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Ethical Issues Perceived by Clinical Ethicists

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Ethicists often work alone in rural locations while also holding leadership roles. Who helps the ethicist when he/she experiences an ethical dilemma or moral distress?" asked an ethicist. Purposes of this descriptive exploratory convenience research project were to (1) Identify the ethical issues personally experienced by clinical ethicists while fulfilling their professional role, and (2) Describe the resources that clinical ethicists have or desire for resolving these personally experienced ethical situations. A random purposive sampling strategy was implemented. IRB approval was obtained. 12 clinical ethicists participated. Eight of the participants had experienced a personal ethical issue while performing their clinical ethicist role. Ethical issues described include: maintaining confidentiality, non-professional communication, moral distress, identifying the correct decision-maker, acts of deception, and conflicts created by dual roles. Each of these identified work related ethical issues reflects potential or actual communication breakdowns, such as lying, failure to disclose values, or incidents of miscommunication.

Keywords: Ethicists, Ethical Issues, Ethical Communication, Moral Distress, Qualitative Research

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Ethicists often work alone in rural locations while also holding leadership roles. Who helps the ethicist when he/she experiences an ethical dilemma or moral distress?" asked a clinical ethicist attending the 6th International Conference on Clinical Ethics Consultation in Portland Oregon. The literature is full of numerous and varied clinical ethical cases and questions where healthcare professionals and patients require the assistance of an ethics consultation. However, little is known about the ethical issues personally experienced by the clinical ethicist while fulfilling his/her clinical ethics role and duties nor the resources needed and/or utilized by these ethicists to resolve these personally experienced ethical issues. The purpose of this research project was to investigate whether clinical ethicists personally experience work related ethical issues and if so, how they worked to resolve these ethical issues.

Background

Ethics consultation. In 1992, JCAHO mandated that every health care institution receiving Medicare monies have an ethics mechanism to assist with clinical ethical issues (Aulisio et al, 2009). However, the Joint Commission did not stipulate the structure, credentialing, or process these ethics mechanism should

utilize. Thus, healthcare institutions have adopted a variety of group ethics mechanisms (ethics committees, small consultation teams, and liaison services) each with their own specific benefits and limitations or utilize an individual clinical ethicist model. Healthcare ethics mechanisms traditionally perform three functions: clinical consultation (either at the patient's bedside or in conference), ethics education (instructing patients and healthcare professionals about clinical ethics) and policy development (providing input into institutional and societal policies related to healthcare ethics topics) (Aulisio et al., 2009; LaPuma & Schiedermayer, 1991; Richter, 2009).

Ethics consultants are experts in using ethical theory and principles to inform clinical ethical questions (University of Washington School of Medicine, 2013). This expertise may be developed during the consultant's professional degree (MD, nursing or dentistry) or through a professional academic program, such as Masters Programs in Bioethics; certificates in bioethics, clinical ethics or clinical ethics consultation; or doctoral programs in healthcare ethics. Despite the availability of formal academic programs, clinical consultants may receive their ethics education more informally through continued education modules, professional conferences, grand rounds, or intensive ethics courses (American Society of Bioethics and Humanities, nd). To date, there is no certification exam for qualifying to serve as an ethics consultant. Little is known about the impact educational preparation has upon the clinical ethicist's experience or perceptions when providing an ethics consult.

The American Society for Bioethics and Humanities (ASBH, 2011) has outlined the core competencies expected for persons providing ethics consultation as well as the *Code of ethics and professional responsibilities for healthcare ethics consultants* (ASBH, 2014). While these documents discuss how the ethicists should proceed in the event of a conflict of interest, these guidelines do not address how the ethicist should proceed if personally experiencing an ethical issue while providing an ethics consultation. Nevertheless, the code stipulates that the ethicist is expected to remain morally neutral throughout the consultation.

Clinical ethicists function independently when providing an ethics consultation. The individual clinical ethicist model is viewed as providing more flexibility than ethics committees in regards to scheduling discussions with stakeholders. Another perceived benefit for the clinical ethicist model is clearer accountability and visibility by the individual consultant with the stakeholders involved in the ethical situation. However, a major limitation to the individual clinical ethicist model is the lack of multiple perspectives during ethical analysis (Richter, 2009).

Regardless of the consultation style, the clinical ethicist must understand the medical goals and trust the medical assessments made by the members of the healthcare team. There may be times when the clinical ethicist must challenge not only the physician but also the patient's goals, values and understanding of what medicine can reasonably accomplish (Bishop, Fanning, & Bliton, 2009; Truog et al., 2015). Thus, the possibility exists that the clinical ethicist might personally experience moral feelings or uncertainties (i.e., an ethical issue) when the clinical ethicist chooses to implement a more authoritarian model of decision-making

where the consultant suggests views and values that are important and ought to be considered during decision-making.

A clinical ethicist may experience an ethical question or moral uncertainty when the factual and emotive evaluations of an ethics consultation do not match, in other words "*if we made the right ethical decision, then why don't I feel better or happy?*" The quality of an ethics consultation may be evaluated in four ways. First, the soundness of the ethical reasoning provided in conforming to ethical principles and standards (Adams, 2011). Second, the stakeholder's satisfaction with the consultation. Satisfaction may reflect whether the stakeholder's values were respected throughout the consultation. However, satisfaction with the consultation does not necessarily mean that the stakeholder found the consultation to be *helpful*. Third, evaluation should note whether the ethical issue was resolved, and finally whether stakeholder education on relevant ethical content occurred (Pfafflin, Kobert, & Reiter-Theil, 2009).

Moral distress. Moral distress occurs "when one knows the morally right thing to do, but one is prevented from doing so by some sort of constraining factor" (Weber, 2016, p. 244). This constraining factor could include perceived limitations posed by another person or organization, as well as legal requirements. When moral distress is experienced, there will be a negative impact upon not only the person experiencing the moral distress but also the person's work milieu (Weber, 2016). Besides negative feelings, other attributes of moral distress are feelings of "powerlessness, conflicting loyalties and uncertainty" (Russell, 2012, p. 19). The experience of moral distress is not limited to healthcare professionals (Weber, 2016).

Several antecedents must be in place for moral distress to occur. First, the person must possess moral sensitivity. Second, a moral conflict with clashing values is perceived. Lastly, a power imbalance exists, which triggers the attribute of powerlessness (Russell, 2012). It is unknown if these antecedents are present prior to the clinical ethicist experiencing work related moral distress.

The consequences of experiencing moral distress are wide and varied. The person might experience emotional, spiritual, and/or physical responses (Weber, 2016); altered relationships, job satisfaction and/or role performance (Russell, 2012). Epstein and Hamric (2009) believe that after experiencing moral distress and its related consequences, the person will continue to experience the enduring feelings of moral residue. Epstein and Hamric postulate that over time multiple experiences of moral distress and its associated moral residue will create a crescendo effect where subsequent experiences of moral distress are experienced more acutely than previous incidences of moral distress.

Little is known about how or if clinical ethicists experience moral distress while performing their professional role. Does serving as a consultant to the healthcare team create a power imbalance for the ethicist? Since ethicists are involved in multiple ethical situations, does this change their susceptibility to moral distress and associated moral residue? Finally, further research is needed to describe the professional as well as personal consequences that result when a clinical ethicist experiences moral distress during their professional role.

Ethical Issues Perceived by Clinical Ethicists

The ethical issues personally perceived by clinical ethicists while fulfilling their ethics role and duties are an under-researched phenomenon. In their anthology of *“Complex Ethics Consultations: Cases That Haunt Us”*, editors Ford and Dudzinski (2008) presented 28 clinical ethics consultations where the clinical ethicist felt there were unresolved haunting aspects. Many haunting scenarios were described with a variety of ethical questions. However; only five contributing clinical ethicists identified their haunting case as being an ethical issue for them personally. Three of the five cases involved experiences of moral distress. One clinical ethicist experienced an ethical issue as a result of being too new, overwhelmed and inexperienced in the clinical ethicist role to effectively resolve a complex ethical consult. The fifth clinical ethicist (Stuart Finder) wrote;

I was flooded with self-doubt and questions that I already knew could not be fully answered or settled. I thus found myself deep in the throes of a genuine *moral* experience, the kind I knew, that often prompted my nursing and physician colleagues to request an ethics consultation. (Ford and Dudzinski, 2008, p. 130)

Based on these accounts, the possibility for a clinical ethicist to personally experience an ethical issue or moral uncertainty exists. In addition, Dr. Finder identified the irony that at times a clinical ethicist could benefit from personally having an ethics consultation performed for the ethicist’s benefit. More research is needed to identify what types of ethical issues are experienced by clinical ethicists when fulfilling their ethics role and duties and the resources used to help resolve these ethical issues.

Objectives

The objectives for this study were to:

1. Identify the types of ethical situations personally experienced by clinical ethicists as a result of fulfilling their professional ethics role.
2. Describe the resources that clinical ethicists have or desire for resolving the ethical situations they personally experience when fulfilling their professional ethics role and duties.

Methods

A qualitative descriptive exploratory convenience design was implemented to investigate the ethical issues clinical ethicists personally experienced while performing their professional role. A descriptive design is appropriate for “elaboration of the context of a situation, as well as the retrospective happenings and prospective plans surrounding a life event” (Parse, Coyne, & Smith, 1985, p. 91), such as the ethical issues experienced by clinical ethicists. The study was approved by the university’s Committee on Human Research for Behavioral Sciences.

Sample Population

Potential participants were recruited from an international population of persons who attended the 6th International Conference on Clinical Ethics Consultation/7th International Society for Clinical Bioethics in Portland Oregon. Attendees were invited to participate in the study if the attendee considered him/herself to be a clinical ethicist.

Survey

Since little is known about the ethical situations personally experienced by clinical ethicists, the authors created a descriptive survey (see Figure 1) based on themes noted in the review of the literature. The survey began with an open-ended question asking the participant to “describe an ethical situation you personally experienced in your role as a clinical ethicist.” Since ethicists are skilled at identifying ethical issues, the participants were asked what ethical term or label they would use to describe their ethical situation. As a means to more fully understand the clinical ethicist’s ethical decision-making style, questions addressing the participant’s desired outcome and available resources for the ethical situation were included. Two questions were included to investigate whether the participant perceived experiencing moral distress.

In addition to collecting information regarding the ethical situation, a variety of broad demographic questions were included, which included geographical continent where the ethics consultation was provided, practice setting, consultation role, number of consultations provided annually, educational preparation for role, years of experience within role, and presence of an ethics mentor. Based on the belief that clinical ethicists should progress in level of ethics consultation proficiency throughout their careers, subjects were asked to self-identify their perceived level of proficiency (Dreyfus & Dreyfus. 1980). To protect confidentiality, subjects were not asked disclose age or specifics regarding their work environment.

Content validity for the survey was established by a consultant with over 20 years of experience providing ethics consultations and researching clinical ethical issues. The survey was formatted using REDCap™ (Research Electronic Data Capture) “a secure web application for building and managing online surveys and databases,” which allows data to be submitted anonymously (REDCap™, 2016, para 1).

Procedures

A written list of conference attendees with contact information was disseminated to all conference attendees of the 6th International Conference on Clinical Ethics Consultation/7th International Society for Clinical Bioethics in Portland Oregon. Verbal permission to use this contact list for research purposes was obtained. The conference attendees were divided into two cohorts. Those living in North America versus other continents. A random purposive sampling strategy was then applied to both cohorts to promote the likelihood that the final sample characteristics would be representative of the population of persons attending the conference (83% North America and 17% from other continents). The researcher transmitted the Invitation to Participate and Information Sheet to 150 potential participants (124 attendees from North American and 26 attendees from other continents) via e-mail. Twenty-one (14%) emails were undeliverable and 2 individuals emailed the primary investigator indicating that they attended the conference, but were not clinical ethicists. Two weeks later, a second email was sent thanking the participants, who had already participated, and extending another invitation for others to participate. After deciding to participate, each participant gave implied consent by completing and submitting the anonymous electronic REDCap survey. Data were collected over a 3-week period.

Data Analysis

In qualitative methodology, data analysis is ongoing and evolves throughout the data collection process. The narrative responses were coded line by line for major concepts. Codes were identified from an initial code list generated from the review of the literature and/or the participant's exact words. The coded interviews were compared for similarities and differences in coding. As coding progresses, a group of substantive codes evolved. Descriptive statistics were used to analyze quantitative data.

Results

Sample. Twelve participants completed the survey. 9 participants (75%) were from North America and three (25%) from Asia, Europe or South America. Thus, the overall response rate was 9.5%. The participants were primarily female (66.6%). The participants were experienced clinical ethicists with three participants (25%) reporting 6-10 years of experience and 5 participants (41%) reporting 10-20 years of experience. Fifty percent of the participants (n=6) performed more than 24 ethics consultations per year. Seven of the participants (58%) identified themselves as healthcare professionals. In addition, the participants were highly educated with 6 (50%) participants reporting doctoral preparation (5 doctorally prepared in ethics and one non-ethics PhD with a 6 year ethics fellowship). Four (33%) participants did not have any formal academic ethics education with two (16%) of these participants describing no ethics education beyond their original healthcare professional education. Of the 4 participants with no formal ethics education, two participants perform more than 24 consults per year (see Table 1).

Ethical Issues Personally Experienced by Clinical Ethicists

Eight participants identified personally experiencing an ethical situation while fulfilling their professional clinical ethics duties. Since Ethicist #6 described personally experiencing three different ethical situations, a total of 10 ethical situations were described. These personally experienced ethical situations occurred when the ethicist:

- Disagreed with another health care professional's actions (Ethicist #2, #4, #6, #8)
- Experienced differences of opinions with family decision-making (Ethicist #1, #6)
- Recognized the unrelieved suffering of the patient (Ethicist #3)
- Experienced uncertainty or difficulty applying ethical reasoning to a specific patient situation (Ethicist #6, #11)
- Perceived a conflict of roles (Ethicist #12)

The 8 participants, who reported having personally experienced an ethical issue, described their skill acquisition as being advanced beginner (25%), proficient (25%) and expert (50%) (See Table 2).

Since ethicists are skilled at identifying ethical issues (LaPuma & Schiedermayer, 1991), the participants were asked, "What ethical term or label would you use to describe the ethical situation you described." Each of the ethical

terms/labels identified by these eight participants described the ethical situation from the patient's perspective rather than from the ethicist's perspective. None of the participants described their work related ethical situation as involving moral distress, but subsequently when specifically asked, two (25%) of these participants (Ethicist #2 and #6) reported experiencing moral distress during their ethical situation. When coding the ethical situations, the researchers agreed that the second ethical situation described illustrated a lack of moral courage. However, the researchers did not perceive a sense of moral distress when reading/coding the sixth ethical situation, which may be related to the ethicist's writing style and/or level of description. In Table 3, the ethical terms identified by each participant are compared to the ethical labels assigned by the researchers when attempting to code the ethical situation from the ethicist's perspective.

The fact that four (33%) ethicists noted never having personally experienced an ethical situation while fulfilling his/her professional role was an unexpected result. Comparisons between participants who have or have not experienced a work related ethical situation cannot be made. Data were not collected regarding the employment setting, perceived level of skill acquisition, presence of a mentor, and type of ethics service from ethicists who had not personally experienced an ethical situation while fulfilling their professional role.

Impartiality in decision-making. The participants identified a variety of desired outcomes that were important to them during the described ethical situation. These outcomes included:

- Healthcare provider and family comfort with decisions
- Impartiality in decision-making (n=3)
- Learn from the experience (n=2)
- Confidence in ethical recommendations, and
- Protect the patient

Resolved satisfactorily. Five out of the eight (63%) participants noted that the identified ethical situation was resolved to their personal satisfaction. Participants, who were personally satisfied with the outcome of the ethical situation, noted the presence of consensus with colleagues, perception of being supported and ability to discuss the ethical situation with another healthcare professional. Participants, who were not personally satisfied with the outcome of their ethical situation, explained that decision-making lacked objectivity, the situation remained unchanged, or the perception that the clinical ethicist lacked the ability to effect change.

Six (75%) of the 8 ethicists, who experienced a work-related ethical issue, reported that the ethical situation influenced how they performed their job by improving methodological processes, improving inter-personal relationships and/or increasing personal knowledge and confidence. Each of the eight participants believed that they had a mentor or colleague who they felt comfortable contacting for assistance when personally experiencing an ethical situation.

Resources

Two (25%) of the 8 ethicists felt that the resources currently available to them were sufficient and included: multi-disciplinary ethics boards, codes of ethics, and "psychosomatic and spiritual support" (Ethicist #1). Six (75%) of the ethicists

noted the desire for additional resources in helping them cope with personally experienced ethical dilemmas in the workplace. The specific resources desired by the ethicists are described in Table 4.

Communication barriers. Communication barriers, actual and/or potential, were noted as impacting/creating each of the described ethical situations, including: deception, failure to disclose values, miscommunication, and unprofessional communication. Ethicist #1 noted deception when the patient's second wife did not notify the patient's sons about their father's illness. Ethicist #1 described, "I have been upset with her lies and tried to convince her to limit treatments and to inform the other family members." Second, a healthcare professional's failure to disclose professional and/or personal values were illustrated. Ethicist #2's ethical situation occurred during a transplant team meeting when "members of the team openly acknowledged that if the surgeon had been present, they would not have felt "safe" expressing their views. In other words, the surgeons listed whomever they wanted and the [input] from the selection committee was largely ignored." There was no information provided about whether Ethicist #2 communicated his/her professional values or acted in any way to correct this breach in the transplantation protocol.

Miscommunication was instrumental in creating an ethical situation for Ethicist #5. "It was a perfect storm of difficulty in this case with vacation call coverage, new consulting physicians, administrative changes and miscommunication, and it resulted in numerous questions about how the system could be improved (toward which we were working)." Finally, unprofessional communication complicated an ethics consultation for Ethicist #8. "Staff describing, talking about patient in uncompassionate, judgmental way that seemed to affect what they believed should happen with patient." Ethicist #8 did not discuss how she responded to this communication barrier.

Discussion

Sample. Twelve clinical ethicists participated in this survey. The sample included slightly more participants from Asia, Europe or South America (n=3 or 25%) than the original population (83% North America and 17% from other continents). Ethicists from North America were over represented in the original population of ethicists attending a professional ethics consultation conference, which may be related to conference venue, financial resources and/or the ethicist's ability to communicate in English. The limited number of participants from continents other than North America may also relate to the fact that countries outside of North America have been slower to adopt clinical ethics consultation (Aulisio et al., 2009; Richter, 2009). Thus, the cohort purposive sampling strategy based on geographic continent was effective. The use of an international sample strengthens the generalizability of the findings and supports the growing recognition that healthcare ethical concerns are not limited to North America.

Fourteen percent (n=21) of the email invitations were returned to the primary investigator as undeliverable, which may illustrate the transient nature of the population and/or email services. In addition, the primary investigator received two emails from potential subjects noting that the person was interested in ethics, but was not a clinical ethicist. The potential exists that other individuals received

invitations to participate that may not have met the inclusion criteria. Thus, response rate may be artificially low due to sampling issues.

The ability to collect data anonymously via an electronic survey was a perceived strength as well as a limitation of this study. The identification of ethical situations has the potential to illuminate organizational and/or legal issues as well as personal values and beliefs, which potential participants might not have felt safe enough to share without the protection of anonymity. However, the inability to ask probing or clarifying questions limited in part the potential richness of the data collected. Despite being urged to “Be as descriptive as possible by describing the setting, including direct quotations of dialogue as well as your personal thoughts and feelings”, participants on average described their ethical issue in 149 words (range 26 – 491).

Work related ethical situations. Ethicists do experience work related ethical situations and are able to recognize this occurrence. However, these ethicists did not describe the ethical situation from their perspective, but rather the participants focused on how ethical situations were being experienced by/impacting the patient. The American Society for Bioethics and Humanities (ASBH, 2009, 2014) directs that the preferred process for clinical ethics consultation is the facilitation model, which aims to analyze the ethical uncertainties and gain consensus between the various stakeholders. It is unclear whether the clinical ethicist’s values and voice should ever be heard or included in the facilitation process since clinical ethicists are urged not to make substantive recommendations. Thus, the facilitation process may create a situation where the clinical ethicist personally experiences an ethical issue that goes unaddressed while in the midst of attempting to resolve an on-going clinical ethics consultation.

The survey was created based on the assumption that only clinical ethicists who had experienced a work related ethical issue would participate (as described in the invitation to participate). Thus, the researchers were surprised when four subjects completed the survey noting that they had never experienced a work related ethical issue. This assumption created a limitation in data collection since no demographic data were collected from these four ethicists, which ultimately limited the ability to make comparisons between clinical ethicists who did and did not experience a work related ethical situation.

The ethicist’s inability to recognize personally experiencing a work related ethical situation may be associated with the practice of describing ethical situations from the patient’s perspective. The possibility exists that these clinical ethicists had not experienced a work related ethical situation, because the ethicist felt educationally prepared for the consultation as well as perceived being supported by the organization (Aulisio et al., 2009). However, an ethicist’s inability to recognize him or herself as a key stakeholder during the ethical situation may create a decision-making environment where the ethicist does not feel empowered to intervene, such as when Ethicist #4 stated, “While I sat there with my mouth open, a member of the team cut him off.”

This inability to act may be related to lack of moral courage. Moral courage occurs when an individual “is committed to moral principles, cognizant of the actual or potential risk that upholding these principles may require, and willing to endure

the risk.” (LaSalla & Bjarnoson 2010, para 6). One might postulate that acting with moral courage may share many of the same attributes as being an advocate, which is an expectation of the clinical ethicist’s role. If a clinical ethicist does not perceive having the positional power to intervene, then the likelihood exists that the ethicist may experience lack of moral courage during complex ethical situations when consulting. Further research is needed to describe the level of personal and/or professional risk an ethicist may create and is willing to act upon when up-holding ethical commitments and/or challenging the ethical behavior of other members of the inter-disciplinary healthcare team during an ethics consultation. In addition, further study is needed regarding whether the use of the facilitation consultation model impacts the ethicist’s actions when involved in a personally experienced ethical situation.

Moral distress. When specifically asked, two of the ethicists identified that they had experienced moral distress during their work related ethical issue. However, neither of these ethicists initially identified their work as involving moral distress. Moral distress is a two-part phenomenon. Initially, the person experiences acute distress during the ethical situation when the individual recognizes the correct course of action but is prevented from carrying out this action. Following the situation, the person experiences moral residue related to “yielding one’s moral values without defending those values” (Epstein & Hamric, 2009, p. 332). Are clinical ethicists ignoring their own personal feelings and values when fulfilling their work related activities? Or did these ethicists in this study under-report their experiences of moral distress due to defining moral distress too narrowly (Weber, 2016)?

Ignoring or not recognizing one’s moral distress may create over time accumulated moral residue. If left unacknowledged, ethicists may experience an increase in moral distress during future personally experienced ethical situations (Epstein & Hamric 2009), which might result in role dissatisfaction. It is unknown whether including a question regarding moral distress in the survey-triggered feelings of moral residue in these two ethicists. Alternately, did the inclusion of a question on moral distress indirectly validate and/or provide permission for the ethicist to acknowledge repressed feelings of moral distress and residue? It is unclear from the ethical situations described in this study what actions, if any, these two ethicists took in response to experiencing moral distress during their work related duties. Further research is needed to describe how and when ethicists experience moral distress and the actions taken to address the subsequent moral residue. In addition, little is known about whether clinical ethicists experience professional burnout or fatigue as a consequence of repeated experiences with moral distress and/or unresolved ethical issues (Epstein & Hamric 2009; Whitehead et al., 2015).

Resources

When asked, “what resources do you believe are needed to assist you to resolve ethical situations in your clinical setting?” many of the responses centered on the theme of support, be it from an oversight committee, physicians, other ethicists or superiors in general. Ethicist #6 cited the desire for the authority to act as being crucial for the resolution of personally experienced ethical issues. This begs

the question of why this ethicist believed not already having the *authority to act*. The possibility exists that this perception is related to a poorly defined professional clinical role. Whether ethicists function solely as a consultant, or whether they should have a stronger role as an integral part of the decision-making team is an important distinction. At issue is whether or not the ethicist perceives having the power to stop an ethically inappropriate situation from progressing. Without this power, ethicists, such as Ethicist #6, may experience more frequent personal ethical dilemmas in the workplace. Though it is not explicitly mentioned, it is also possible that the desire for the authority to act stems from a lack of moral courage in the face of political pressure or possible reprisal. This is plausible as the participant also cited the desire for support from leadership and physicians as being a desired resource.

Ethicists #1 and #8 both noted the same desire for a *network of ethicists*, either internal or external to their organization. It is not clear how this network should be organized. A multitude of options exist, though the end remains the same: the fulfillment of the need for the ethicist to consult with peers to resolve a situation that is personally ethically distressful. One can imagine that such networks could take the form of blogs, hotlines, weekly meetings/workgroups or the practice of consulting in teams rather than individually. However, the subjects did not expound upon in what form peer support should be available. In addition, little is known about the usefulness of any of these support networks in helping to relieve a personally experienced ethical dilemma in the work place. Intuitively, networks with more immediate and/or personal interactions may have the most impact. For example, if an ethicist chooses to write a blog post about a personally experienced ethical issue in the workplace, and seeks advice from professional colleagues from all over the globe, support could come in minutes, or it could come in hours, days, or perhaps even longer. However, this method raises serious concerns about patient confidentiality as potentially protected information could inadvertently be disseminated on the Internet. On the other hand, the practice of consulting in pairs or having a specific ethics mentor would allow for immediate feedback and support from a colleague.

Ethicists #1, #2 and #12 cited the need for sufficient support and supervision, such as from the Institutional Ethics Committee (IEC), which ties back into the previously discussed ideas of the authority to act through the assignment of a defined role, as well as having adequate support from leadership. The existence of an ethics committee was perceived as an integral part of validating the clinical ethicist's authority to act and may provide a mechanism for addressing the barriers impeding the ethicist's ability to act during situations involving moral distress. An IEC's recommendations may be perceived as holding more power and/or individual members of the IEC may also possess additional organizational power through their primary roles. Thus, the ethicist's desire for increased support from the organization's leadership may also be helpful in promoting the ethicist's moral courage to act when personally experiencing a work related ethical issue.

Future Research/ Recommendations

Further research is warranted related to both the topic and research design. First, little is known about the effectiveness of anonymous electronic surveys as a data collection methodology. Does the promise of anonymity actually promote subject participation in studies concerning potentially sensitive topics, such as ethical decision-making? Would subjects in studies concerning potentially sensitive topics volunteer to break anonymity and provide their email address to allow follow up dialogue (either verbally or electronically) with the researcher? Do subjects provide richer descriptions during in-person interviews vs. electronic surveys using the same questions? Ultimately, researchers must determine whether the ease and cost effectiveness of using electronic surveys does in fact outweigh any potential loss in data richness.

Further research is needed to more clearly describe the defined roles and responsibilities clinical ethicists have within the healthcare organization. For example, when does the ethicist have the power to intervene and effect change despite the objections or lack of agreement by other key health care providers? In addition, do persons without specialized ethics education serving on an institutional ethics committee perceive different ethical situations while fulfilling their ethical responsibilities than consultants with formal ethics education?

If all ethical issues do in fact involve a communication breakdown (Bosek, 2002) would an educational strategy focused on communication minimize the clinical ethicist's perception of an ethical issue when fulfilling the clinical ethicist role? In addition, would the use of role-play or simulation provide the clinical ethicists with the opportunity to test out moments of moral courage that could then be replicated in the clinical setting?

Finally, what is the impact of professional social networks, such as blogs, hotlines or support groups, on a clinical ethicist's ethical deliberation, recommendations and actions during a personally experienced work related ethical issue or a challenging ethical consultation? Does the ethicists educational background, experience and/or age impact the resources sought out and/or used to help resolve personally experienced ethical situations when carrying out their professional responsibilities?

Conclusion

Clinical ethicists do perceive personally experiencing work related ethical situations. However, when asked to label the ethical issue, these ethicists consistently framed the ethical situation from the patient's perspective rather than from the ethicist's perspective. Most of these ethicists expressed a desire for more support for their role and authority to act. If ethicists feel more supported, this may translate into fewer personally experienced ethical situations in the work place. Unexpectedly, some clinical ethicists denied ever experiencing personal ethical situations when performing their professional duties. Future research is needed to better understand what influences some ethicists to personally experience an ethical situations when fulfilling their work related duties.

References

- Adams, D. M. (2011). The role of the clinical ethics consultant in "unsettled" cases. *The Journal of Clinical Ethics*, 22(4):328-334.
- American Society of Bioethics and Humanities. *Academic programs*. (nd). Accessed June 19, 2017. <http://asbh.org/professional-development/academic-programs>.
- American Society of Bioethics and Humanities. 2011. *Core competencies for health care ethics consultation*, 2nd ed. Glenview IL: Author.
- American Society of Bioethics and Humanities. (2014). *Code of ethics and professional responsibilities for healthcare ethics consultation*. Accessed June 19, 2017. <http://asbh.org/uploads/publications/ASBH%20Code%20of%20Ethics.pdf>.
- Association of Bioethics Program Directors. (2008). *Assessing the accomplishments of bioethics and medical humanities faculty members being considered for promotion or tenure in academic health centers*. Accessed June 19, 2017. <http://asbh.org/uploads/publications/Guidelines for Tenure and Promotion.pdf>
- Aulisio, M. P., Moore, J., Blanchard, M., Bailey, M., & Smith, D. (2009). Clinical ethics consultation and ethics integration in an urban public hospital. *Cambridge Quarterly of Healthcare Ethics*. 18:371-383.
- Bishop, J. P., Fanning, J. B., & Bliton, M. J. (2009). Of goals and goods and floundering about: A dissensus report on clinical ethics consultation" *HEC Forum*, 21(3):275-291. doi:10.1007/s10730-009-9101-1.
- Bosek, M. S. D. (2002). Effective communication skills: The key to preventing and resolving ethical situations. *JONA'S Healthcare Law, Ethics, & Regulation*, 4(4):93-97.
- Dreyfus, S. E., & Dryfus, H. L. (1980). A five-stage model of the mental activities involved in directed skill acquisition. Last modified May 1980." Accessed June 19, 2017. <http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA084551&Location=U2&doc=GetTRDoc.pdf>.
- Epstein, E. G., & Hamric. A. B. (2009). Moral distress, moral residue, and the crescendo effect. *The Journal of Clinical Ethics*, 20(4):330-342.
- Ford, P. J., & Dudzinski, D. M. eds. (2008). *Complex ethics consultations: Cases that haunt us*. Cambridge, UK: Cambridge University Press.
- Joint Commission on Accreditation of Health Care Organizations. (1992). *Accreditation manual for hospitals*. Oak Brook Terrace, IL: Author.
- LaPuma, J., & Shiedermayer, D. L. (1991). Ethics consultation: Skills, roles and training." *Annals of Internal Medicine*, 114:155-160.
- LaSalla, C. A., & Bjarnoson, D. (2010). Creating workplace environments that support moral courage." *Online Journal of Issues in Nursing*, 15(3):1. doi: 10.3912/OJIN.Vol15No03Man04
- Monagle, J. F., & West, M. P. (2009). Hospital ethics committees: Roles, memberships, structure, and difficulties. In E. E. Morrison (Ed.). *Health care ethics: Critical issues for the 21st century* (pp. 251-266). Sudbury, MA: Jones and Bartlett Publishers.

- Parse, R. R., Coyne, A. B., & Smith, M. J. (1985). *Nursing research: Qualitative methods*. Bowie, MD: Brady Communication Company.
- Pfafflin, M., Kobert, K., & Reiter-Thei, S. (2009). Evaluating clinical ethics consultation: A European perspective. *Cambridge Quarterly of Healthcare Ethics*, 18:406-419.
- REDCap™ (2016). Software. Accessed June 19, 2017. <http://www.project-redcap.org/>.
- Richter, G. (2009). Clinical ethics as liaison service: Concepts and experiences in collaboration with operative medicine." *Cambridge Quarterly of Healthcare Ethics*, 18:360-370.
- Russell, A. C. (2012). Moral distress in neuroscience nursing: An evolutionary concept analysis. *Journal of Neuroscience Nursing*, 44(1):15-26. doi: 10.1097/JNN.0b013e31823ae4cb.
- Truog, R. D., Brown, S. D., Browning, D., Hundert, E. M., Rider, E. A., Bell, S. K., & Meyer, E. C. (2015). Microethics: The ethics of everyday clinical practice." *The Hasting Center Report*, 45(1):11-17. doi: 10.1002/hast413
- University of Washington School of Medicine. (2013). *Ethics committees, programs and consultation*. Accessed June 19, 2017. <http://depts.washington.edu/bioethx/topics/ethics.html>
- Weber, E. (2016). Moral distress, workplace health, and intrinsic harm. *Bioethics*, 30(4):244-250. doi 10.1111/bioe.12181.
- Whitehead, P. B., Herbertson, R. K., Hamric, A. B., Epstein, E. G., & Fisher, J. M. (2015). Moral distress among healthcare professionals: Report of an institution-wide survey. *Journal of Nursing Scholarship*, 47(2):117-125. doi 10.1111/jnu.12115

Figure 1: Survey

1. Please describe an ethical situation you personally experienced in your role as a clinical ethicist. Be as descriptive as possible by describing the setting, including direct quotations of dialogue as well as your personal thoughts and feelings.
2. What word or phrase would you use to label the ethical situation you described in question 1?
3. What was the most important outcome to you during this ethical situation?
4. Do you believe that you knew the correct/right action to take to resolve this ethical situation, but were prevented to implement this correct/right action?
YES NO
Please explain.
5. Do you feel that the ethical situation you described was resolved satisfactorily?
YES NO
Please describe why or why not.
6. What resources do you believe are needed to assist you to resolve ethical situations in your clinical setting?
7. Has the ethical situation you described influenced how you carry out your current clinical ethicist role?
YES NO
Please explain.
8. On which continent do you provide ethics consultation?
 - a) North America
 - b) South America
 - c) Europe
 - d) Asia
 - e) Africa
 - f) Australia

9. Describe the setting where you provide ethics consultation
 - a) Urban
 - b) Suburban
 - c) Rural
 - d) Other, please describe.
10. Which of the following best describes the institution where you provide ethics consultation?
 - a) Academic medical center
 - b) Community hospital
 - c) Multi-setting corporation
 - d) Other, please describe.
11. Which of the following best describes the ethics service in which you work?
 - a) Solo consultant
 - b) Part of an ethics consultation team
 - c) Member of an ethics committee
12. Approximately how many ethics consultations do you provide in a calendar year?
 - a) Less than one a month (0- 11)
 - b) 12-24
 - c) More than 24
13. What type of preparation did you have to qualify/prepare you for your clinical ethicist position?
 - a) Doctoral degree in ethics
 - b) Masters degree in ethics
 - c) Certificate in bioethics
 - d) Continuing education course work in ethics
 - e) On the job training or mentoring
 - f) Hold a degree as a healthcare professional (MD, RN, SW, etc.)

14. Which of the following best describes your experience as a clinical ethicist?
- a) Less than one year
 - b) 1-5 years
 - c) 6-10 years
 - d) 10-20 years
 - e) More than 20 years
15. Do you have a mentor or colleague that you feel comfortable contacting for assistance when you are personally experiencing an ethical situation?
- a) Yes
 - b) No
16. What level of skill-acquisition do you believe you have related to your role as a clinical ethicist?
- A) Beginner
 - B) Advanced beginner
 - C) Competent
 - D) Proficient
 - E) Expert
17. How frequently do you believe that you have personally experienced an ethical situation while fulfilling your role and duties as a clinical ethicist?
- A) Only once
 - B) Once a year or less
 - C) Once a month
 - D) Once a week
 - E) Daily
18. What is your gender?
- a) Male
 - b) Female
 - c) Transgendered
19. What is your age?
- a) Under 30 years of age
 - b) 30 - 44 years of age
 - c) 45 – 59 years of age
 - d) 60 years of age or older

Table 1: Participant Preparation for Ethics Consultant Role

Ethicist	Ethics Education (PhD, MA &/or Certificate)	Continuing Education	On the Job Training	Health Care Professional
1	X	X	X	X
2		X	X	X
3	X	X		X
4			X	X
5	X		X	
6	X	X	X	
7				
8	X			
9				X
10	X			
11	X		X	X
12				X

Table 2: Participant Experience as a Clinical Ethicist

Ethicist	Years of Clinical Ethicist Experience	Ethics Consults Provided Per Year	Perceived Skill Acquisition
1	10-20	0-11	
2	10-20	>24	
3	<1	0-11	
4	1-5	0-11	
5	6-10		Expert
6	10-20	>24	Proficient
7	6-10	>24	Advanced beginner
8	10-20	>24	Expert
9	10-20	>24	Proficient
10	6-10		Expert
11	1-5	>24	Expert
12	1-5	0-11	Advanced beginner

Table 3: Ethical Term Used to Describe the Ethical Situation

Ethicist	Ethical Term (self-described)	Ethical Term (researcher)
1	Partiality in judgment	Lack of objectivity
2	Deception, coercion, authority gradient (Moral distress?)	Lack of moral courage
3	Paternalism	Best interest of patient
4	Patient privacy	Confidentiality
6	Ethical conundrums and paradigm paradoxes (Moral distress?)	Complexity of decision making
8	Personal integrity lapse	Lack of objectivity and professional integrity
11	Quality management	Moral distress
12	Dual role	Professional integrity

Table 4: Additional Resources Desired to During Personally Experienced Ethical Situations in the Workplace

Resource Desired	Number of Ethicists
Authority to Act	1 (12.5%)
Network of Ethicists	2 (25%)
Institutional Oversight/Ethics Committee	2 (25%)
Open Decision Making Culture	1 (12.5%)
Support from Leadership	2 (25%)