THE DESIGN AND USE OF THE BIOETHICS CONSULTATION FORM

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ABSTRACT. The emergence of the ethics consultation as a means to resolve moral crises in clinical medicine has revealed the need for a worksheet that would facilitate intake and analysis. The author developed the "Bioethics Consultation Form" as an attempt to remedy this need. The form is arranged in an outline format and is a useful asset to ethics committee discussions and record keeping. The first section covers basic intake data concerning the patient's medical and personal information, advance directives, and values, as well as the values of the physician and family. After the intake section is completed with the above data, the ethics consultant then turns to the analysis section. This second section allows for (1) the discussion of conflicting values, (2) the identification of priorities, and (3) the elucidation of ethical norms relevant to the case.

The Bioethics Consultation Form was adopted by the Patient Care Advisory committee of the Franklin Square Hospital Center in Baltimore, Maryland in 1986. The methodology in the use of the form will be discussed. Further, the potential spectrum of consultative cases that can be analyzed using the form will be highlighted.

Key words: Bioethics Consultation Form, clinical ethics, ethics consultation, hospital ethics committee, Patient Care Advisory Committee, values

1. INTRODUCTION

The ethics consultation has emerged in the United States as an important means to resolve ethical dilemmas in clinical medicine. However, there is a need for a form that will facilitate the intake and analysis of such consultations, particularly for the sake of ethics committee members who are not trained in clinical bioethics. The Bioethics Consultation Form attempts to address this need by detailing pertinent questions that fulfill basic intake requirements and by assisting the development of an argument of resolution. The simplicity of language and format of the form allows for those educated in basic medical ethics to utilize it, so that it is accessible to all members of an ethics committee, not just to those trained in clinical bioethics. The purpose of this paper is to illustrate the organization and function of the Bioethics Consultation Form in the clinical realm.

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2. DEVELOPMENT OF THE FORM

In 1986, the Franklin Square Hospital Center empowered its Patient Care Advisory Committee to consult on ethically significant clinical cases when requested by the patient, the patient's family or the health care team. The author, a member of the committee, decided that it would be helpful to develop a form that would clarify the intake and analysis phases of the consultation process for committee members. Since the committee is made up of physicians, nurses, social workers, clergymen, hospital administrators and the hospital counsel, the form's ethics language needed to be easily understood so that a fundamental bioethics background would be sufficient to utilize it. "Ethics Work-ups" per se, have been developed in the past, such as Thomasma's Ethics Work-up which is an excellent example of a narrative work up, from which the basic concepts of this form are based [1]. However, Thomasma's narrative format is superseded in the Bioethics Consultation Form by a simpler outline format. The outline format, historically used in clinical medicine for the History and Physical, is readily discernible by physicians as a clinical consultation in the area of medical ethics. The decision to use an outline also reflects the need of a form that all committee members can use in asking a variety of open-ended questions pertaining to basic patient medical information, patient, family and health care team values (as well as how they impact on the case). The form then addresses the formulation of an argument after an articulation of the conflicting values of the various parties involved in the case. Further, commonly cited bioethical precepts, as well as an area for "Other Principles or Virtues", are listed at the end of the form in order to help clarify the bases of the argument of resolution. The reasoning behind the inclusion of this section is to facilitate the formulation of arguments by committee members by identifying those ethical tenets that may support their theses. The Bioethics Consultation Form is illustrated in the Appendix.

3. DESCRIPTION OF FORMAT

3.1. The Intake Worksheet

The Medical and Social Data section elicits basic information concerning the patient and his or her family. First, the patient is identified on the form solely by his or her chart number in order to preserve patient anonymity, while allowing for record keeping and retrospective analysis of the case history. Second, the patient's age and sex are identified. Third, the Medical Problem list is ascertained from both the physician's perspective and the medical record. The latter

may reveal divergent viewpoints about the priority of the patient's problems from various members of the health care team. The medical problems may be then entered onto the form, accompanied by the treatment plans. If there are many medical problems, those most ethically relevant to the case should be listed. Fourth, the evaluation of prognosis may be elicited from multiple inputs, such as the attending physician, all available consultants, housestaff, and nursing staff. An increased spectrum of comments will enhance the probability that the predicted prognosis is reliable. Fifth, the Patient's Attitude and Competence allows for the evaluation of the patient's overall ability to make decisions, based on parameters of psychological wellness (e.g., the mini-Mental Status Exam) and possession of autonomous capacities of comprehension, judgment and freedom from constraints.

The sixth area of information to be collected (F, G, H) deals with the values of the patient. The patient's occupation and religion helps to understand his or her value background. Basic questions regarding health and life support decisions should next be asked. Most importantly, the existence of a living will, to allow for the withholding or discontinuance of life sustaining measures, or other advance directives, or the appointment of a durable power of attorney should be ascertained. If no advance directives have been made, and the patient is competent at the time of the bioethics consultation, a determination of the patient's preferences should be attempted. A helpful adjunct to the living will in this regard is the Values History – designed by Doukas and McCullough [2–4]. The Values History is an advance directive instrument that elicits the values of the patient pertaining to terminal medical care and a series of advance directives addressing acute and long term medical therapies. The Values History is intended to help facilitate discussions about termination of care between patients and their physicians. The advance directives within the Values History address the use or withholding of (1) Acute Care Designations (e.g., cardiopulmonary resuscitation, ventilator use, and intubation by endotracheal tube), (2) Chronic Care Designations (e.g., Total Parenteral Nutrition, intravenous hydration, feeding tubes, dialysis, and medications), and (3) Other Advance Directives (e.g., proxy designates, organ donation, autopsy and admission to the Intensive Care Unit).

The family's situation and values are next evaluated in order to assess the impact of the family in influencing the patient's medical care. As mentioned above, the existence of an agent who is empowered as the guardian or durable power of attorney to legally make decisions for the incompetent patient should be established, but may or may not be a family member. Further, if no such agent is named, then the next of kin should be queried about medical decisions (if no living will or advance directives exist).

If the patient is irreversibly incompetent, then the family's reasoning in their

proxy consent should be carefully scrutinized for possible conflict of interest. Family dynamics can influence individual decisions by introducing competing opinions within the family. The existence of these varied viewpoints should be recognized as a crucial aspect of the family's ability to agree on a course of treatment.

The task of separating the family's values and beliefs from the patient's is often quite difficult. However, it is best to approach the incompetent patient's family members by asking them how the *patient* would respond to a particular health care question (thereby respecting the patient's prior value system) and then following this inquiry by asking how the family members themselves feel about this decision. This exchange thereby enhances communication between the health care team and the family, while respecting patient autonomy, and avoiding the psychological burden of placing decision making directly on the family's shoulders.

The second section addresses how the specific case value factors of all those concerned with the patient's care are brought to bear on the specific case. First, the competent patient's viewpoint is clarified as to the particular dilemmas brought up in the case. If the patient is not competent, then advance directives pertaining to the case are called to attention. If no such advance directives exist, then the guardian or durable power of attorney will state the proxy position of the patient to the best of his or her ability. If no designated proxy exists, then the family performs this function of providing a substituted judgment on behalf of the patient. Lastly, if no family is involved, a decision based on substituted judgment may ultimately need to come from the courts. The health care team's perspective is next contrasted with the patient's actual or proxy-related values. This portion of the intake should be elicited from attending physicians, consultants, housestaff, nursing staff and social workers. Other potentially relevant persons with important input might include hospital administration and counsel, and the chaplain service.

At the end of the second section, the dilemma present in the case may be readily discernible as simplistic or logistical and therefore resolvable without the convening of the entire Patient Care Advisory Committee. In either case, the consultant should state "Resolved" on the disposition line and then proceed to the Analysis Worksheet in order to reflect the reasoning that supports resolution. If the case is complex, the Disposition line should state "To Committee" in order to reflect the necessity of convening the entire Patient Care Advisory Committee. The consultant's Intake Worksheet is then photocopied for the benefit of the rest of the committee for use at the time of convening for case discussion. Beneath the Disposition line the date of the referral and by whom (i.e., the patient, the patient's family or the health care team) and the date of the consultation and by whom should be recorded.

3.2. The Analysis Worksheet

The Major Value Conflicts section attempts to delineate the opposing ethical viewpoints which the various parties hold in a clinical case. The differing viewpoints are contrasted at this point by committee consensus (or by the individual committee member if the case does not warrant committee review). The next section deals with prioritizing the various values that have arisen during the case as determined by the judgment of those analyzing it. The rationale section requests the justification of why one value might be placed above another or why a value might be omitted (e.g., because of a faulty or irrelevant argument). From this development of the analysis worksheet, an Argument of Resolution can be formulated, which would scrutinize the general arguments of the case and then focus on the prioritized values. The Argument of Resolution serves to demonstrate a thoughtful conclusion which reasonably accounts for the ethical principles relevant to the case. The final section, termed the Basis of Support, facilitates the formulation of the Argument of Resolution by listing several pertinent ethical norms that could justify the argument. Such a listing facilitates committee discussion and formulation of the Argument of Resolution by highlighting some of the major tenets in medical ethics. The advantage of stimulating discussion and ascertaining the foundation of proposed arguments was the rationale used by the author (and the Patient Care Advisory Committee) in this decision. The form includes the ethical norms of Autonomy, Beneficence, Contract Keeping, Honesty, and Justice. The Beneficence principle was further clarified for the benefit of all committee members by the subheadings of Paternalism and Avoidance of Harm to Third Parties. The applicable tenets may be checked off and then described on their right by explaining the basis upon which they are supportive of the argument. Also, below the listed norms, other applicable principles or virtues may be cited to support the Argument of Resolution. The Bases of Support may then be framed in language of values, rights and/or duties. Thus, when the Analysis Worksheet is completed, the consultant or Patient Care Advisory Committee will have formulated an argument which attempts to resolve the medical dilemma at hand. As a result, the argument's evolution and supporting ethical norms are highlighted when such a conclusion has been reached. In addition, the minutes of each Patient Care Advisory Committee meeting are transcribed and are available to serve as a supplementary source of describing the committee's formulation of an argument.

4. FORMAT ATTRIBUTES

The Bioethics Consultation Form is a valuable asset to the ethics consultant. Its concise format makes it well suited for ethics committee members who have a

limited background in bioethics. The form is not verbose in its use of bioethics language and is thereby understandable even to those with the most basic comprehension of medical ethics. Further, when the form has been utilized for a consultation, its readability has allowed other committee members to grasp the medical facts, value conflicts and Argument of Resolution. As a result, the form enhances inter-professional communication within the ethics committee during the discussion and analysis phases of consultation. Given the form's pragmatic goal of facilitating the resolution of clinical ethics conflicts, every attempt has been made to maintain ethical neutrality in the language used. The risk of bias has been reduced by using open-ended questions in an outline format. It is hoped that the Bioethics Consultation Form will be a helpful asset that will expedite the performance of the clinical ethics consultation in the intake and analysis phase while making record keeping more manageable.

5. USE OF THE FORM

The Bioethics Consultation Form was adopted for the use of the Patient Care Advisory Committee of the Franklin Square Hospital Center in November of 1986. Since that time, the form has been used in a variety of circumstances. First, the form has been used for 'curbstone' consultation by the author and other committee members on several occasions for the analysis of straightforward clinical case problems in ethics. On these occasions, the form was completed with resolution of the case without the convening of the entire committee. In these circumstances, the committee was able to quickly ascertain and reflect on these cases when they were discussed at the next monthly committee meeting. Second, the form was also useful for the intake and analysis of information of ethically complex cases prior to their presentation to the entire committee. Further, the photocopies of the consultant's Intake Worksheet forms, when distributed to the rest of the committee, facilitated the discussion of these cases by distilling the medical record to those data that were most ethically relevant.

Committee members expressed their satisfaction with the form, reporting that it clarified the intake and facilitated the analysis of complex cases. It should be noted that the Patient Care Advisory Committee reaches a conclusion by attempting to come to a consensus. If a Majority/Minority difference of opinion arises, it would be reflected in the wording of the Argument of Resolution. Alternatively, two separate Analysis Worksheets could be used to demonstrate the development of each separate argument.

The form also was an instructive tool in the author's former duties in the monthly Bioethics Case Conferences at Franklin Square Hospital Center. These

conferences serve as a means to educate the hospital's housestaff on the various methods of clinical case analysis. Case examples drawn from the clinical experiences of the residents and the author have been analyzed using the form, thereby stimulating discussion while also inculcating basic bioethical precepts.

6. PRACTICAL CONSIDERATIONS

Several questions arise when putting forward an instrument such as the Bioethics Consultation Form. Specifically, what is the validity and reliability of the Bioethics Consultation Form, as well as the philosophical implications of its structure? It is obvious that the use of such a form, with its open ended method of requesting information, could potentially result in disparate responses within each area of information. Yet, it would not be unexpected if two bioethics consultants, looking at the same circumstances of an ethics consultation formulated differing viewpoints of the case. The disparities that might emerge, whether using this form or not, could be based upon their methodology of eliciting medical data from the health care team, their perspective of interpreting the respective values of those involved in the case, and their own medical, philosophical and religious values in weighing these case-related values and constructing an argument of resolution. The Bioethics Consultation Form is only a tool intended to outline and frame the articulated viewpoint of the health care professional rendering a consultation on an ethically difficult case so that it will be readily understood by others involved in the same process. Further, the information gathered will only be as precise as the consultant involved in the intake – simple descriptions of each area of inquiry will not serve the process as effectively as a more detailed solicitation of data. As a result, the form may be best served by being incorporated into a word processing program where the areas of inquiry can be expanded upon in a narrative format (beyond the two pages displayed in the Appendix). Similarly, the information will be only as reliable as the sources – therefore, the consultant should be inquisitive of as many members of the health care team and family to most accurately assess the intake section of the form.

In terms of case analysis, the form is intended to facilitate, not arbitrate. The analysis section attempts to help the ethics consultant or committee articulate an argument of resolution based upon examining and weighing the ethical strengths of the values that come into conflict in a specific case. Those involved in the consultation must carefully examine the relevant claims that emerge in the case. The form is neutral to different ethical theories about which norms are relevant and how to manage conflicts. The list of supporting ethical norms is provided merely as an aid to the consultant of several commonly cited norms in the

bioethics literature, with an area for discussing other pertinent ethical considerations. Lastly, since the time of the presentation of this paper in 1987, several noteworthy publications in this area of bioethics consultation have come into print. The reader is urged to refer to these to gain a perspective of other formats used [5] and the practical impact of ethics consultations [6–8].

7. OTHER USES OF THE FORM

While this form would be of value for many ethics consultative functions with adult patients, adjustment for use with minors and newborns may be helpful. For example, the role of the parent to speak on behalf of the minor patient is of crucial importance, for the patient's values and beliefs may have significance inversely proportional to his or her age. This observation is particularly noteworthy if the patient has not yet reached adolescence.

Given its coherent and straightforward format, the form would be a useful asset to the medical record, so that other members of the health care team can comprehend the ethical parameters of the patients under their care, given a basic understanding of medical ethics. The placement of the form in the chart must be determined by the bioethics committee that uses it, as well as the health care team that requests the consultation. At Franklin Square Hospital Center, the Bioethics Consultation Form is placed in the chart only upon the request of the attending physician. If the consultation is not to be placed in the chart, a summary note by the Patient Care Advisory Committee chairman is written into the progress notes of the medical record.

8. CONCLUSION

The Bioethics Consultation Form attempts to clearly outline the intake and analysis requirements of the bioethics consultant. The open ended format allows for the clarification of the myriad of medical and ethical information needed by the bioethics consultant in formulating an argument of resolution. In structuring the Bioethics Consultation Form in this way, it is hoped that the form will fill an important need in the clinical bioethics consultation process and be useful in communicating information to other ethics committee members who are likewise involved. The Bioethics Consultation Form is therefore offered as a means to facilitate the collection, the communication and the record keeping of those health care professionals who are involved in clinical bioethics consultation.

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APPENDIX

Bioethics Consultation Form

Intake Worksheet

I. Medical and Social Data
- A. Patient's Chart Number:
- B. Age & Sex:
- C. Medical Problem List: Treatment:
  1.
  2.
  3.
  4.
  5.
- D. Prognosis:
- E. Patient's Attitudes & Competence:
- F. Patient's Occupation:
- G. Patient's Religion:
- H. Patient's Values and Beliefs:

  Living Will:
  Other Advance Directives:
  Durable Power of Attorney/Guardian:
- I. Family Situation:
  Dynamics:
- J. Family's Values and Beliefs:

II. Related Case Specific Value Factors:
(Medical, Professional, Social, & Personal)
- A. Patient:
- B. Health Care Professional(s):
- C. Other Relevant Persons:

Disposition:_____
Case referred by: Date:
Intake by: Date:

Bioethics Consultation Form
Analysis Worksheet
Date: / /

III. Major Value Conflicts:

IV. Prioritize the Values

[Rationale]:

V. Argument of Resolution

Supporting Ethical Norms	Basis of Support (Values, Rights, & Duties)
[ ] AUTONOMY	
[ ] BENEFICENCE ~Paternalism ~Avoidance of harm to third parties	
[ ] CONTRACT KEEPING	
[ ] HONESTY	
[ ] JUSTICE	
[ ] OTHER Principles or Virtues	

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