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Scientific Contribution

Survey on the experience in ethical decision-making and attitude of Pleven University Hospital physicians towards ethics consultation

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Abstract. *Background* Contemporary medical practice is complicated by many dilemmas requiring ethical sensitivity and moral reasoning. *Objective* To investigate physicians' experience in ethical decision-making and their attitude towards ethics consultation. *Methods* In a cross-sectional survey 126 physicians representing the main clinics of Pleven University hospital were investigated by a self-administered questionnaire. The following variables were measured: occurrence, nature and ways of resolving ethical problems; physicians' attitudes towards ethics consultation; physicians' opinions on qualities and skills of an ethics consultant, and socio-demographic characteristics. Data analysis included descriptive statistics, χ^2 and t-test. *Results* Response rate was 88.9% ($n = 112$). Men and women were equally represented (48.2%–51.8%). The sample consisted of experienced physicians: 42.9% had 11–20 years experience, and 33% had 21–30 years. According to 84.8% of respondents, ethical problems have been discussed in their specialty. Predominant dilemmas included relationships with patients and relatives (76.8%) and team work (67.6%). Over ¾ of physicians needed an advice in solving ethical problems. Ninety six percent responded positively to ethics consultation. They would mainly request it for resolving conflicts (72.5%), and in case of concern for the rightness of their decisions (52.7%). The image of an ethics consultant was built of clinical competence (70.9%), ability to deal with conflicts (59.1%), communication skills (58.2%), tolerance for different views (55.4%), and a special qualification in ethics (52.7%). *Conclusions* The study underlined that Pleven University hospital physicians face similar ethical dilemmas as their colleagues in other countries do. The expressed positive attitudes to ethics consultation should serve as a basis for further research and development of ethics consultation services.

Key words: cross-sectional survey, ethical decision-making, ethical problems, ethics consultant, ethics consultation, physicians' attitudes, university hospital

Background

With the tremendous advances in medical technology, growing costs of health care, scarcity of resources, increasing public expectations and demands, and value transition, medical practice is complicated by many dilemmas that require not only clinical decision but ethical sensitivity and moral reasoning. Faced with complex moral questions, health care providers, patients, and families are increasingly turning to ethics consultants for assistance (Boitte, 1998).

Ethics consultation evolved out of the field of bioethics, which was itself largely a product of the 1970s. Formal ethics consultative services were first introduced in the early 1980s (Spike and Greenlaw, 2000; Yen and Schneiderman, 1999).

Ethics consultation can be done by specialized individuals or by an ethics committee; the ASBH (American Society of Bioethics and Humanities)

formulates two extremes of orientation: an authoritarian and a facilitation approach and criticizes both recommending an "ethics facilitation" approach. In *the authoritarian approach* consultants are the primary moral decision makers. In *the facilitation approach* ethicists just ensure that voices of all parties are heard, assist the involved individuals in clarifying their own values, and facilitate the building of morally acceptable shared commitments or understanding within the context, but do not especially help to find ethically justified solutions (Ausilio et al., 2000; Hoffman et al., 2000). A systematic change of perspectives is suggested by Reiter-Theil (2000, 2003) as a valuable approach to integrate different views of the problem combined with the reflection of ethical principles that give orientation.

The goal of ethics consultations is to improve the quality of patient care by identifying, analyzing, and attempting to resolve the ethical problems that arise in the practice of clinical medicine (Yen and Schneiderman, 1999). The problems that have led to ethics consultation requests according to DuVal et al. (2001) are: end-of-life issues (futility, withdrawal of life-sustaining treatment, etc); patient autonomy; conflict between or among involved persons; genetics; abortion; substance abuse; religious and cultural issues; professional conduct; truth-telling and confidentiality; justice issues; and beneficence.

In a later study DuVal et al. (2004) define the occasions in which ethics consultation would be requested: need of help in mediating conflict among different points of view; having someone with special skills and experience in ethics; someone capable of providing clear direction; someone who knows the law, institutional policy, federal regulations, or national standards; need of clarification of ethical issues; alternative suggestions for ethically appropriate courses of action; need of professional reassurance that a decision was the correct one; receiving more complete information.

The most helpful person physicians spoke to when resolving ethical dilemmas they encountered was another physician or colleague (42%). A small number (14%) of physicians reported that they spoke with no one (DuVal et al., 2004). Fewer than 20% of the respondents in another study (Slowther et al., 2001) felt that ethical decisions were an intrinsic part of a clinician's work and that support from senior colleagues was more appropriate than external help.

External consultation can be offered by an *ethics consultant*. There are different views about the task of the ethical consultant and skills he/she should possess. Steinkamp and Gordijn (2001) see the task of the ethicist to give members of every professional group equal opportunity to share their views. For balancing the role and mediation, it may be helpful not to be a member of the team in charge of the patient (Reiter-Theil, 2000). The ethics consultant should be either a trained ethicist with clinical experience or an experienced clinician with additional professional training in ethics. The consultant, according to La Puma and Schiedermayer (1991), should be able to identify and analyze moral problems in patient care; use reasonable clinical ethical judgement in solving these problems; communicate effectively with health care professionals, patients and families; negotiate and facilitate negotiations; teach and assist in problem resolution. Agich (1995) and Reiter-Theil (2000) added also ability to think and communicate clearly, empathy and understanding, as well as the ability to identify sources of disagreement and points of shared belief and value. The consultant should have knowledge in moral reasoning and ethical theory; bioethical issues and concepts; health care systems; clinical context; health care institution in which the consultation is done; institutional policies; beliefs and perspectives of the patient and staff; relevant codes of ethics, professional conduct and guidelines of accrediting organizations; health law (Ausilio et al., 2000).

Ethics consultation can be valuable for health professionals, patients and their families in a number of ways. Ethicists can introduce ways of analyzing the ethical aspects of patient care that are helpful in coming to consensus. They can provide some information about relevant codes and law. The language of ethics can serve as a common language in which conflicting viewpoints can be discussed (Reiter-Theil, 2001). Satisfaction with ethics consultation is also studied. DuVal et al. (2004) reported that 26% of physicians who had either personally initiated a consultation request or participated in one initiated by others, reported that the consultation changed the existing plan of treatment, while 72% reported they learned something from the consultation that might prove helpful in the future. Yen and Schneiderman (1999) found that over 90% of physicians and social workers in their study agreed or strongly agreed that the ethics consultant played an important role in identifying and analyzing ethical issues; 70% in resolving ethical issues; 74% in educating the medical team; 78% in increasing confidence in patient management; and over 90% would recommend an ethics consultation to others in the same circumstances. There are, though, reasons for

hesitation to using ethics consultation: the process is too time consuming, consultations make things worse, consultants are unqualified, consultations are unhelpful, solutions are not consistent with good practice, difficult to access, confidentiality concerns, and fear of reprisal (DuVal et al., 2004). Slowther et al. (2001) indicate some other concerns, such as: cost of setting up such a service; need for a rapid response to requests for advice in urgent clinical situations; increasing bureaucracy; and compromising clinical autonomy of health professionals (see also Foerde et al., (2008), in this issue).

In Bulgaria, ethics consultation does not exist. Until 1991, there was not even a separate ethics course in medical curricula; as a result, many physicians did not receive any medical ethics education. Bearing in mind the experience of other countries in ethics consultation and the lack of clinical ethics traditions in Bulgaria, we were interested in studying how physicians solve ethical dilemmas in their practice and their attitudes towards the potential introduction of ethics consultation.

The objective of this study is to investigate Pleven university hospital physicians' experience in ethical decision-making and their attitudes towards ethics consultation.

Methods

A cross-sectional study design was used to achieve the research objective. The sample consisted of 126 physicians working on a full-time labour contract in a university hospital of Pleven. A multi-stage sampling procedure was applied: firstly, 10 clinics were randomly selected among all 62 university clinical units; secondly, all the physicians in the selected clinics were invited to participate.

In September 2004 an anonymous questionnaire was administered to each physician in the selected clinics together with a prepaid self-addressed envelope. The participants were asked to respond to the questions and mail back the questionnaire within 2 weeks after receiving it. The survey instrument was drafted based on a review of the ethics consultation literature and in consistence with the particularities of the medical practice situation in Bulgaria. The questionnaire consisted of 14 multiple choice questions including also a category "other" for expressing a different opinion. As in Bulgaria clinical ethics consultation practice and trained ethics consultants are still not available, the questionnaire contained a detailed introductory part explaining the concept of ethics consultation to the respondents. The questionnaire contained 4 groups of questions concerning: (1) occurrence, nature of ethical dilemmas and strategies to address them in clinical practice; (2) physicians' attitudes towards ethics consultation; (3) physicians' opinions on personal characteristics and skills of an ethics consultant; and (4) three physicians' sociodemographic characteristics (gender, years of professional experience, specialty). Participation did not involve the collection of personally identifiable information. The first group of questions encompassed the real experience of the respondents. The second and third group required the respondents to place themselves in a hypothetical situation of an ethics consultation service. All the variables were measured qualitatively except the variable "length of service" that was measured by an interval scale.

Statistical data analysis was performed by Microsoft Office Excel package using descriptive statistics to summarize response frequencies. To compare differences between groups Chi-square (χ^2) test and Student's unpaired t-test were used. The differences were significant at the level $P < .05$.

The survey was organised in accordance with the ethical standards and the protocol was approved by the institutional ethics committee.

Results

Respondent characteristics

Of the 126 administered questionnaires 119 were returned; but in 7 questionnaires some sociodemographic characteristics were missing and they were excluded from the analysis. Thus, the number of participants was reduced to 112 (final response rate 88.9%).

General and socio-demographic data are presented in Table 1. The proportions of males and females were almost equal (48.2% to 51.8%). The sample consisted of very experienced physicians. The vast majority of respondents (42.9%) had 11–20 years of service, followed by those with 21–30 years (33%), and 8% of physicians had even more than 30 years of professional experience. Only 16.1% had less than 10 years of practice, 6.3% had less than 5 years. There was no significant difference in the length of service for males and females ($\chi^2 = 2.61$, df $= 3$, $P > 0.1$).

The respondents represented the main clinical specialties: obstetrics and gynecology (13.4%), internal medicine (13.4%), surgery (12.5%), pediatrics (9.8%),

Table 1. General and sociodemographic data of the responding physicians (n = 112 out of 126)

Variables	n	%
Gender		
Males	54	48.2
Females	58	51.8
Length of service		
Less than 10 years	18	16.1
11–20 years	48	42.9
21–30 years	37	33.0
Above 30 years	9	8.0
Specialty		
Obstetrics and Gynecology	15	13.4
Internal medicine	15	13.4
Surgery	14	12.5
Orthopedics	5	4.5
Pediatrics	11	9.8
Psychiatry	11	9.8
Neurology	8	7.0
Anaesthesiology	7	6.3
Dermatology	7	6.3
Ophthalmology	5	4.5
Others	14	12.5

psychiatry (9.8%), neurology (7%), anaesthesiology (6.3%), dermatology (6.3%), etc.

Physicians' views on the occurrence and nature of ethical problems encountered

A high percentage (84.8%) of respondents indicated that ethical problems have been discussed in their specialty. Such response was slightly higher in female physicians (87.9%) as compared to males (81.5%). However, the difference was not significant (χ^2 = 0.8, df = 1, $P > 0.1$). Furthermore, the participants were asked if they have discussed ethical problems and on what occasions? As is shown in Table 2, almost all respondents who answered "yes" to this question underlined that they have discussed ethical problems in personal communication with their colleagues (94.7%). About one third (36.2%) indicated that such issues have been considered at conferences and other scientific forums, and 20% of participants responded they had done so "in scientific publications".

A fundamental question of the survey was: Have you personally ever encountered ethical problems in your practice and if yes, what were the main types of ethical dilemmas? The results presented in Table 3 confirmed that 96.4% of the responding physicians have encountered some ethical problems. The prevailing ethical dilemmas were "relationships with patients and relatives"

Table 2. Discussion of ethical problems in physicians' practice (n = 112)

Responses	n	%
No	17	84.8
Yes	95	15.2
If yes, on what occasion?		
In scientific publications	19	20.2
At scientific conferences and other forums	34	36.2
In personal communication with colleagues	89	94.7
Other occasions	10	10.6
Total	95	*

* Results add up to more than 100% because multiple responses were possible.

Table 3. Occurrence and types of ethical dilemmas encountered in physicians' practice (n = 112)

Responses	n	%
No	4	3.6
Yes	108	96.4
If yes, what type of dilemmas?		
Relationship with patients and relatives	83	76.8
Team work	73	67.6
End-of-life issues	34	31.5
Informed consent	33	30.6
Resource allocation	31	28.7
Confidentiality	27	25.0
Biomedical research	17	15.7
Violation/protection of patients' rights	14	13.0
Problems of reproduction	13	12.0
Organ donation and transplantation	5	4.6
Total	95	*

* Results add up to more than 100% because multiple responses were possible.

(76.8%) and "team work" (67.6%). The latter was more frequent among women than among men (76.4% to 58.5% respectively – $P < 0.05$). The other types of ethical dilemmas were ranked as follows: "problems at the end-of-life" (31.5%), "receiving informed consent" (30.6%), "rationing of scarce resources" (28.7%), "truth-telling and confidentiality" (25%), "experiments on human beings" (15.7%), "violation/protection of patient rights" (13.0%), and "problems related to reproduction" (12%).

Physicians' perceptions about the need and sources of advice in resolving ethical problems

The other fundamental question was: Have you needed some advice/help in solving ethical dilemmas and if yes, what was the main source of advice? Responses to this question were significantly

Table 4. Need and main sources of advice/help in solving ethical problems ($n = 112$)

Responses	Total		Males		Females	
	n	%	*n*	%	*n*	%
No	22	19.6	15	27.8	7	12.1
Yes	90	80.4	39	72.2	51	87.9
If yes, what are the main sources of advice/help?						
Colleague involved in the case	58	64.4	25	64.1	37	72.5
Head of the department	53	58.9	23	53.8	28	54.9
Colleague not involved in the case	18	20.0	12	30.8	6	11.8
Third party (friend, relative)	14	15.6	7	17.9	7	13.7
Others	6	6.7	2	5.1	4	7.8
Total	90	*	39	*	51	*

* Results add up to more than 100% because multiple responses were possible.

different in males and females (Table 4). About 80% of the respondents pointed out that they needed some advice or help in solving ethical problems; for females this proportion was 87.9% as compared to males (72.2%) – $\chi^2 = 6.15$, df $= 1$, $P < 0.025$. As far as the main source of advice is concerned, the first rank was attributed to "a colleague involved in the case" (64.4% for the sample as a whole, 72.5% for women and 53.8% for men respectively), followed by the category "head of the department" (58.9% total, 54.9% and 64.1% for females and males respectively). The other categories (colleague not involved in the case, third party, others) were less relevant.

Physicians' attitudes towards ethics consultation

Although in Pleven university hospital there has been no experience with ethics consultation offered by a specially trained clinical ethicist, the participants considered such consultation to be of great benefit for themselves, as well as for the patients and their relatives. The responses in Table 5 underline that 89.3% of the physicians responded very positively to the possibility to have an ethics consultation. In accordance with the previous data, females were more convinced of the benefits of an ethics consultation (96.6% for females to 81.5% for males). The difference is statistically significant ($\chi^2 = 8.13$, df $= 1$, $P < 0.005$). Female physicians would personally look for an ethics consultation more often than men (89.7% to 72.2% respectively) – $\chi^2 = 7.83$, df $= 1$, $P < 0.01$.

The predominant dilemmas that might lead to requests for ethics consultation requests were ranked as follows: "looking for help in resolving conflicts" (72.5%), "concern for the rightness of a decision or practice" (52.7%), "anticipation of a bad situation" (39.6%), "desire to consider ethical aspects of a situation" (35.2%), "looking for help in interacting with patients and relatives" (28.6%), and "uncertainty in a particular situation" (19.8%). There were no significant differences between men and women regarding the triggers of requests for ethical consultation.

Table 5. Attitude of responding physicians towards ethics consultation ($n = 112$)

Questions and responses	*n*	%
Would ethics consultation be beneficial?		
No	12	10.7
Yes	100	89.3
Would you personally request ethics consultation?		
No	21	18.8
Yes	91	81.2
If yes, on what occasion?		
Looking for help in resolving	66	72.5
Conflicts	48	52.7
Concern for the rightness of a decision or practice	36	39.6
Anticipation of a bad situation	32	35.2
Desire to consider ethical aspects of a particular situation	26	28.6
Looking for help in interacting with patients and relatives Uncertainty in a particular situation	18	19.8
Total	91	*

* Results add up to more than 100% because multiple responses were possible.

The number of physicians who would not request an ethics consultation was 21. Sixty four percent of them responded that they mainly preferred to rely on their own decision. For 30.3% ethics consultation would just take time and would delay the therapeutic process, and

24.2% did not believe in the usefulness of ethics consultation.

Physicians' views about the personal characteristics of an ethics consultant

The last focus of our survey concerns the perceptions of the responding physicians about the personal and professional characteristics of an ethics consultant (Table 6). One hundred and ten physicians answered this question. The respondents were very concrete about the personal and professional qualities of a clinical ethicist. Most of the participants in the study specified 4–5 characteristics. The majority was in favor of "clinical competence" as the most important quality of an ethics consultant (70.9%), followed by "the ability to deal with conflicts" (59.1%), "communication skills" (58.2%), "tolerance to different viewpoints" (55.4%). Next "special qualification in ethics" (52.7%) and "competence in psychology" (42.7%) were ranked. There were slight, but insignificant differences in the preferences between males and females ($P > .05$).

Discussion

This is the first survey in Bulgaria examining the nature of ethical problems physicians are facing and their attitudes towards ethics consultation. The response rate in the study was 88.9% and much higher than in previous similar surveys – 53% to 72% (DuVal et al., 2001, 2004; Yen and Schneiderman, 1999). The high response rate can be attributed to the personal contact established by the investigator with each physician, providing detailed explanation of the objectives and the anonymity of the study. These characteristics of the study also contributed to the quality of the received information.

The prevalence of highly experienced physicians can be explained with the study setting. In a university hospital, appropriate professional experience is a position requirement. Consequently, no analysis of ethical problems by years of service was performed due to of the relative homogeneity of the study group.

Considering the occasions at which ethical problems are discussed, the relatively low percentage of publications and scientific events deserves attention. This can be explained by a lack of publications on ethical problems as a whole in the national medical literature.

Two aspects were not analyzed in detail and would be appropriate objectives for future studies. The first one regards the significant gender differences found in: the nature of the ethical dilemmas encountered the need of advice/help in ethical decision-making, the main source of advice, the attitude to ethics consultation. As the survey instrument was drafted based on a critical analysis of the ethics consultation literature in which no significant differences were found despite the bigger gender differences in the studied groups (80%–20% in favour of men – DuVal et al., 2001, 2004), we did not include appropriate questions to clarify this issue. The second uninvestigated aspect is the relation between the physicians' specialty and most common ethical problems encountered. The latter was not done due to the small number of physicians in some clinical units. Consequently, for studying this aspect a large-scale survey is necessary.

Several findings of the survey are noteworthy: First, 96.4% of responding physicians encountered ethical dilemmas and their main source of advice was a colleague involved in the case and the head of the department. Bearing this in mind, it is important that considerable effort should be focused on teaching ethics and training clinicians to resolve ethical dilemmas.

An interesting second finding was the great difference between the first two dilemmas (relationship with patients and relatives – 76.8% and team work – 67.6%) pointed out by the respondents and the other options in the questionnaire. These problems are core issues in medical ethics (Ten Have, 2001) but a recent development in the area of bioethics emphasizes more on end-of-life issues (see also Beck et al., (2008), in this issue), patient autonomy, resource allocation, biomedical research, etc. However, such dilemmas still are not

Table 6. What qualities and skills should an ethical consultant possess? ($n = 112$)

Responses	*n*	%
Clinical competence	78	70.9
Ability to deal with conflicts	65	59.1
Communication skills	64	58.2
Tolerance to different views	61	55.4
Special qualification in ethics	58	52.7
Competence in psychology	47	42.7
Respected colleague (professorship)	21	19.1
Empathy	18	16.4
Total	110	*

* Results add up to more than 100% because multiple responses were possible.

widely addressed in our practice due to the lack of tradition in ethics education and training in Bulgaria. Officially, a separate course of ethics was introduced to the medical curriculum only in 1991. As it was pointed out above, the majority of participating physicians had more than 10 years of experience and probably had not had the opportunity to pass such an ethics course. Consequently, profound understanding of the term ''ethical dilemma'' was lacking. Ethical dilemmas were mainly associated with rules of professional conduct. Analyzing our findings, we realized that it would be useful to investigate the possible relation between any kind of ethics education and recognized ethical problems.

Third, it seems that the physicians themselves felt uncertain in ethical issues and the majority of them expressed positive attitudes towards ethics consultation. This should draw the attention of health authorities to the need of ethics consultation services. Illustrative data are presented by DuVal et al. (2004). Seventy-nine percent of physicians included in their study reported that ethics consultation services were available at their predominant practice site. Physicians whose practices were hospital based were significantly more likely to have access to ethics consultation services at their predominant practice site than physicians who were either in group or in solo practices. The results of Slowther et al. (2001) also show that the majority of physicians (89%) agreed or strongly agreed that such services should be available.

Fourth, expressed concerns in relation to ethics consultation as delay in the therapeutic process, lack of information about the availability, and fear of restricted clinical autonomy should be addressed in the establishment of ethics consultation services. Procedural rules should be more expeditious, health professionals should be informed about the non-instructive nature and the availability of such services.

Fifth, according to the respondents' opinion the most valued quality of the ethics consultant was clinical competence. Typical for our reality is the fact that physicians consider the opinion of experts with medical education to be more adequate and they are more willing to take it into account. At the same time, other skills of the consultant were not underestimated. In accordance with the main ethical problems recognized above, ability to deal with conflicts, communication skills, and tolerance to different views were also appreciated. Special qualification in ethics was ranked only on 5th place, which is again consistent with the lack of traditions in ethics already discussed.

Conclusion

Ethical dilemmas are an inseparable part of everyday medical practice. The study underlines that Pleven University hospital physicians face similar ethical dilemmas as their colleagues in other countries do. To be more confident in their actions they need better ethics education and ethics consultation services available. Despite the fact that we still do not have trained ethical consultants in Bulgaria, physicians expressed positive attitudes towards ethics consultation. This should serve as a basis for further research and development of ethics consultation services.

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