View across the pond: insights from a national survey on clinical ethics services in Switzerland

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ABSTRACT

We present the results of the fourth national survey on the state of ethics consultation services (ECS) in Swiss hospitals, dating from early 2020. While 59% of the general and the psychiatric hospitals had ECS, only 27% of the rehabilitation hospitals disposed of such structures. More than two thirds of these ECS were organized in the form of committees and an increasing number of hospitals rely on external consultants. Their tasks and the topics they address are manifold. It is remarkable that most respondents consider it their task not only to analyze ethical conundrums and facilitate decision-making but to make decisions themselves. The level of ethics training of those working for the ECS remains conspicuously low. We discuss potential explanations and consequences of our results.

In the three target articles, Ellen Fox et al. present data from their seminal study on ethics consultation in US general hospitals (Fox, Danis, et al. 2021, Fox and Duke 2021, Fox, Tarzian, et al. 2021). Their main finding is a widening gap between a professional, expert approach to ethics consultation at the large, urban, teaching hospitals and a non-expert, more committee-based approach of ethics consultation at the small, rural, non-teaching hospitals. This finding may reflect disparate context-dependent needs, but it may also signal a worrisome inequity of access to ethics support services (ECS).

Their study has global relevance for the field of clinical ethics far beyond the USA. In Europe, one of the countries with the longest tradition of clinical ethics consultation is Switzerland (Jox and Reiter-Theil 2022). Situated in the center of the continent, with a large immigrant population from neighboring countries and four national languages, this country is often regarded as Europe in a nutshell. This is also reflected in a diversity of cultural values between the regions of this small country of 8.5 million inhabitants (Porz, Kössler, and Mosimann 2022). Interestingly, it is the only European country with successive national surveys on the state of clinical ethics consultation. After 2002, 2006, and 2014, the most recent national study from early 2020, following an analogous methodological approach as the US study asking best informants at the hospitals, has just been published in German and French in the Swiss medical journal (Zentner et al. 2022). Its results may enrich the international discussion on the topic.

We briefly summarize these findings for the present context, focusing on (i) the number of hospitals with ECS, (ii) the nature and activities of them, (iii) the training of the professionals in charge of them, and (iv) the most common ethical issues dealt by these services. While focusing on the current survey from 2020, we also draw comparisons to the three previous surveys (Salathé et al. 2003, Salathé et al. 2008, Ackermann, Balsiger, and Salathé 2016).

While 59% of the general hospitals and 59% of the psychiatric hospitals had ECS, only 27% of the rehabilitation hospitals disposed of such structures. Across all responding 217 hospitals together, 50% had ECS, which is only a slight increase compared to the last surveys in 2014 (42%) and 2006 (44%), after a steep increase from 2002 (18%). More than two thirds of these ECS (69%) were organized in the form of clinical ethics committees, 27% had professional ethics consultants, and 27% relied on contracts with ethics consultants from outside of the hospital, who work as independent ethicists, staff of private ethics firms or part-time agents with their main employment at another

hospital. The latter percentage has significantly increased from 7% in 2014 to 27% in 2020.

When asked about the activities of the ECS, respondents in Switzerland indicated a variety of tasks: more than two thirds reported performing ad hoc case consultations, retrospective case deliberations, ethics guideline and policy development, continuing professional education in ethics, as well as counselling the hospital management on ethical issues. It is remarkable that 62% of the respondents consider it their task not only to analyze and facilitate decision-making but to make decisions themselves in individual patient cases, a percentage continuously rising from 52% in 2014 and 40% in 2006.

The level of ethics education of the persons responsible for the ECS is quite mixed: 30% reported having an academic ethics education (e.g., master's or doctoral degree), another 29% indicated having some form of structured ethics training (e.g., certificate of advanced studies or ethics as part of their professional education), while 18% mentioned only minimal training in ethics and 29% stated that they do not have any kind of ethics education at all. To contextualize these results, there is currently neither a standardized educational curriculum nor a certification procedure for clinical ethics consultants in Switzerland.

When asked about common ethical issues in their ECS, most respondents consistently stated classical topics, such as withholding and withdrawing life-sustaining medical treatment, advance care planning, decisional capacity, goals of care, resuscitation, cognitively impaired patients, artificial nutrition and hydration, coercive measures, value conflicts within the team or with patients' families. Thematically, it is striking that the ethical topics that are omnipresent in the media and the public discourse, such as artificial intelligence, digitalization, gender transformation, genetics, transplantation, or artificial reproduction, were reported as the least common topics of ECS.

What can these findings about ECS in Switzerland contribute to the American and international debate on ethics consultation in health care? First, it is noteworthy that the Swiss study included more than just the general hospitals, which was the case in the US survey, and showed a markedly reduced frequency of ECS in rehabilitation hospitals. This finding, which might be similar in other countries and in other non-acute sectors of the health care system, raises the question of equal access to ethics consultation (Hurst et al. 2007). The focus of our health care systems on acute interventional treatment may lead us to neglect ethical questions in post-acute care, long-term care, or preventive

care. In Germany, a rising movement of out-of-hospital ethics consultation is beginning to organize itself, with a recurrent series of conferences and a web-based public registry of more than 40 health care ethics services in the community.

Another remarkable finding of the Swiss study is the fact that more and more hospitals seem to rely on external ethics consultants. While it has not been investigated in the Swiss study, we presume that it is rather the small, rural hospitals that opt for this model since it may be more cost-efficient for them. Taken together with the findings from the current US survey by Fox et al. and the recent pilot reports of telemedicine ethics consultation, potentially spurred by the Covid pandemic (Kon and Garcia 2015), this underscores the need to empirically study the most appropriate forms of ethics consultation in small, peripherally located hospitals.

A concern that both the Swiss and the US studies nurture is the diverse range of ethics education and qualification that ECS practitioners have. In some European countries, there is a current tendency to move towards introducing formal certification of health care ethics consultants, especially since the first national certification model introduced by Germany in 2015 is evolving successfully with now more than 1900 certified professionals (Picozzi et al. 2018, Schochow, Schnell, and Steger 2019). Yet, the question remains whether every professionals involved in ECS in any health care context needs certification or whether it could make sense to provide other forms of clinical ethics training below this threshold as well, for example for clinicians who serve as ethics liaison persons or ethics committee members (Ranisch et al. 2021).

Maybe linked to the question of ethics training is the results from the Swiss study that a high number of clinical ethics consultants reported to make decisions in individual patient cases. This behavior is clearly at odds with the relevant recommendation of the Swiss Academy of Medical Sciences that sees the ethics consultant as a pure facilitator of decisions made and accounted for by patients, proxies, and health care professionals (Swiss Academy of Ethics in Medicine 2017). Yet, this posture might be difficult to adopt for professionals who work both as clinicians (as their main professional identity) and as ethics consultants (as side activity on a voluntary basis). It seems paramount to us that ethics consultants within a given health care system adhere to a common understanding of their role in order to avoid confusion and inequity.

Finally, it should be noted that the Swiss study, whose results have been briefly presented and discussed here, was conducted in winter 2019/2020, just before the first clinically relevant outbreak of the Covid-19 pandemic. As the past two years have been

marked by intense discussions on various pandemic-related bioethical issues both in the health care institutions and in the public, we hypothesize that this might have had a significant impact on clinical ethics consultation as well. Therefore, the Swiss Academy of Medical Sciences plans to launch another national survey once the pandemic will be over.

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