Clinical Ethics as Liaison Service: Concepts and Experiences in Collaboration with Operative Medicine

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Introduction

Over the past decade, clinical ethics has received growing attention in Germany as in most European countries. In the mid-1990s, most European countries made efforts to establish healthcare ethics committees (HEC) and clinical ethics consultation (CEC) services. The development of clinical ethics discourse and activities in Germany, however, was delayed and, consequently, is still in its natal phase. Until the end of the 1990s, the only institutionalized bodies of ethical reflection were the research ethics committees at university medical centers and at the State Physician Chambers. In March 1997, the Catholic and Protestant hospital association in Germany recommended the implementation of HECs, modeled after the American HECs. Consequently, the establishment of clinical ethics consultation in the form of HECs started in Germany in denominational hospitals, followed by a small but increasing number of community hospitals. Although university hospitals are still reluctant to create HECs[1] due to the hierarchical structure of the German medical system, a scientific initiative to foster ethics consultation was started in October 1998 by Stella Reiter-Theil from the University of Freiburg.[2] At present, one-third of the university medical centers have established a HEC, and few have an institutionalized ethics consultation service.

Due to the rigid German medical system and the strong, physician-driven hierarchy in German medical decisionmaking, the establishment and institutionalization of clinical ethics in practice has a number of prejudices and fears to overcome. Expressions like ''ethics consultant,'' ''ethical/moral knowledge and expertise,'' or ''clinical ethics committee'' may often be misunderstood by physicians and patients as representing an erosion of professional autonomy and a further bureaucratization of the physician–patient relationship. For example, one may imagine ethics consultants or committees to be individuals or groups with legal immunity and anonymity and the authorization to dole out binding judgments, or a supervisory sort of body, or even an individual or group with special moral knowledge or virtue.[3] In this regard, newly established HECs report a lack of requests for ethics consultations and affirm that the distance between clinical staff and HECs is very difficult to bridge. Therefore, one approach to overcome these types of issues is to develop an ethics liaison service similar to the one that is functioning successfully at the Marburg University Medical Center.[4]

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The ethics liaison service is designed to enable and empower physicians and other clinicians/healthcare professionals to address ethical questions and problems as they arise in the course of individual patient care without formal ethics consultation. The possibility, advantages, and disadvantages of implementing such an approach for clinical ethics in the German healthcare context are described in the following section.

Concepts of and Approaches to Clinical Ethics Consultation

The physician–patient relationship in the German healthcare system is changing dramatically under the influence of three factors: growing recognition of the rights of individuals in medical decisionmaking, value heterogeneity, and the increasing complexity of decisionmaking due to the technological development in all areas of medical care. These three factors create a greater necessity for physicians and other healthcare professionals to spend more time with patients and create a need for patients to be more actively involved in their healthcare, particularly in decisionmaking. These salient features are driving medical decisionmaking in Germany from a traditional paternalistic approach to a democratic, shared decisionmaking process.

Because of these changes in the clinical setting, the awareness of clinical ethics is growing, and the need for ethics consultation is being increasingly recognized. Some German physicians consider the introduction of democratic decisionmaking structures a threat to physician authority and power.[5] They compare ethics consultation as an acting moral ''police'' that will erode the decisionmaking authority of physicians. On the other hand, there is some concern that an increasing utilization of ethics consultation may put ethics at the periphery of clinical practice, something that had best be left to experts. Clinical ethics in general and ethics case consultation in particular must pay attention to these fears and introduce concepts and procedures that are compatible with the German healthcare context.

If complexity of technology-driven modern healthcare, value heterogeneity, individual rights, and the implications of a changing physician–patient relationship create a need for clinical ethics, we need to carefully set up and define the goals of clinical ethics and ethics consultation. In setting up an ethics case consultation service, it should be clear that ethically and legally informed clinicians—especially physicians and nurses—are the key moral problem solvers in patient care. Four elements characterize the role of ethics case consultation and vary in constancy from case to case: moral diagnostician (always), educator (always), mediator (when needed), and bridge to authority (when indicated).

Ethics consultation is a service provided by an individual consultant, team, or committee to address the ethical issues involved in a specific clinical case. The goals of clinical ethics and ethics consultation can be described as follows[6]:

- to maximize benefit and minimize harm to patients, families, and healthcare professionals and institutions by fostering a fair and inclusive decisionmaking process that honors patient/proxy preferences and individual and cultural value differences among all parties of the consultation (educator, mediator);
- to increase shared decisionmaking in the resolution of ethical problems in individual patient care (educator, mediator);

- to facilitate resolution of conflicts in a respectful atmosphere with attention to the interests, rights, and responsibilities of those involved (educator, mediator);
- to prevent poor outcome of cases involving ethical problems (mediator, educator);
- to increase knowledge of self and others (mediator, educator);
- to inform institutional efforts at quality improvement, appropriate resource utilization, and policy development by identifying the causes of ethical problems, and to promote practices consistent with the highest ethical norms and standards—organizational ethics (bridge to authority); and
- to assist individuals in handling current and future ethical problems by providing education in healthcare ethics, that is, to increase knowledge of clinical ethics (educator).

In light of these goals, a clinical ethics program has to cover the following areas:

- *education*, by providing instruction in clinical ethics for clinicians, patients, surrogates, and the larger community,
- *policy development*, by conducting policy studies and making recommendations for institutional and community guidelines that may address various ethical issues, for example, DNR orders, forgoing life-sustaining treatment, surrogate decisionmaking, advance directives, brain death determination, and
- *ethics consultation*, by providing a process for case consultation at the bedside or conference room.

Clinical ethics case consultation needs to be woven into a clinical ethics program and should not be separated from the other tasks. Ethics consultation can be successful only by carrying out each of these three different objectives (Figure 1). From this point of view the top priority for clinical ethics programs is not ethics

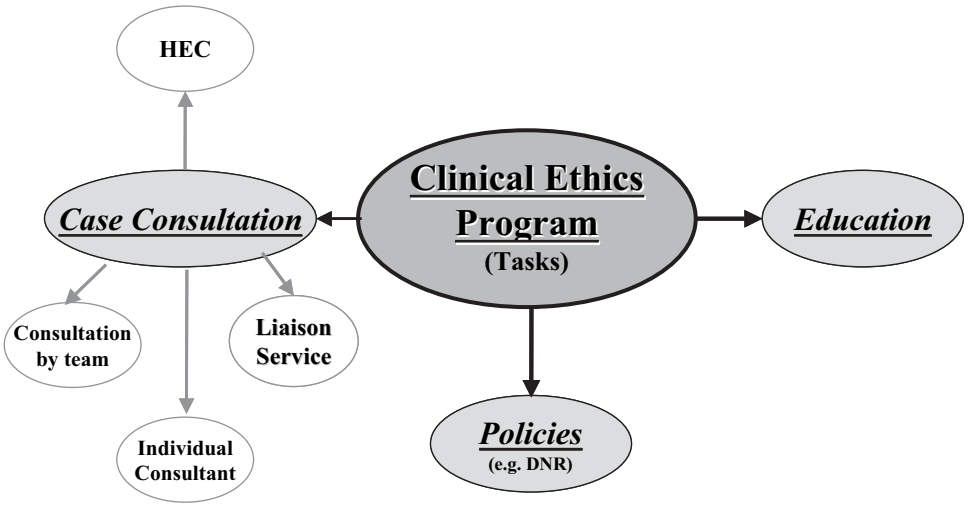

Figure 1. Diagram of a clinical ethics program with different approaches to clinical ethics case consultation.

case consultation in itself; it is education for clinicians to broaden their ethical perspectives and practice skills in participating in a shared decisionmaking process and working through ethical problems. This is so because clinicians are the primary moral problem solvers in patient care, a role that has to be respected by ethics consultation. By affirming the priority of education and the primary role of clinicians as moral problem solvers, the impression that the standard for resolving ethical problems in patient care is ethics case consultation can be avoided. If ethics case consultation were to be the standard of care, clinicians would be obliged to request it for each identifiable ethical problem. Such a practice would displace clinicians as primary moral problem solvers and result in disaster.

Therefore, the approach of clinical ethics case consultation should be pragmatic and problem centered, as well as striving to enable and empower clinicians to deal appropriately with ethical problems. As a method of moral problem solving, such a "clinical pragmatism" was introduced by Fins, Bacchetta, Fletcher, and Miller in 1996.[7] Drawing upon theories of John Dewey, clinical pragmatism is an applied philosophical methodology for the clinical setting. This method, designed to be useful for practitioners, integrates guidance of judgment with guidance of process. Clinical pragmatism seeks to integrate clinical and ethical decisionmaking by focusing on inductive moral reasoning and the development of moral consensus. It is a method for assessing the relevant facts, diagnosing the moral problems, considering the options, setting goals and negotiating a decision for an acceptable plan of action, and evaluating the results. It is meant to guide the ethical assessment process with the goal of reaching an ethically acceptable consensus, but it does not guarantee the "right" decision. In approaching moral problems, the method of clinical pragmatism seeks solutions that are workable in real contexts of clinical settings in which clinicians and patients interact. Clinical pragmatism treats moral rules and principles as hypothetical guides that identify a range of reasonable moral choices for the deliberations of patients, families, and clinicians. Through a thorough process of inquiry, discussion, negotiation, and reflective evaluation, clinical pragmatism aims to reach consensus about good outcomes in those cases that pose moral problems. Such a pragmatic perspective on clinical ethics is able to integrate, on a theoretical level, different ethical viewpoints that share some common ground: (1) an ethics of principles, (2) casuistry (case-based ethics), and (3) an ethics of care.[8]

In achieving the goals of clinical ethics case consultation, the American Society of Bioethics and Humanities (ASBH) produced a report on core competencies for healthcare ethics consultation in which it described three different approaches to ethics consultation.[9] The report distinguishes two rather extreme approaches, the "authoritarian approach" and the "pure facilitation approach," and develops an alternative one, "ethics facilitation," that aims to overcome the inadequacies of the two others in reaching the expected goals of ethics case consultation.

The *authoritarian approach* to ethics consultation is defined by "the emphasis on consultants as the primary moral decision makers at the expense of the appropriate moral decision makers."[10] The ASBH report characterizes the authoritarian approach in terms of outcome and process. Outcome authoritarianism emerges when ethics consultants take over the role of moral experts, whereas in process authoritarianism consultants fail to include all relevant decisionmakers in the decisionmaking process. The authoritarian approach contradicts clinical practice, whereby clinicians are—and should be—the key moral problem solvers, because

they, and not a consultant, are primarily in charge of their patients. The authoritarian approach is very similar to the traditional medical consultation model in the sense of undertaking an independent investigation and issuing a recommendation. In this process, it fails to achieve the goals of ethics consultation as characterized previously.

The *pure facilitation approach* is characterized by the single goal of forging consensus among involved parties. In merely facilitating consensus, ethics consultants risk forging a consensus that falls outside acceptable ethical boundaries by failing to clarify the implications of individual, institutional, societal, and legal values in a given case. Consensus by itself is not a justifiable ethical solution to a clinical ethical dilemma.

The *ethics facilitation approach* is described by the ASBH report as most appropriate for healthcare ethics consultation in contemporary society, and is defined as follows:

> The ethics facilitation approach is informed by the context in which ethics consultation is provided. It involves two core features: identifying and analyzing the nature of the value uncertainty and facilitating the building of consensus. To identify and analyze the nature of the value uncertainty or conflict underlying the consultation, the ethics consultant must: (1) gather information, . . . (2) clarify relevant concepts, . . . (3) clarify related normative issues, . . . and (4) help to identify a range of morally acceptable options within the context. Healthcare ethics consultants also should help to address the value uncertainty or conflict by facilitating the building of consensus among involved parties. This requires them to (1) ensure involved parties have their voices heard, (2) assist involved individuals in clarifying their own values, (3) help facilitate the building of morally acceptable shared commitments or understandings within the context. In contrast to the two other approaches, the ethics facilitation approach recognizes the boundaries of morally acceptable solutions normally set by the context in which ethics consultation is done. In contrast to the authoritarian approach, ethics facilitation emphasizes an inclusive consensus-building process. It respects the rights of individuals to live by their own moral values. In contrast to the pure facilitation approach, ethics facilitation recognizes that societal values, law, and institutional policy . . . have implications for a morally acceptable consensus. The ethics facilitation approach is fundamentally consistent with the rights of individuals . . . and the fact of pluralism.[11]

Therefore, the irreducible *contextual* dimension is the key feature of clinical ethics consultation, and any approach and methodology of clinical ethics must be sensitive and responsive to it. Context-sensitive, moral reasoning is the challenge that every clinical ethicist must meet.

Clinical ethics case consultation can be provided in several ways: by an ethics consultative group as a whole (such as a HEC), by a subgroup of a consultative group, or by individual consultants (Figure 1). Starting with an official request by the healthcare professionals or the patient, surrogate, or family, the ethics consultation service will be called into an actual patient case that presents difficult and unresolved ethical problems. All of these different settings of clinical ethics case consultation have advantages and disadvantages but share the feature of acting on an ethical dilemma in a concrete case of patient care.[12]

Clinical ethics consultation by a HEC is the approach recommended by the German Catholic and Protestant hospital association and constitutes, at present, the main approach in German clinical ethics case consultation. Ethics consultation by a large group (HEC) has the potential of having diffused accountability and being depersonalized, bureaucratic, insensitive, inflexible, close-ended, time limited, and removed from the clinical setting. An additional hurdle to this approach is the distance between healthcare professionals and the HEC. Therefore, to call for an official ethics consult amounts to a big step that is recognized as an extraordinary and bureaucratic action. It does have, however, the advantage of providing multiple perspectives and opportunities for queries from persons of diverse backgrounds and for correcting the potential narrow or idiosyncratic views of individual consultants.

Clinical ethics case consultation by an individual consultant is much more flexible in terms of scheduling interviews with healthcare professionals, patients, and families to explore and clarify the ethical issues at stake. It permits an open-ended process that is flexible to extend over a period of time and to allow for ongoing discussion and pursuit of issues that require clarification. Furthermore, an individual ethics consultant is more visible and accountable than a committee. In contrast to the whole committee approach, the individual consultant approach lacks the multiple perspectives afforded by diverse professional backgrounds and, therefore, risks leading the discussion in actual patient-care decisionmaking as an individual expert comparable to the traditional medical consultant model.

An approach to clinical ethics consultation that combines the advantages and avoids the disadvantages of the committee and individual consultant approaches is the creation of small consultation teams that serve as an extension of the HEC. This method is used at many places in the United States as well as in Germany (University Medical Center Erlangen).[13]

An additional option for ethics case consultation is the *ethics liaison service*, in which the clinical ethicist belongs to the team of a unit (e.g., intensive care unit [ICU]) or department and is not called in on particular cases for ethics consultation. Ethics liaison services are rare and not reported in detail in bioethics literature. At the Cleveland Clinic, Ohio, a Critical Care Ethics Liaison Program was established as one part of the ethics consultation service in the late 1990s,[14] although rounding with physicians on ICUs was a tradition by the former chair of the bioethics department at this particular institution.

The incorporation of the ethics facilitation approach within the method of clinical pragmatism endows the regular and frequent presence of the clinical ethicist with some advantages in comparison to the on-call ethicist or HEC. Thus, the liaison ethicist is able to do the following:

- to be present frequently and on a regular basis on the floor during daily work,
- to anticipate ethical issues—discussion of cases and actions on rounds, personal discussions or staff meetings before an ethical problem occurs as a dilemma or crisis (preventive ethics),
- to provide a speedy response to any ethical concerns raised by staff, patients, families, or surrogates,
- to provide assistance and support for staff and patients (in choosing a surrogate decisionmaker, obtaining legal guardianship, arranging staff–family

or surrogate meetings, mediating conflicts between care givers and patients, families, or surrogates, and withdrawing life sustaining treatment),
- to provide relevant and accurate information as an information resource on ethical and legal issues whenever it is needed (DNR order, life-forgoing treatment, living wills and advance directives, and patients rights),
- to enable and empower physicians and other clinicians to deal appropriately with ethical issues by themselves through informal teaching during rounds and staff conferences,
- to reduce bureaucracy by addressing ethical questions and problems as they arise in the course of patient care without the necessity of formal ethics consultation,
- to lower hierarchy (e.g., in mediating intrastaff conflicts when disagreement within the therapeutic team arises about an individual patient's care), and
- to increase attention for clinical ethics within the hospital with a chance that clinical ethics case consultation will spread to other clinical departments and services.

To underscore the importance of these features of an ethics liaison service it must be said that this concept has clearly many advantages compared to other approaches. A main advantage is the fact that, with a clinical ethicist regularly on hand, sensitivity to the ethical dimension of clinical practice can be increased in all involved healthcare professionals. This might entail greater and faster recognition of ethical problems arising in the course of patient care. With a clinical ethicist on the team, questions about ethical issues can be asked and ethical problems can be discussed beforehand to prevent ethical crises or dilemmas. Such a preventive approach is clearly more effective than a crisis-management approach to recurrent ethical problems.

Our experience with hundreds of ethics case consultations and teaching clinical ethics consultation in a German curriculum points to the fact that most clinicians prefer a nonformal, lower bureaucratic approach to dealing with clinical as well as ethical problems. They prefer an individual clinical ethicist whom they know and trust over a committee approach. It can be supposed that an ethics liaison service is the most successful one in reaching the priority goal of ethics consultation, that is, in educating clinicians in clinical ethics. Such an approach makes access to clinical ethics much easier than using official and formal ethics consultation requests or continuing medical education. Learning clinical ethics in daily routine within a respected and trusted relationship, clinicians can overcome their notoriously bad habit of collapsing ethical problems into medical or legal problems. They can listen to each other, including the clinical ethicist, and deliberate about ethical issues in a nondefensive way.

The familiarity and good relationship with the clinical ethicist as a team member can also create some difficulties or disadvantages to ethics consultation. By being too attached to individuals or, even worse, to a subgroup of the team (e.g., physicians *or* nurses), the clinical ethicist might lose objectivity and not be able to foster a fair and inclusive decisionmaking process. Impartiality is a moral demand for all clinical ethicists conducting case consultation but is more of a daily challenge for a liaison ethicist.

The ethics liaison service is much more time-consuming for the clinical ethicist than ethics consultation on request; thus it may be more suitable for smaller organizational units in a hospital where ethical problems arise recurrently in the

course of patients care (as in ICUs). To include a (critical care) ethics liaison service into a broader ethics consultation program, as is done at the Cleveland Clinic, may have the above mentioned advantages and can be viewed as progress in the development of clinical ethics.

Clinical Ethics Liaison Service at the Marburg University Surgery Department

Marburg University Medical Center is a public 1,255-bed tertiary hospital with 28 clinical departments affiliated with the Philipps University School of Medicine. Intensive care units exist in the departments of internal medicine, pulmonology, cardiology, anesthesiology, pediatrics and neonatology, urology, heart surgery, and surgery. The surgical intensive care unit (SICU) has 12 beds and belongs to the department of trauma and reconstructive surgery and to the department of visceral-, thoracic-, and vascular surgery.

An ethics consultation service at the SICU was established in 1998.[15] Before starting the ethics consultation service at the SICU, the clinical ethicist analyzed the need; negotiated with the chairman of the surgery department; introduced the concept and goals of clinical ethics; and clarified the setting by interviewing the senior physician, residents, and nurses, and giving one grand round on clinical ethics consultation. As the concept of an ethics liaison service was explained to physicians, nurses, and other clinicians of the SICU, it became clear that the start of such a service would be an experiment and an ongoing learning experience and process. An advantage in the creation of the ethics liaison service was the fact that it was introduced as a combined bottom-up/top-down approach, that is, at the request of attendants, residents, and nurses and after negotiation and approval by the chair. After clarifying the setting, the clinical ethicist joined the team and became a member of the SICU. During the first period (1998–2003), the liaison service was provided by an individual consultant, a physician–ethicist with a background in internal medicine, gastroenterology, and philosophy and ethics. In 2004, a medical sociologist with a background in medicine, sociology, and ethics was invited to join the team.

The ethics facilitation approach based on the method of clinical pragmatism was adopted by the clinical ethicist. The physicians on the unit were relieved by the fact that the clinical ethicist did not function as a moral decisionmaker, and they learned to participate in a shared decisionmaking process with patients, families, and proxy and nurses. It was clear from the beginning that clinicians had to learn that clinical ethics consultation was indeed different from medical consultation. In the beginning of the ethics liaison service, the clinical ethicist was asked explicitly to give recommendations and advice and to make decisions. It was important to clarify the concept of ethics facilitation to the clinicians repeatedly, so that the role of the clinical ethicist as educator and mediator became clear during the first year of service.

The clinical ethicist meets with staff regularly once a week to go on rounds when the residents change shifts and during staff conferences. The ethicist accompanies rounds with the attendant, residents, medical students, and nurses and offers them a chance to ask questions where ethical problems might be at issue. During rounding with physicians, medical students, and nurses it became clear that the contextual dimension of clinical ethics consultation was the most important point during these rounds. The broadening of the perspectives of patients was very much

appreciated by the staff. Most questions that arose involved acceptance of advance directives, withdrawing life-sustaining therapy, writing a DNR order, choosing a surrogate decisionmaker, obtaining legal guardianship, and determining how to resolve a disagreement about a patient's care within the therapeutic team.

During a 5-year period (2000–2004), 595 cases were discussed in ethical terms on rounds with the clinical ethicist (Table 1). The majority of these cases are very familiar to any clinical ethicist. An exception to these ordinary clinical ethical issues are ethical problems originating in difficulties in prognostication (151 cases). This point is not reported as a frequent clinical ethical issue in bioethics literature. In his book *Death Foretold: Prophecy and Prognosis in Medical Care*,[16] Christakis demonstrates how difficult prognostication is and how important it is to a sound, clinical decisionmaking process. Prognosis is a fundamental, though implicit, basis for many theoretical and practical ethical decisions in medical care, and prognostic uncertainty may considerably complicate such decisions. Prognostication and death are tightly interwoven and profoundly affect decisions to initiate, withhold, or terminate life support for critically ill patients, especially in a SICU. Therefore, prognosis is a key element in the shared decisionmaking process, especially with respect to end-of-life care and the avoidance of disrespectful overtreatment. A prognosis can radically reshape the physician's and the patient's therapeutic management of a condition, resulting, for example, in a shift from a curative to a palliative approach to care.

Prognosis is also a feature of the concept of futility. This means that it is because of a prognosis that one can assess not only that the patient is unlikely to recover spontaneously, but also that the intervention will likely be ineffective. Predicting risks and benefits for patients in the presence of uncertainty is technically difficult and emotionally frightening for all physicians. Substantial uncertainty leads to one of two extremes in the formulation of prognoses (pessimism or optimism) and one of two extremes in therapeutic decisionmaking (aggressiveness or passivity). Any of these directions can harm patients. When prognostication in the course of patient care is unavoidable, physicians cope with difficulties in a number of ways, including recourse to certain cognitive biases, magical ideas, and very often a ritualistic

Table 1. Ethics Liaison Service Cases at the SICU of the Marburg University Surgery Department (2000–2004)

Withdrawing of life support	
Respirator therapy	9
Dialysis	15
Catecholamines i.v.	51
Foregoing life sustaining treatment vs. additional operation	118
DNR order	46
DNR order in OR	1
Advance directives/living wills	103
Terminal sedation	4
Medical futility	56
Prognostication	151
Dealing with conflicts	
With patients, families, or surrogates	31
Interstaff conflicts	10

optimistic attitude. The attitude not to abandon patients therapeutically at the end of life often leads to a course of action that tends to avoid prognostication, which very often leads to disrespectful overtreatment. The avoidance of prognostication, as much as needlessly incorrect prognosis, will harm patients and contradicts ethical sound decisionmaking in medical care. The discussion of the course of critically ill patients in the SICU during ethics rounds must take very seriously the contextual dimension of an individual patient into consideration, including crucial prognostication to reach the goal of maximizing benefit and minimizing harm to patients, families, surrogates, and healthcare professionals alike.

Physicians, nurses, and other staff of the SICU not only accepted the ethics liaison service, but they highly appreciated the low bureaucratic, low hierarchic approach to ethics consultation and easy access to clinical ethics issues. Evidence of the preventive measure of an ethics liaison service was that only 14 of the 595 discussed cases reached the level of an official ethics consultation request during the reported 5-year period. Taking advantage of the above described characteristics of an ethics liaison service, the team of the SICU became much more self-confident in handling ethical issues in patient care.

In starting a clinical ethics consultation service with an ethics liaison service on the SICU, rather than a HEC approach to ethics consultation, we avoided the experiences of many HECs in Germany, which struggle in the beginning and have had only a small increase in requests for ethics consultations in patient care over the past years. In contrast, the local strategy in Marburg to start an ethics consultation program with an ethics liaison service was accepted and rapidly integrated into daily healthcare. The successful implementation of the ethics liaison service at the SICU was followed by an extension of this service to various other ICUs (anesthesiology, pulmonary critical care, internal medicine, and pediatric and neonatal), and was accompanied by an increasing number of formal ethics consultation requests from different departments of the Marburg University Medical Center. Taking the hierarchical structure of the German medical system into consideration and reflecting on the experience in Marburg, it must be said that the ethicist's capacity as a physician was initially advantageous, but that should not be a judgment in favor of physician ethicists versus ethicists with different professional backgrounds. Since we successfully introduced a medical sociologist as an additional ethics consultant, it has become clear that the medical community also accepts other professionals as clinical ethicists.

Notwithstanding the advantages of the ethics liaison service, there are also problems associated with this approach. Due to its liaison character documentation, reporting and supervision are especially problematic features. Ethics consultation, like all other medical consultations, should be documented in the patient's medical record. Good documentation requires an appropriate note in the medical record and a longer detailed account of the case suitable for evaluation and review.[17] The goals of documentation are (1) to inform all hospital staff caring for the patient of the issue and important details of the consultation, (2) to keep an accurate history of all phases of the patient's care, (3) to aid in education in clinical ethics and health law, and (4) to aid in quality assurance.[18] Although the ethics liaison consultant together with the physician and nurse in charge write notes in the patient's chart, documentation of the specifically ethics input is different from formal ethics consultation requests, because the process of ethics liaison service is informal and consists of bedside discussions without the framework

of formal consultation. Whereas for official ethics consultations in various institutions a record or documentation protocol form is used, it is difficult or awkward to do the same in an ethics liaison service due to the much more informal process. Because of the importance of the documentation for report, review, evaluation, and quality management, we are still in the process of developing an ethics consultation report system that is combined with the establishment of a HEC.

The combination of a HEC with an ethics liaison service whose members report to the HEC on a regular basis in order to discuss, review, and supervise decisions, as well as broaden both the perspectives of the individual ethics consultants and members of the HEC, seems to us to be the most promising approach to establishing a self-reflexive and pragmatic clinical ethics service in large hospitals with intensive care units.

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