other committee activities and how might that vary? These are among the many questions we have aimed to address through an advanced practice working group composed of bioethicists and lawyers who are active in a number of Boston-metro hospital ethics committees.

Our multi-disciplinary panel, the working group's steering committee, comprises individuals from four different hospitals with different combinations of training and institutional roles in law and/or bioethics and different perspectives on the topics at issue. Panelist 1 is an inhouse hospital lawyer (primary role) who also serves as cochair of the hospital ethics advisory committee and occasionally provides clinical ethics consultation, and who has training in both law and bioethics. Panelist 2, who is trained in both law and bioethics, directs a hospital ethics service and cochairs the hospital ethics advisory committee. Panelist 3 is an inhouse hospital lawyer who often advises on cases involving patient care and ethics issues and who advises the hospital ethics committee, but who does not have formal training in ethics or ethics consultation. Panelist 4 is an intensive care unit physician, who serves as cochair of a hospital ethics committee, directs the clinical ethics consult team, and is currently pursuing advanced training in bioethics.

Panelists will describe how the legal-ethics relationship is structured in their home institutions and will take up the questions identified above from their perspectives and experience.

Discussion will include presentation of results from a pilot local survey of hospital lawyers and bioethicists, as well as some preliminary conclusions regarding this complex and important institutional relationship.

1083

Ethics for Junior Doctors in Emergency Medicine

Carolina Spruyt

Junior doctors who have recently graduated are often very quickly independently responsible for patients. The medical system in which they have to develop their skills is hierarchical and their position is, at that point, at the bottom of the ladder. They have limited control over their working life: the roster, what and where they do their rotations, and how to plan their days at work.

At Brighton and Sussex University Hospital, a system has been introduced with fellowships whereby junior doctors can spend a year in emergency medicine combining work with research, teaching, or management. Management has enabled this to improve doctors' satisfaction. One of the projects supported is in medical ethics, where a middle grade doctor with a strong interest in teaching medical ethics is specifically trained and teaches this to the recently graduated staff.

The teachings are specifically set up to enable junior doctors to speak openly about situations they find difficult and to empower them to deal with difficult situations and to develop their own ethical judgement in pragmatic clinical situations. The meetings take place every three months and on an individual basis per request. The different meetings are given a different theme, with preference taken on a theme requested by the doctors for the next meeting. The feedback that has been given from the sessions is that the doctors feel it helps them improve their skills in a broader fashion, but is still very applicable to their emergency medicine rotation.

Management has actively supported a system of introducing these themes to the emergency medicine department so that junior doctors not

only get a chance to learn, but also discuss and learn from each others' difficult situations.

1084

Is Ethical Climate an Outcome of Moral Case Deliberation? Evaluation of Quality in Practice in the Eyes of Managers

Mia Svantesson, Marit Silén

Background: Studies from different perspectives in the Euro-MCD project[1] contribute to the revision of the European Moral Case Deliberation Outcomes Instrument (Euro-MCD).[2] Managers may have a bird's-eye view of the impact of MCD.

Objective: To describe first-line managers' experiences of what MCD has meant for daily practice.

Method: Eleven firstline managers at Swedish workplaces that had conducted MCD meetings in the Euro-MCD project were interviewed; thematic analysis was applied.

Results: The impact on daily practice was interpreted as improved ethical climate: a closer-knit and more emotionally mature team, morally strengthened individuals including themselves as moral role models, as well as ethics leaving its marks on everyday work and more morally grounded actions.

Conclusion: At the conference, the concept of ethical climate will be discussed, and whether we captured it, and whether it ought to be an outcome in the Euro-MCD instrument.

References:

1. https://www.researchgate.net/project/Euro-MCD-Project-Measuring-Outcomes-of-Moral-Case-Deliberation

2. Svantesson, M., et al., Outcomes of moral case deliberation-the development of an evaluation instrument for clinical ethics support (the Euro-MCD). *BMC Med Ethics,* 2014. 15: p. 30.

1085

Cultivating Character: Mapping Organizational Factors that Influence the Character of Surgeons in Training

Pleuntje Verstegen, Jos J. Kole, Stef Groenewoud, Frank Van den Hoogen

Background: The pedagogic environment of future doctors changes over the years: it starts at university, a more theoretically based setting, and changes to training in a predominantly practical setting, the clinic. The current training and examination of junior specialists seems to fall short, since these practices do not incorporate what is often implicitly and informally evaluated and judged by clinical educators as sometimes decisive requirements for being a good specialist: character traits, i.e. virtues.

Virtues are mainly acquired through practical experience, and a virtue-based ethics program would suit this training within a clinical practice. We propose to introduce an explicit virtue-based educational program, integrated in clinical practice, that also acknowledges the cultivating influence of organizational factors on character. Organizational factors, such as time pressure or hierarchy, stimulate or undermine the cultivation of character, as receiving great support from colleagues or having too little time for interaction with patients influences one's practical experience. Hence, we aim to identify stimulating and/or undermining factors. We will focus on junior surgeons' training, as this specialty seems to emphasize technical abilities over other qualities, and its invasive nature might gain from virtues such as honesty, empathy, decisiveness and courage.

Research objective: The aim of this study project is twofold: (1) we aim to identify which organizational factors stimulate and/or undermine junior surgeons' learning environment, and, with this first part, (2) introduce our research project on the development of character cultivation programs and evaluation instruments of specialists in training.

Methods/results: Organizational studies and organizational documents were analyzed. Organizational factors will be subdivided in "formal" and "informal" organizations, and further specified in four themes, namely: (non-)cooperative colleagues and supervision (culture), hierarchy (structure), evaluation/examination (content), and time pressure. Influence is described as a gradual scale ranging from positive (stimulating) to negative (undermining).

1086

A Novel Approach to Training Your Ethics Committee

Katherine Wasson, E. David Cook

Objective: (1) Identify the need to train ethics committee members on ethics consultation skills. (2) Demonstrate how to use the Assessing Clinical Ethics Skills (ACES) tool to train ethics committee members. (3) Facilitate small group role play to have participants practice ethics consultation skills and learn techniques to apply to their own ethics committee training.

How best to train ethics committee members, as well as individual ethics consultants, and evaluate their knowledge and skills continues to be explored and debated. Ethics committee members may or may not serve as ethics consultants, and need a working knowledge of what constitutes a "good" consult in order to provide salient input and review. Given the variety of membership and resources available to train ethics committee members, novel approaches are needed. Yet, for those conducting and reviewing ethics consultations, interpersonal skills are crucial to identify and clarify ethical issues, build trust and rapport with stakeholders, and navigate emotionally charged situations of potentially conflicting values. However, gaining those skills can be challenging if the members do not see "live" ethics consultations or if their organization has limited numbers of consultations each year.

The ACES tool provides a clear framework for demonstrating and evaluating ethics consultation skills. A website, which is freely available, provides multiple videos of ethics consultations and training on how to evaluate the skills of ethics consultants. The tool contains 12 key items and identifies specific behaviors and skills that the CEC should demonstrate in an ethics consultation. The ACES tool can be combined with other education and training materials within different organizations to provide a well-rounded education in ethics consultation. The workshop will use a combination of training videos, didactics, and small group role play to demonstrate how to use these materials to train ethics committee members and individual CECs.

1087

Does Ethics Consultation Simulation Impact Trainees' Ability to Evaluate Other Clinical Ethicists?

Katherine Wasson and William Adams

The Assessing Clinical Ethics Skills (ACES) tool evaluates the interpersonal skills of ethics consultants both in simulated consults and via a training website that contains four ethics consultation videos that train the user to apply the ACES tool and rate the skills of the ethics consultant in each case. This presentation tested whether conducting a simulated ethics consultation, and personally being rated with the ACES tool, affected how accurately graduate students rated an ethics consultant on the website before and after their simulation experience.

Methods: Student users who completed at least one graduate ethics consultation course performed an ethics consult in a simulated environment and received feedback using the ACES tool. A linear mixed effects model was used to test for a change in their ACES performance following the simulated consult. Because users could contribute multiple pre- and post-intervention performance data, random intercepts were allowed for each student to account for their in-subject correlation.

Results: Fifty-six users contributed 122 ACES performance data for this analysis. In this sample of data, there was no statistically significant change in ACES performance from pre-intervention to post-intervention (Mdiff = -0.24 percent, 95 percent CI: -4.72 percent to 4.25 percent; $p = .92$). The items with the most frequent incorrect responses were "Health professionals and administrators should distinguish their clinical role from their ethics role as needed" (k = 42 incorrect attempts) and "Explain the rationale for the ethically (in) appropriate options" (k = 40 incorrect attempts). Items with no incorrect attempts included "Avoid distracting behaviors," "Summarize the potential options/choices already discussed," and "Facilitate discussion about options (pros/cons) including ways forward."

While conducting a simulated ethics consultation did not change students' abilities to answer correctly, certain items on the ACES tool proved more or less difficult to score correctly. The discussion will examine potential explanations for these results.

1088

Does Age Matter? Clinical Ethics Case Review of Surrogate Decision Making from the Womb to Advanced Age

Laura Webster, Cynthia Coleman, David Mann

Surrogate decision making presents unique challenges to healthcare staff. This panel explores surrogate decision making for the full spectrum of patients' ages, from perinatal to senior, through clinical ethics case reviews. Each presenter will detail an ethical dilemma that arose from a case featuring surrogates of patients at different ages. The presenters' experience expands across the full array of ages. Dr. Mann works as a perinatal anesthesiologist who works with clinicians and parents on innovative intrauterine fetal surgeries. Dr. Webster serves as an ethics consultant for patients from birth to aging seniors. Dr. Coleman works at a large safety net adult hospital with eight intensive

care units. The three presenters plan to provide an overview of age-specific challenges related to surrogate decision making. The panel will explore a range of standard methods on how ethicists elicit narratives and analyze the ethical standards for surrogate decision making for patients without capacity across the age spectrum. The panel will compare and contrast the similarities and the differences throughout each case and will interact with the audience using polling software, if possible, to unpack each case presentation.

1089

Good Ethics Consultation in Chronic Illness: Overcoming Epistemic Injustice

Tatjana Weidmann-Hügle

Clinical ethics and clinical ethics consultation have significantly been shaped by the structure, language, logic, and dynamics of acute care medicine. These factors are manifest in established models for clinical ethics consultation (CEC). As a consequence, the ethics consultation process frequently involves epistemic injustice, characterized by a lack of attention to a patient's ethically important chronic illness experiences.

Gaining insight into what is ethically relevant can be achieved from empirical studies in medical sociology and in psychology. This body of literature indicates that the diagnosis of a chronic illness represents a disruption of a person's life in many ways. Most fundamentally disrupted is the person's identity: the sense of self, of who am I? Transformation and renegotiation of one's construction of identity necessarily follows and entails experiences which are normatively relevant for good CEC.

In my presentation, first, I will show how established models in CEC pay too little attention to important aspects of being chronically ill. To give a voice to these experiences in ethics consultation, they need to be integrated in the structure of a decision-making model. Second, using Parkinson's disease, a progressive neurological disorder, as a paradigmatic example, I will propose such an approach for CEC in chronic illness. Theoretically, this approach is grounded in narrative hermeneutics. It is structured by disease-specific thematic clusters, and is based on the analysis of empirical studies on the illness experience in Parkinson's disease. Thus, ethically relevant aspects of the chronically ill patient's illness experience can unfold in a systematic way. This is especially important for CEC in acute care settings, where time is limited, and it is not uncommon that communication about illness experiences is difficult.

1090

IVF for Sick Mothers

Laura Winkler, Kristina Würth, Charlotte Wetterauer, Jan Schürmann, Stella Reiter-Theil

Background/aims: While it may be debatable whether the state should influence personal decisions such as having children, the Swiss federal act on assisted reproductive medicine includes the future child's well-being as a selective criterion. Assisted reproductive treatment is only permitted in couples who, based on their age and personal circumstances, will be able to care for and bring up the child until the age of majority. Should in vitro fertilization (IVF) be offered to a patient with high risk for maternal health deterioration (general condition, diabetes) and related anticipated risk of fetal malformation?

Method: An ethics consultation (EC) was requested by the department of reproductive medicine to discuss a 36-year-old, lung-transplanted patient with cystic fibrosis (a genetic lung disease), diabetes, and hypertension asking for IVF.

Results: The EC concluded in supporting the doctor's preference to not offer IVF. Ethical reasons included the high risk for the future child's well-being, both short- and long-term (according to the law), as well as the prevention of harm for the mother to be.

Discussion: In the Swiss society, the value context is supportive of reproductive medical interventions, and patients' autonomy is considered a binding maxim. Healthcare teams, however, have a professional and ethical duty, which in Switzerland is legally binding, to consider the future child's well-being (and to carefully assess and communicate the maternal risks). Physicians are not obliged to fulfill a patient's wishes in the case of lacking indication or justification.

Conclusions: In a case such as this one, the focus of the EC should lie in supporting the healthcare team in making a well-reflected decision whether or not to offer a certain treatment, rather than interfering with personal reproduction choices. The couple should be informed that, in case of spontaneous pregnancy, the patient would be entitled to any help.

1091

A Confucian Ethical Code to Tackle Challenges in Pricing

Gabriel Hong Zhe Wong, Teck Chuan Voo

Based on an analysis of a landmark case *Lim Mey Lee Susan v. Singapore Medical Council* in Singapore, in which a doctor was professionally disciplined for overcharging a wealthy patient, a judgment upheld by the Singapore courts, this presentation will discuss the notion of an "ethical price" (EP) and its determination with respect to the provision of healthcare services. It will first examine the limitations of a legal approach for setting an ethical limit to pricing. From there, it will argue that Confucian philosophy provides a useful ethical framework to explore EP, with focus on the context of Singapore. The following questions are addressed: Given the recognition that markets need not be amoral, but can function in harmony with the wider ethical universe, can Confucianism provide guidance on determination of an EP? What values guide this determination? Can it be established in an objective fashion? The strengths and limitations of a Confucian value base as regards the determination of an objective EP will be analyzed through an examination of the shortcomings of the doctor's behavior in the *Susan Lim* case, as well as other case scenarios. The presentation will conclude with some practical suggestions on how Confucian-based ideas can be applied to decision making on pricing and the importance of this for medical professionalism and ethics teaching.

1092

Systematic Review of Tools to Assess the Quality of Ethics Consultations

Nicholas Yue Shuen Yoon, Yun Ting Ong, Lalit Kumar Radha Krishna

The nature of each clinical ethics consultation (CEC) varies by virtue of its settings, context, and purpose. This variability underpins the lack of a tool to ensure the quality of CECs. Informed by a scoping review of "What factors should be considered in ensuring an effective ethics consult?" this systematic review seeks to evaluate prevailing tools to assess the quality of ethics consultations. The following databases: PubMed, EMBASE, JSTOR, ERIC, Scopus, and PsycINFO were reviewed. Based on this, a mix of frameworks, such as checklists and questionnaires that employ quantitative, qualitative, and/or mixed-methods were found. Differences were also found depending on who appraised the outcomes. We hope to present our PICO[1] and recommendations for a holistic, flexible, mixed-methods approach to assessing the quality of CECs.

Reference:

1. PICO is a mnemotic device in evidence-based practice.

Posters

Authors and Abstracts of Posters from ICCEC 2019, Listed by Poster Number

1093

When Cancer Kids Say "No!": Capacity, Oncology, and Consent

Philip Crowell

Pediatric oncology may occasionally present ethics services with complex clinical ethics challenges, for example, when a pediatric patient says "no" to a highly effective treatment option. A good consultation in complex care will require meeting with the team, the family, and the patient in a variety of configurations, and sometimes with the pediatric patient one-on-one, to identify the goals of care and the patient's preferences. It is critical to know the hospital's policies on patients and families who refuse life-saving treatments, and the legislation that guides hospitals, doctors, child protection services, and the courts. Since there are societal expectations concerning the protection of children, there are duties and obligations beyond respecting the autonomy of the patient. However, with adolescent patients who have a "growing capacity," it is vital to know how to assess and support this growing "muscle."

In the case presented, a central question is: Does the patient have capacity to make the decision to pursue or refuse treatment for her cancer? What steps should the team take to engage with the patient, particularly given that the family appears to be extremely hesitant and suspicious of standard treatments of chemotherapy and radiation? What are the team's obligations to the patient, since she is still a minor under governmentally protective legislation? The case study will detail a process and the ethical challenges when capable adolescent patients make bad decisions or when substitute decision makers make poor decisions. What happens if pediatric oncologists decide to call the Ministry of Child Protection in order to force an adolescent patient into treatment? What are the practical, ethical, and legal implications for patients and their families? In conclusion, we explore the implications of "best interests" arguments and the usefulness of the harm principle.

1094

Ethics in Clinical Pastoral Education

Paul Cummins, David Fleenor, Jo Hirschmann

Background: Healthcare chaplaincy was once one of several roles that clerics assumed as part of ministry. However, over time it has evolved into a profession. As professionals within clinical healthcare settings, healthcare chaplains should have a basic understanding of clinical ethics and its affect on patient care. While a Clinical Pastoral Education (CPE) Residency program must meet accrediting standards in the U.S., there is wide latitude in establishing curricula.

Objective: This poster will present the results of two concurrent projects. First, it will report data on the place of clinical ethics in CPE residency programs. Second, it will report data on the incorporation of a clinical ethics course into the curriculum of the CPE Residency program at the author's institution.

Methods: Data on the percentage of CPE Residency programs with ethics curricula will be gathered through the administration of a survey to program directors. In addition to gathering data on whether programs have curricula, the survey will gather data on what is taught, how it is taught, and who teaches in the ethics curricula. The poster

will also include a description of the development and implementation of an ethics curriculum at the author's institution. It will present data on assessment of students and how students evaluate their learning.

Results: At this time, the survey is being reviewed by an institutional review board, and the curriculum will be implemented in winter 2019 quarter, so there are no results to report.

Conclusion: The hypothesis of the survey is that clinical ethics is not taught to CPE residents in a deliberate manner, although it should be. Based on the other survey results, the author's experience implementing the new curriculum, and the students' evaluation of the course, the presentation will recommend a basic curriculum for programs to adopt.

1095

How Can Psychological Concerns Be Smoothly Introduced into Clinical Ethics Education in Healthcare Organizations?

Kenji Hattori

Background: Clinical ethics is distant from ethics as moral philosophy. The latter inquires what the ideal rational moral life should be like and tries to formulate the fundamental but abstract moral principles. The former faces up with concrete difficulties in individuals' flesh-and-blood lives under specific circumstances. This is why we should take full advantage of intuitive insights or empirical psychology. And yet, quite a few healthcare professionals and students tend to be reluctant to utilize such subjective moments because they have been educated to put weight on objectivity and evidence.

Objective: We should work out some ways of having professionals and students embrace psychological concerns and of developing their competencies.

Method: We examined the acceptability of some types of education to provide a foundation for psychologically applicable concerns for clinical ethics in an organization.

Results: Both healthcare professionals and students were, beyond expectations, likely to show a positive attitude to reading well-written short stories and exchanging their interpretations about the inner worlds of the characters and their relationships, rather than psychological doctrines. Fictitious stories, especially written by female authors, e.g., Alice Munro, Jhumpa Lahiri, and Ramona Ausubel, as well as very popular stories for children enjoyed great popularity. Such stories, in contrast with real clinical cases, relieved trainees' tension when they examined the differences in their interpretations, and aroused their vivid interest in psychological aspects of the characters in the stories.

Conclusion: Empirical psychological aspects of clinical ethics should be taken seriously. We found utilizing well-written fictitious short stories was very useful in education in healthcare organizations. We do not need to cling to case studies that use real cases that actually haunted us in wards.

1096

When Identities Intersect: Adapting an Intersectional Lens into Clinical Ethics Consultation Frameworks

Claire Horner, Sophia Fantus, Lisa Campo-Engelstein

There has been increased attention in medicine and healthcare ethics to address social determinants of health (SDOH) and to inform careproviders of the ways in which social conditions, economic and environmental factors, and social inequalities shape patients' experiences and overall well-being. Intersectionality, as a descriptive phenomenon, may be applied as a means to understand how SDOH influence patients' experiences in healthcare. Intersectionality promotes social justice by examining the ways in which identity, community, institutions, and stigma contribute to human experience; individuals are conceptualized as multi-faceted, belonging to intersecting and interacting social categories that enact experiences of both privilege and marginalization.

SDOH and intersectionality are elements that are implicit in clinical ethics consultation (CEC) frameworks that help identify ethical problems and elucidate patients' preferences and values. In this presentation, we begin with a case study to demonstrate how an intersectional lens can be applied to CEC and how it may be useful in disclosing and examining the role that SDOH plays in already existing CEC frameworks. An intersectional approach can facilitate understanding of SDOH by appreciating how health disparities, health literacy and access to health services, community and educational resources, socio-economic status, and social norms and attitudes are compounded by a patient's intersecting identities. An intersectional approach within CEC can be a starting point at which to identify elements of SDOH that may influence patients' care and trigger ethical conflict.

This presentation will demonstrate how to: (1) identify patients' intersecting identities relevant for CEC practice, (2) consider an intersectional approach when gathering initial information from members of the care team after being consulted; (3) introduce types of questions clinical ethicists may ask to address how SDOH contribute to and play a role in individual patient preferences and values; and (4) establish scenarios to strategize how SDOH may influence goals of care.

1097

The Effect of Role Models on the Moral Behaviors and Attitudes of Medical Students

Bisma Hussain

A role model is defined as a person who serves as an example of the values, attitudes and behaviors associated with a role. Role models can serve as important figures who others admire and want to emulate. Physicians are perhaps some of the most important role models for medical students.

The positive qualities exhibited by physicians offer a potentially useful method of teaching clinical ethics and reinforcing positive behaviors and attitudes in medical students. Therefore, this poster aims to evaluate the effect of role models on the moral behaviors and attitudes of medical students.

Literature searches were conducted using U.K. National Health Service evidence, in which Medline, PubMed, and HMIC were searches. Forward citation searching using Google Scholar was also used for the most relevant articles. Articles published before 1996 where deemed too old, and older English articles were included in the literature review. All article types were included in order to present a holistic representation of the literature.

Results revealed that students were able to identify positive qualities in the role models they encountered (Jochemsen-van der Leeuw, van Dijk and Wieringa-de Waard, 2014). Furthermore, students desired to emulate the positive role models they observed in practice, and in some cases went on to follow in the same speciality. But students who were faced with negative role models were said to be more susceptible to imitating those negative traits later in their careers (Burgess, Goulston and Oates, 2015).

In conclusion, there is evidence to suggest that the role models within an organization can provide strong social and psychological cues that can stimulate and direct the behaviors and attitudes of medical students. By doing so, physicians as role models can provide a realistic method for the development of ethical conduct in the subsequent generation of physicians, thus supporting the practice of good clinical ethics in years to come.

1098

Doctor's Duty to Advise: The Singapore Experience

Hsi-Yen Loke, Ming Xian Grace Chew

On 12 May 2017, the Singapore Court of Appeal set out a new legal test for the civil standard of care regarding a doctor's duty to advise. Known as the Modified Montgomery Test, it was a shift to a patient-centric test, away from the Bolam-Bolitho Test that it replaced that was doctor-centric.

This shift in relation to the provision of advice by doctors came after the Singapore Medical Council's Ethical Code and Ethical Guidelines (ECEG) came into force on 1 January 2017. Interestingly, notwithstanding that the ECEG had come into force prior to the Modified Montgomery Test's being articulated, it had already endorsed a patient-centric view by stating that doctors must ensure that patients are made aware of "material risks (including those that would be important to patients in their particular circumstances)," among other things.

This is all the more interesting, as departure from the ECEG is commonly used as a basis for professional misconduct prosecutions by the Singapore Medical Council in disciplinary proceedings against doctors.

While the civil law of negligence (as in the case of the Modified Montgomery Test) and the quasi-criminal nature of disciplinary proceedings against doctors have differing purposes and outcomes, it is interesting to note that for the brief period in 2017, the medical profession appeared to have diverged from the civil standard of care in respect of advice provision, before the Court of Appeal moved to align the two.

Further details and discussion of the above will be provided in poster form.

1099

Mr. B Takes a Fall

Janet Malek

Mr. B is a 48-year-old man admitted to the hospital with worsening advanced heart failure. He is undergoing evaluation for placement of an LVAD (left ventricular assist device). Mr. B has the capacity to make decisions regarding his medical care, but is inconsistent in his willingness to fol-

low the instructions and guidance of the healthcare team. He occasionally refuses recommended medications and often ignores the requests of his nurses. Of particular concern, Mr. B gets out of bed routinely without calling for assistance, despite repeated admonitions about the dangers of doing so. One afternoon on his way to the bathroom, Mr. B takes a fall. Fortunately, he does not suffer serious injury, but the healthcare team becomes increasingly concerned. A telesitter (a mobile camera monitored remotely) is ordered so that nursing staff can be notified if he attempts to get out of bed. Mr. B complains loudly and consistently that he wants it removed because its light keeps him up at night. He also refuses to allow an in-person sitter to be in his room due to privacy concerns, insisting that the sitter put his chair just outside the room.

Despite repeated conversations with Mr. B about the importance of the hospital's safety procedures, he continues to ignore instructions and refuse these interventions. The healthcare team feels an ethical duty to respect a competent patient's refusal, but also feels a conflicting ethical obligation to follow through with the hospital's safety and quality improvement initiatives. They want to provide the best care possible for Mr. B and are unsure about whether and to what degree they should accommodate his risky behavior. The team calls the Ethics Consultation Service to help resolve their dilemma.

1100

A Faith-Based Moral Challenge in Ethics Consultation

John Moskop

Clinical ethics consultants may confront difficult challenges when they receive consultation requests in situations when the primary stakeholders disagree about medical treatment based on differences in fundamental moral commitments. This presentation will describe a case in which an intensive care unit medical team recommends relief of suffering as the primary goal of care for a patient with advanced disease. The patient's family rejects the team's recommendations and insists on continuing life-prolonging measures and on limiting narcotic pain medication for their loved one; they explain that these decisions are based on their religious convictions.

The team requests an ethics consultation, and a clinical ethics consultant gathers information from medical team members and the patient's family members. The consultant elicits the moral reasoning underlying the preferences of the team and of the family, but is unable to identify a treatment plan that is acceptable to both.

The poster will consider how various approaches to the provision of clinical ethics consultation would guide the consultant in this case, including the authoritarian, pure consensus, and ethics facilitation approaches described in the *Core Competencies for Healthcare Ethics Consultation* report of the American Society for Bioethics and Humanities, and alternative approaches in which consultants adopt the role of advocates for patients, clinicians, or institutions. It will identify potential strengths and weaknesses of each of these approaches in addressing this case situation.

1101

Evaluation of Case Consultations: Lessons from 192 Consultation Protocols at Hannover Medical School

Gerald Neitzke, Marcel Mertz, Katja Freund

There is an ongoing debate on the evaluation of clinical ethics consultation. Besides meth-odological challenges, a lack of data is often a problem. The Clinical Ethics Committee (CEC) at Hannover Medical School provides a considerable number of consultation-reports that allow a retrospective analysis of type and frequency, main conflicts, focal issues, methods, results, and reporting quality of the consultations. The poster will focus on the significance of such data for quality assurance and methodological development in ethics consultation.

From 2001 to 2016, 757 documented consultations took place. Reports were included if they (1) reported a consultation with several persons/perspectives seeking a solution, and (2) the documentation was exhaustive; 192 reports fulfillled the inclusion criteria. Consultation was requested predominantly by physicians, from all clinical specialties. The requests were mainly related to therapeutic conflicts (beginning and end of life, other somatic crisis). Core areas of consultations included prognosis, indications, patients' preferences, balancing benefit and burden, and patients' welfare. A living will (*patientenverfügung*) was available in 23 percent of cases, but solved only one-third of therapeutic conflicts. In a majority of cases, other expressions of patients' preferences were relevant. Ethics consultation found a solution in 97 percent of the cases; 86 percent in a consensus of all parties involved. The solutions varied from maximum treatment (31 percent) or

limitation of treatment (28 percent) to allowing patients to die (42 percent). Nevertheless, a total of 81 percent of patients died in the course of their treatment after the consultation. Thus, CEC is not a "death committee," but a reasonable partner in clinical decision making when ethical conflicts arise. The poster shows how empirical data can be used for specific aims on different levels: (1) informing committee members, (2) developing consultation services provided, (3) reflecting, developing, and refining consultation methods, (4) quality assurance of consultations, and (5) of reports.

1102

Systematic Review of Core Training Requirements and Curricula of CEC Members

Yun Ting Ong, Lalit Kumar Radha Krishna

The nature of clinical ethics consultations (CECs) varies, from its setting to its indications. It also varies as a result of the consultant's competency, experience, training, and abilities. Informed by a scoping review of the question, "What factors should be considered in ensuring an effective ethics consult?" this systematic review seeks to evaluate prevailing tools to assess the quality of ethics consultants and what training they should have before being deemed competent to be a part of a CEC. The following databases—PubMed, EMBASE, JSTOR, ERIC, Scopus, and PsycINFO—were reviewed. Based on this, little information was found on the core competencies of CEC members and the core curriculum for their training. We hope to present our PICO[1] and recommendations for a training program for CEC members and a tool to assess their competency to be a part of the CEC.

Reference:

1. PICO is a mnemotic device in evidence-based practice.

1103

Challenges in the Management of Endoscopic Procedures

Andreea Luiza Palamaru, Elena Toader, Tudor-Stefan Rotaru

Background: Medical ethics represent medical staff's constant reflection over what is moral in medical interventions. Several principles are considered the basis for a proper medical practice, such as respect for patients' autonomy, beneficence, nonmaleficence, and justice. Starting from the premise that all the states of the European Union are concerned with the aspects of "safety" and "patients' well-being," procedures prior to the endoscopy should involve a thorough ethical communication.

Objective of the research: This research aims to evaluate whether a preprocedural discussion with a psychologist can bring more benefits to the physician-patient relationship, in the context of modern medicine.

Methods: We conducted a study, representing a qualitative research of data obtained from semi-structural interviews with 30 patients who received endoscopic procedures at the Institute of Gastroenterology and Hepatology Ia.i, Romania.

Results: Patients said they felt better understood by the physician when a prior discussion with the hospital psychologist was carried out. This may be an opportunity to increase patients' satisfaction, a directive followed in all countries of the European Union. The issue of ethical management is of particular interest, as both medical equipment manufacturers and large pharma companies have the slogan, "Our priority is the patient."

Conclusion: Good communication and interaction between the endoscopist and patient is beneficent, as it may make the patient's healthcare experience more satisfying. Ethical aspects of endoscopic procedures need more attention and scrutiny than they have received up to now.

1104

The Dark Wood of Peer Review

Frederick Paola, Robert Walker

Robert Bolt's "A Man for All Seasons" employs one of the great metaphors of 20th century literature—that of the legal system as a wood, beneficently providing protection against the malign elements. Bolt's Sir Thomas More acknowledges the apparent ambivalence of the "wood" that is the law, insofar as the same laws that shield him also shield "the Devil" (i.e., King Henry VIII). But the accidental failure of law-as-shield to discriminate between saint and sinner is not the sole danger lurking in the wood, for the law can be wrongfully wielded as a weapon to effect an injustice. Ironically, the very law to which More looked for sanctuary was used to endow the proceedings against him, and by extension his execution, with a veneer of verisimilitude. Malicious (or sham) peer review represents a similar abuse of the law. Malicious peer review occurs when a physician

is disciplined not because of a *bona fide* finding of incompetence or misconduct, but for some other improper motive. While there is no dearth of literature regarding malicious peer review, little has been written about it from a professionalism perspective. Malicious peer review, we submit, is particularly and insidiously toxic to medical professionalism. Latham has written that, according to the Parsonian model of professionalism, elements of medical professionalism include: (1) the expert authority of the medical professional; (2) the medical professional's role as a mediator between individual patients and society; (3) the medical professional's motivations; and (4) the medical professional's acts of profession, which include acts related to professional self-regulation. Corruption of any of these elements undermines medical professionalism. We submit that, as a corrupt act of profession, malicious peer review—or malice masquerading as justice—undermines medical professionalism, and arguably does so in an especially damaging manner.

1105

Ten Years of Clinical Ethics Consultation at the University Hospital Innsbruck

Ursula Riccabona, Verena Stühlinger

In 2019 the Clinical Ethics Committee of the University Hospital Innsbruck is 10 years old. Reason enough to wrap up, evaluate (Neitzke et al., 2013), and reflect on the committee's activities. The poster gives a structured overview of a decade of diligent analysis and challenging decision support. It will present the organizational background and work of a committee at a University Hospital that takes care of more than 50,000 patients per year. Based on the results of a qualitative interview study conducted in 2015 and 2016 with members of the committee, key success factors for the implementation and establishment of the committee are revealed. In addition, results of this study give deeper insights into the main tasks that members of the committee allocate to the committee's work. With the aim of identifying and describing main fields and topics of the committee's work in education and case consultation, a content analysis of the committee's activity reports and meeting minutes is conducted. Results of this descriptive activity evaluation are related to international standards and the results of the employee survey conducted in 2008, accompanying the implementation of the committee (Tschugg, 2009). The poster concludes by discussing how the results of this wrap-up and alignment can contribute to the further development and organization of the committee.

1106

Ethical Expertise and Evaluation of Clinical Ethics Support Services (CESS)

Jan Schildmann, Joschka Haltaufderheide, Stephan Nadolny, Jochen Vollmann

Background: Clinical ethics support services (CESS) have been implemented widely. There have been numerous calls for an evaluation of CESS in recent decades. However, there is considerable controversy regarding how to evaluate CESS appropriately.

Methods: We reconstruct different models of CESS and built-in concepts of (ethical) expertise by means of analysis with a conceptual framework. We analyze normative and empirical criteria relevant to describe (ethical) expertise in the context of CESS.

Results: Firstly, we identify empirical and normative characteristics of CESS and distinguish them from usual interventions in healthcare. We argue that the complex structure and processes of CESS and its inherent normative character are two features that pose challenges to define criteria for evaluating the quality of CESS. Secondly, we explore how far the concept of ethical expertise can serve as a starting point for evaluating CESS. We make explicit different understandings of ethical expertise within two different models of CESS and describe the relevance of the different concepts of ethical expertise for evaluating CESS using an analysis with conceptual frameworks.

Discussion: Ethical expertise in CESS corresponds with end points that are relevant to empirical evaluation research and the normative premises underlying (different models of) CESS. We discuss the feasibility of reconstructing the ethical expertise underlying existing models of CESS and suggest methods for empirical-ethical research that can further our knowledge about the quality of CESS in healthcare.

1107

Dealing with Medical Error: A Wobbly Bridge Between Clinical and Organizational Ethics

Kurt Schmidt

Dealing with medical error is one of the most difficult and unpleasant areas of clinical ethics. Even when institutions are fundamentally

dedicated to openness and transparency, with a willingness to establish a positive error culture, the hurdles on the path to realization are high, and resistance is par for the course. This will come as no surprise since the persons directly responsible for medical errors, as well as all others involved, frequently react with emotions like shame, guilt, and self-doubt.

Appropriate ways of dealing with medical error cannot be developed by a single member of staff working alone. A superordinate concept is required that encompasses the entire organizational body, not least because the issue affects both the surrounding people (next of kin, colleagues, and so on) and the hospital as an institution (insurance, the press, and so on). This concept must also be developed preventively, i.e., before an error can occur, and communicated to all employees.

So, who is ultimately responsible, and who should start the ball rolling? If a clinical ethics committee limits itself to the processing of individual ethical questions, then it will be unable to meet the challenge of this sensitive organizational ethical task. Or is it (always) necessary to set up an additional committee for organizational ethics? This poster aims to show how a bridge can be built between these aspects, and which methods can be used. The following five steps will serve as orientation: (1) Making a fundamental decision on how to deal with medical error. (2) Protecting the "first victim" from further harm. (3) Standing by to help the "second victims." (4.) Communicating and implementing the finished concept. (5) Further training that includes examples from film and television.

1108

Transparency and Confidentiality: Redesigning Clinical Ethical and Legal Consultation

Dorothea Touwen, Martine De Vries, Marleen Eijkholt

In our academic medical center, for years, clinical ethics and legal consultation were done by only one person, who, in the eyes of the health care professionals (HCPs), embodied ethics and health law. He didn't share his consults with his colleagues, claiming confidentiality, nor was any ethics policy developed in the hospital, as prior experiences and cases were not be reported. Since this person's retirement, our department of medical ethics and health law has had to redesign its clinical ethics and law consultation service. The new policy is to aim at transparency, sharing of experiences, and rotating clinical ethics consultations. A structure is being created to develop ethics policy in the hospital, uniting the practices of separate departments and making available best practices. This raises several questions, primarily in view of the problem of how to deal with confidentiality. How can we aim for transparency and derive general conclusions when we are not able to discuss cases, since we have to respect the privacy of patients and the professional caregivers involved? Another issue is the relationship between the clinical ethicists, who are on call 24 hours, and the Hospital Ethics Committee installed by the Board of Directors. How are the clinical ethicists to contribute to the committee, and must they share the identities of the healthcare providers (HCPs) who ask for advice or that of their department? HCPs often define their problem in legal terms, while our consultation frequently leads to a reformulation to the moral question, "What is the good thing to do?" This raises the question of the relationship between the hospital lawyer and the clinical ethics and law consultation team. Futher, how are we to deal with the knowledge that junior doctors report that sometimes they are "told off" for asking the clinical ethicists for advice?

1109

Scoping Review of the Factors of an Effective Clinical Ethics Consultation

Nicholas Yue Shuen Yoon, Yun Ting Ong, Lalit Kumar Radha Krishna

Clinical ethics consultation aims to address challenging ethical issues in healthcare in diverse psychosocial, clinical, and cultural settings. Poorly considered recommendations by a clinical ethics consultant (CEC) can be harmful and/or may be poorly received. Guided by the question, "What factors should be considered in ensuring an effective ethics consult?" this scoping review employs Arksey's and O'Malley's methodology to identify the extent, range, and nature of this broad issue. Our search yielded qualitative and quantitative data on the consult process and its outcomes. Three themes were identified, including analysis of the consultant's competencies and credentials, the consult process, and the outcome. A competent CEC must possess adequate ethical knowledge and good interpersonal skills. An effective consultation process must identify all relevant ethical issues, involve all relevant parties, and bridge communication between the medical team and the patient and family. The outcome of ethics consults must be

morally justifiable and fulfill the intended purpose of the consult. All parties should be satisfied with the outcome. Meeting these three objectives, however, can be difficult, given the lack of an agreed upon curriculum for training CECs, no universally acceptable tool to assess ethical issues and consultant competencies, and no means of ensuring amicable and acceptable solutions for involved parties. Each of these issues must be addressed if the quality of clinical ethics consultation is to be consistent, transparent, and accountable.

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education & awards

The Clinical Ethics Immersion is the original experiential and simulation-based education program in clinical bioethics. This program is held biannually and is hosted and directed by the faculty and staff of the John J. Lynch, MD Center for Ethics. This four-day course focuses on the institutional development of bioethics programming and practical reasoning in clinical ethics consultation. Participants round with senior clinical ethicists in intensive care units, respond to case consultation requests, and engage in discussion with invited lecturers and resident instructors. In addition, participants engage in simulated consultations with trained actors in MedStar's state-of-the-art Simulation Training and Education Lab (SiTEL).

The Ethics and Clinical Social Work (ECSW) program is hosted and directed by the John J. Lynch, MD Center for Ethics, and accredited by the National Association of Social Work for bioethics continuing education credits. The ECSW trains social workers to recognize the ethical significance of complexities that arise in the care of hospital patients, develop an understanding of ethical concepts as they relate to social work, and identify opportunities to work collaboratively with clinical ethicists. Combined case study and lecture allow participants to develop skills in ethical analysis.

The John J. Lynch, MD Moral Courage Awards, named after the founder and Medical Director of the Center for Ethics, is a biennial program in recognition of individuals who have demonstrated courage when acting against difficult and ethically challenging circumstances. Established in 2010, this program was designed as an opportunity for hospital leaders to model through exemplification the virtues they consider central to creating and sustaining an ethically sound climate in the hospital. For more information, contact the program director, Kahlia Keita at *kahlia.t.keita@medstar.net*

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