# Need for ethics support in clinical practice and suggestion for an Ethics Consultation Service: views of Nurses and Physicians working in Italian Healthcare Institutions

**Cinzia Leuter, Cristina Petrucci, Valeria Caponnetto, Carmen La Cerra and Loreto Lancia**

*Dipartimento di Medicina Clinica, Sanità Pubblica, Scienze della Vita e dell'Ambiente (MeSVA), Università degli Studi dell'Aquila, Coppito (L'Aquila), Italy*

**Abstract**
***Introduction.*** Ethics Consultation Services (ECS) and Ethical Committees manage several aspects of clinical ethical issues. In Italy there are only Ethical Committees, and, although they should also perform ethical consultations, their activity is limited to approving clinical trial protocols.
***Aim.*** To analyse the opinions of a sample of Nurses and Physicians about their motivations to ask for an ethical consultation.
***Methods.*** A cross-sectional study was conducted on a sample of Italian Nurses and Physicians.
***Results.*** Respondents would request ethical consultations mainly for end-of-life issues and, secondarily, for conflicts with patients' families. Respondents identified the provision of suggestions for hospital policy, the development of ethical guidelines, and the counselling for individual cases requested by clinicians, patients or families as the most important functions of ECS.
***Conclusions.*** ECS activities should focus on counselling and support to decisions in complex ethical situations according to institutional policies and guidelines self-developed.

**Key words**
• ethics consultation
• Clinical Ethical Committees
• healthcare professionals
• end-of-life

## INTRODUCTION

The term "clinical ethics" concerns the approach towards patient care problems and bedside procedures in a context of medical technology evolution [1]. Ethics Consultation Services (ECS) first appeared in the USA in the 1970s and, in the following years, they have spread in all hospitals. Since the 1990s, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has required hospitals to have a multidisciplinary Committee for addressing ethical issues in the healthcare field and assuming three main functions: i) providing individual case consultations for clinicians, patients, or patient's families asking for them; ii) making ethical contributions to hospital policies and developing guidelines; and iii) educating Healthcare Professionals [2, 3]. Based on the North American experience, European Ethical Committees were also established and developed, and they currently provide Healthcare Professionals with support and advice on healthcare ethical

issues [4, 5]. In 2001, the *Clinical Ethics Network* was organized in the UK to promote a deep debate on ethical issues in health care and to develop advice activities in health care facilities [4, 5]. Where ECS have been developed, they are organized differently from each other, either nationally or abroad even though with two organizational models being prevalent. The first model autonomously intervenes in ethical issues and orientates policy, whereas in the second type a team of experts provides case consultation services for certain clinical cases [6-8]. Even though the number of ECS has increased over the years, within facilities in which they operate some challenges in affirming their role still remain despite the growing requests for ethical advice by Healthcare Professionals [6, 9]. Notwithstanding the potential improvement of quality induced by ECS, the organizational variability could be a weakness in their development. Nevertheless, such question can be overcome by the definition of goals and interventions aimed

*Address for correspondence:* Cinzia Leuter, Dipartimento di Medicina Clinica, Sanità Pubblica, Scienze della Vita e dell'Ambiente (MeSVA), Università degli Studi dell'Aquila, Via San Salvatore, 67100 Coppito (L'Aquila), Italy. E-mail: cinzia.leuter@cc.univaq.it.

at improving ECS processes and organization. Particularly, attention should be paid to interventions that increase ECS authority as well as to the recruitment and training of their staff, the identification of quality assessment methods, and the definition of shared policy and organizational guidelines [10-12]. The promotion of ethical support activities in healthcare can be fostered by focusing attention on models that meet and facilitate the needs of Healthcare Professionals and Institutions, emphasising the culture of dialogue about the complexity of the situations that daily come to light in the healthcare practice [13]. Defining the potential expectations of ECS users can bring counsellors close to those who require their intervention and provide hospital governance with guidance to define ethics education programs. Identifying any discrepancies between the consultation supplied and users' expectations may be helpful to assess the quality of ECS and to identify any barriers to their expansion [14].

In Italy, the Ethical Committees have been almost exclusively dealing with the authorization of clinical trials. Therefore, in 1997 the National Bioethics Committee emphasized the need to support Healthcare Professionals and patients, and highlighted the two functions of Ethical Committees, i.e. ethics in clinical and healthcare activities and ethics in biomedical research, that could be performed together [15, 16]. Nowadays, even though an Italian law [17] delegates tasks concerning the ethical field of healthcare activities to Ethical Committees, such as training of Healthcare Professionals and consultation activities [18-20], their activity in hospitals is mainly focused on approving clinical trial protocols [21]. Recently, the Italian National Bioethics Committee suggested again that both the two functions of Ethical Committees (i.e. ethics in clinical and healthcare activities as well as in biomedical research) could be performed by separate organisms and, furthermore, has highlighted the legislative void about these issues [22]. Nowadays, Italy is in the initial phase of the development of ECS, or rather the awareness of the importance of ethical support for Healthcare Professionals. The evidence on the frequencies of ethical issues in the healthcare field and attitude towards ethical counselling in a sample of Italian Healthcare Professionals has highlighted some prevailing factors [20, 23, 24]:

- high frequencies of ethically difficulties in healthcare practice;
- limited use of ethical advice to deal with issues;
- limited specific education in ethics field;
- high willingness to use ECS.

Data drawn from a population of Nurses and Physicians underline a strong need for ethics support in health care activities for situations in which the respondents more frequently experienced ethical difficulties [23]. The objective delay of regulations and organizational strategies and the lack of institutional responses to the need for ethics support in healthcare activities suggest the urgency that the ECS be set up, considering the proposed organizational models and contents. In the years before the conduction of this study, cases of ethical conflicts occurred in Italy in healthcare came to the media limelight. Following these ethical conflicts,

a draft Decree Law had been proposed to the Italian Parliament (the Calabrò decree, from the name of the proponent legislator) with the intention to eliminate the patients' right to refuse treatment. However, this draft Law has never been approved, while a Decree Law has been recently approved [25] introducing the possibility to declare the power of disposition of each person about eventual healthcare treatments. Therefore, the core of this work focuses on how an ECS should be organized to be an autonomous organism, taking into consideration the contribution of the potential users (i.e. Healthcare Professionals) to define its competencies.

## AIM OF THE STUDY

The aim of this study was to analyse the opinions of a sample of Nurses and Physicians about ethical the dilemmas they had experienced during their practice to identify the ethical needs that could be addressed by ECS and the motivations leading to ask for ethical advice.

## METHODS
### Study design and setting

Between March and June 2014, a cross-sectional observational study was conducted distributing a questionnaire to all the healthcare workers of a Local Healthcare Authority in Abruzzo, a region of central Italy, comprising four general university hospitals with numbers of beds ranging from 40 to 317. This methodological choice allowed both to explore the opinions of many Italian healthcare workers about ethical issues and to identify the main themes about which professionals need help and clarification. Three of these hospitals offer ethically sensitive services, i.e. abortions, intensive therapies, oncological treatments, and palliative care. Moreover, in the biggest hospital organ transplants are currently performed. In the Local Healthcare Authority there are no ECS, but an Ethical Committee is available only for evaluating clinical trial protocols. A sample of 351 Nurses and 128 Physicians working in the four hospitals agreed to participate and was surveyed.

### The questionnaire

A previously validated semi-structured questionnaire [24] was used for the data collection. It consisted of 21 items divided into five sections exploring the demographic and occupational characteristics, the knowledge in the ethics field, the experience with ethical issues, the propensity to use ethics consultation, and end-of-life issues. The first four sections of the questionnaire (13 items) were examined in this study. The fifth dimension assessed the opinions of healthcare workers regarding end-of-life issues, also including open-ended questions. The data collected through this section are currently being computed. In the present study, socio-demographic aspects, i.e. job position (Nurse or Physician), job qualification, educational level, work setting, age, gender, and years in practice were assessed through seven items. Knowledge in the ethics field was investigated using both the respondents' self-perceptions, through a single item to which possible answers were "poor", "good" or "very good", and a specific multiple-choice

question requesting whether and how ethical issues had been deepened. Possible answers to this latter item included either "never deepened" or having attended any type of academic or continuous education about ethical issues, even including any current or previous direct involvement in Ethical Committees. Moreover, knowledge was indirectly investigated through the experiences lived during the clinical activities and the ethical consultations requested by respondents at any time in the past. The item investigating the ethics experience described nine situations that could happen in the healthcare practice. These situations investigated four potential areas of difficulty encountered in daily medical and nursing practice:

- "Patient decision making" (a patient's inability to make decisions);
- "End-of-life" decisions and management (the appropriateness of choices in terminal patient care);
- "Conflicts" (conflicts with other members of the caring staff or with the patient's family);
- "Fairness and accessibility" (care choices that are constrained by the scarcity of resources and facilities).

Response options ranged from 0 (never faced) to 3 (often faced) with total scores ranging from 0 to 27; according to scores, respondents were classified into three categories: Low experience (score <9), Medium experience (score 9-14), and High experience (score >14). Cut offs were set based on the possible combinations of frequencies of experiences described, as also carried out by Hurts and colleagues in 2011 after having administered a similar validated questionnaire [26]. Therefore, knowledge concerning ethical issues was assessed based on four perspectives: subjective, assessing self-perceptions; objective, investigating whether and how ethical issues had been deepened; and indirect, assessing both the experiences lived in clinical activities and whether respondents had ever requested ethical counselling in the past. Although a great percentage of respondents reported a good perception of their level of knowledge, preliminary analyses revealed that this had not been achieved through a specific training or the request of information during counselling. Therefore, only the answers regarding the objective and the indirect perspectives were considered as categorization variables in the analyses. Indeed, those who had undergone specific training or had asked for counselling in the past were really few compared to those who reported a good perception of their knowledge [23]. After investigating their level of knowledge, the respondents were asked about any usefulness of seven types of advice in the ethics field that they would have needed in real situations encountered in their clinical practice (i.e. they were asked "Thinking back over the situations encountered, what kind of support would have been useful to you?"). These statements identified three macro-areas of support:

- clarification of issue (help in identifying the ethical aspects of the situation faced, support in weighing the possible consequences of healthcare choices);
- aid in problem solving (advice on alternative and more appropriate choices, information on rules and guidelines in the field of ethics, and obtaining reassurance from experts about the rightness of the choices);

- psychological consultation (psychological support to face difficult ethical situations, advice on how to communicate with the patient and/or family).

These statements were rated on a 4-point Likert scale for measuring the utility or lack of utility of receiving ethical advice (1: not useful; 2: useful; 3: very useful; 4: I do not know) and the answers generated categorical variables. Finally, future willingness to recur to ethics consultation in ethically sensitive situations and the reasons that could lead respondents to ask for ethical advice were assessed through two items (i.e. they were asked whether they would request for specific consultation if they had to face situations requiring ethical decisions and the reasons for which they would make use of an ethical consultation). The latter item included six statements grouped into three types of aid:

- professional support for ethical decision making (understanding ethical implications in healthcare activities and discussing with other professionals);
- help in avoiding and managing potential conflicts (behaving appropriately in conflicts with the patient's family, finding suitable answers to terminal patient's requests, understanding and avoiding legal problems);
- support to ease the emotional charge (getting psychological support in facing ethical problems).

Respondents were supposed to express their level of agreement with these statements through a 5-point Likert scale (from 1: strongly disagree to 5: completely agree), and the answers generated continuous variables.

Data regarding the usefulness of the seven types of advice proposed and the reasons for future use of ethical counselling were presented and analysed according to gender, role, whether having deepened ethical issues, level of experiences with ethical issues, and had asked or not for counselling in the past. Other factors, such as the work setting, years in practice, and self-perceived ethics knowledge were not considered as explanatory factors, because in this sample [23] and in literature [26, 27] they have not been found yet to be associated with the propensity to ask for counselling on addressing ethical issues.

### Ethical approval

Research ethical approval was obtained from the professional Board of "Collegio Infermieri Professionali, Assistenti Sanitari e Vigilatrici d'Infanzia" (IPASVI), an Italian professional organization that represents the interests of Nurses. The Faculty of Medicine of L'Aquila Board also approved this research. The Hospital Ethical Committee and University Research Ethics Boards were consulted and noted that their ethical approval was not required for this type of data because this study did not interfere with the patients' care and did not involve care facilities but, instead, involved only the Nurses and Physicians who voluntarily responded to an anonymous and self-administered questionnaire.

### Statistical analysis

Descriptive analyses were performed for all the data. For this purpose, frequencies and percentages were calculated for discrete and nominal values. Continuous variables were summarized by means and standard de-

viations. The data normality distribution was assessed using the Shapiro-Wilk test. The Wilcoxon-Mann-Whitney and Kruskal-Wallis tests were used to compare average values in continuous variables while the $\chi^2$ test was used for categorical variables. For all the analyses, a bidirectional test was used with a significance level of 0.05. All the data were analysed using IBM SPSS version 19.0 (IBM Corp., Armonk, NY, USA).

## RESULTS

A total of 479 participants completed the questionnaire; 351 (73.3%) were Nurses and 128 (26.7%) were Physicians.

The respondents' characteristics are summarized in *Table 1*. As regard the four perspectives (subjective, objective, and the two indirect) according to which knowledge in ethical field was assessed, many Health Professionals (72.1%) acknowledged themselves to

have a good level of knowledge; few respondents defined their own knowledge as "poor" (18.1%) and "very good" (9.6%). Therefore, since the categories "good" and "very good" were conceptually similar, the answers of the 3-point Likert scale were reduced into two categories such as "poor" and "good". Moreover, the answer frequencies of the category "very good" were very low and the recoding of answers allowed to safeguard key information and avoid a useless fragmentation of the data. In particular, Nurses were found to have better judgement about their own knowledge than Physicians (subjective dimension), but more Physicians than Nurses stated having had specific training in deeper ethics issues (objective dimension). Nevertheless, a little more than half of the sample (66.6%) declared to have deepened ethical issues, though no one had ever been directly involved in Ethical Committees [23]. As regard the third dimension (the first indirect dimension), the mean level of experiences with ethical difficulties was 10.5 (SD 5.5) and the frequencies distribution among the three described levels of experience was:

- Low (0-8): 152 respondents (35.8%);
- Medium (9-14): 159 respondents (37.4%);
- High (15-27): 114 respondents (26.8%).

Both Nurses and Physicians reported a high frequency of ethically sensitive situations in their professional activities, even though Physicians experienced ethical difficulties more often than Nurses [23]. Finally, only 20.1% of the respondents had asked advice on ethical issues in the past (the second indirect dimension).

As regard the usefulness of the proposed three macro-areas of support and advice (clarification of issue, psychological consultation, and aid in problem solving), the answers of the 4-point Likert scale were reduced into three categories: "useful", "not useful", and "I do not know" because the categories "useful" and "very useful" were conceptually similar and the answer frequencies of the category "very useful" were very low. The results regarding such item are shown in aggregated form in *Figure 1* and they have been stratified according to the respondents' characteristics and to three dimensions of knowledge in *Table 2*. All the statements describing possible supports in faced ethical situations were acknowledged by more than 80% of the respondents as useful. Information on regulations and/or national ethics guidelines was referred as the support that would be more helpful, in particular by female respondents (p = 0.01), followed by advice on how to talk to the patient, which was indicated more frequently by both women (p = 0.04) and those who had not deepened their ethics knowledge (p = 0.04). Those who had asked advice on ethical issues in the past were more inclined to acknowledge the usefulness of several types of support than who had never requested an ethical counselling. This is confirmed by the great usefulness that the category "had asked counselling in the past" acknowledged to the consent of experts about the rightness of the choices (p < 0.001). *Table 2* also shows significant differences about the acknowledged usefulness of a key intervention, i.e. the psychological support, between women *vs* men (p < 0.001), Nurses *vs* Physicians (p < 0.001), and those who had asked for counselling in the past *vs* those who had not (p < 0.001).

**Table 1**
Respondents' characteristics

| Characteristics | Nurses | | Physicians | |
|---|---|---|---|---|
| | N | % | N | % |
| *Gender* | | | | |
| Female | 278 | 79.2 | 59 | 46.1 |
| Male | 57 | 16.2 | 61 | 47.7 |
| Not answered | 16 | 4.6 | 8 | 6.3 |
| *Age groups* | | | | |
| 20-35 | 41 | 11.7 | 17 | 13.3 |
| 36-51 | 198 | 56.4 | 48 | 37.5 |
| 52-65 | 101 | 28.8 | 62 | 48.4 |
| Not answered | 11 | 3.1 | 1 | 0.8 |
| *Work setting* | | | | |
| Critical area | 98 | 27.9 | 41 | 32.0 |
| Medical area | 110 | 31.3 | 41 | 32.0 |
| Surgical area | 87 | 24.8 | 25 | 19.5 |
| Other | 18 | 5.1 | 18 | 14.1 |
| Not answered | 38 | 10.8 | 3 | 2.3 |
| *Years in practice* | | | | |
| 1-10 | 56 | 16.0 | 42 | 32.8 |
| 11-20 | 95 | 27.1 | 21 | 16.4 |
| 21-30 | 121 | 34.5 | 34 | 26.6 |
| 31-40 | 70 | 19.9 | 28 | 21.9 |
| Not answered | 9 | 2.6 | 3 | 2.3 |
| *Education* | | | | |
| Graduated | 275 | 78.3 | | |
| Post-graduated | 73 | 20.8 | | |
| Not answered | 3 | 0.9 | | |
| *Job qualification* | | | | |
| Basic | 312 | 88.8 | 38 | 29.7 |
| Advanced | 24 | 6.9 | 101 | 70.3 |
| Not answered | 15 | 4.3 | | |
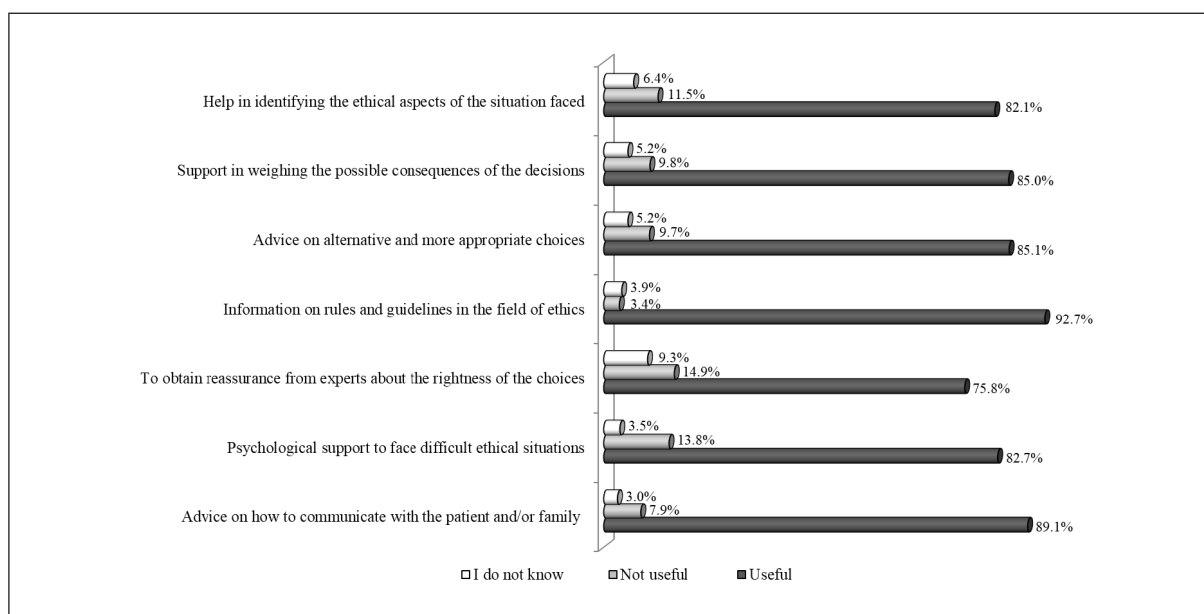
**Figure 1**
Advice considered useful by the respondents.

**Table 2**
Advice considered useful stratified according to the characteristics of the respondents

| Stratification variables | Gender | | | Role | | | Have deepened ethical issues | | | Experiences with ethical issues | | | | Have asked for counselling in the past | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Advice considered useful | Male | Female | *p-value* | Nurses | Physicians | *p-value* | Yes | No | *p-value* | Low | Medium | High | *p-value* | Yes | No | *p-value* |
| Help in identifying the ethical aspects of the situation faced | 89.9% | 86.0% | 0.33 | 86.1% | 91.3% | 0.15 | 88.1% | 90.0% | 0.59 | 86.8% | 87.2% | 87.4% | 0.99 | 96.4% | 84.9% | <0.001 |
| Support in weighing the possible consequences of the decisions | 87.1% | 89.9% | 0.45 | 88.3% | 92.5% | 0.21 | 89.9% | 90.8% | 0.80 | 87.2% | 90.8% | 89.0% | 0.64 | 95.2% | 87.8% | 0.03 |
| Advice on alternative and more appropriate choices | 86.6% | 90.7% | 0.25 | 89.4% | 90.7% | 0.69 | 89.6% | 91.1% | 0.67 | 89.9% | 88.4% | 89.8% | 0.91 | 92.3% | 88.9% | 0.37 |
| Information on rules and guidelines in the field of ethics | 92.0% | 97.8% | 0.01 | 95.6% | 98.3% | 0.18 | 97.2% | 96.7% | 0.78 | 95.9% | 95.9% | 97.2% | 0.84 | 98.8% | 95.7% | 0.18 |
| To obtain reassurance from experts about the rightness of the choices | 86.0% | 82.4% | 0.41 | 81.6% | 87.9% | 0.12 | 85.2% | 80.9% | 0.29 | 83.5% | 80.9% | 87.1% | 0.44 | 93.8% | 80.8% | <0.001 |
| Psychological support to face difficult ethical situations | 72.0% | 90.5% | <0.001 | 91.9% | 70.9% | <0.001 | 84.6% | 89.6% | 0.19 | 87.5% | 81.0% | 90.0% | 0.11 | 97.6% | 82.1% | <0.001 |
| Advice on how to communicate with the patient and/or family | 87.5% | 93.5% | 0.04 | 93.1% | 89.0% | 0.17 | 91.1% | 96.8% | 0.04 | 93.4% | 91.2% | 90.7% | 0.70 | 95.2% | 90.8% | 0.19 |
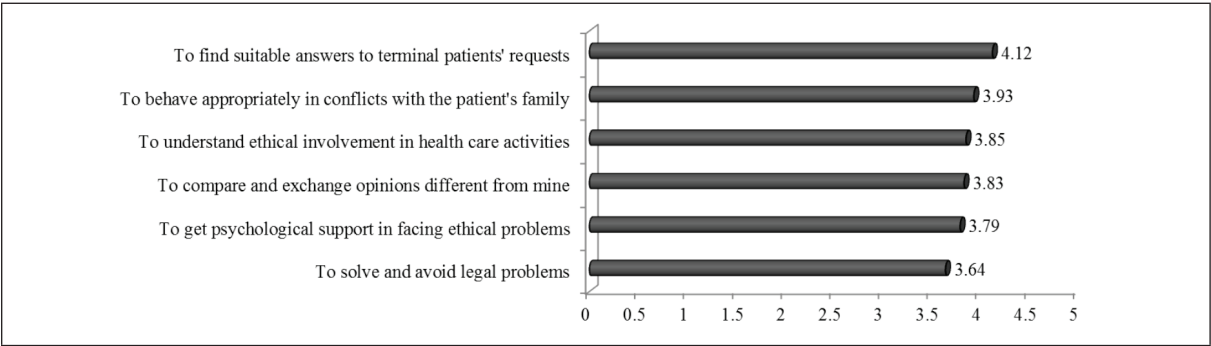
**Figure 2**
Mean level of agreement with the proposed reasons for the use of ethical counselling of respondents who declared to be inclined to ask a specific consultation in ethically sensitive situations in the future.
The level of agreement is expressed through a Likert scale (1 - Strongly disagree - to 5 - Completely agree).

Concerning future possibilities, 85.7% of the respondents declared to be inclined to ask for a specific consultation in ethically sensitive situations in the future. Their mean level of agreement with the proposed reasons for the use of ethical counselling always exceeded the value of 3.5, indicating good agreement *(Figure 2)*. The difficulties concerning "end-of-life" situations received higher scores than other reasons for the respondents' potential requests for ethics consultation, followed by conflicts with the patient's family members. The lowest score referred to the propensity to recur to consultation for self-defence against eventual legal issues. Even though the overall mean level of agreement was high, its stratification according to the respondents' characteristics and the dimensions of knowledge showed a higher mean level of agreement among the respondents with a

higher level of experience in ethical issues compared to participants with a low or medium level of experience in ethical issues ($p < 0.05$), and among the respondents who had asked for counselling in the past compared to those who had not in regard to the majority of the statements ($p < 0.05$) *(Table 3)*. Finally, the great importance that Nurses, more than Physicians, acknowledged to the psychological support to address ethical difficulties was further revealed ($p < 0.001$) *(Table 3)*.

**DISCUSSION**
The results of this study confirm that both Nurses and Physicians frequently face ethically sensitive situations during their professional activities. Consequently, this finding highlights the urgency to establish ECS in Italy. This inevitably implies that the knowledge of

**Table 3**
Mean level of agreement with the proposed reasons for the use of ethical counseling stratified according to the characteristics of the respondents. The level of agreement is expressed through a Likert scale (1: strongly disagree to 5: completely agree)

| Stratification variables | Gender | | | Role | | | Have deepened ethical issues | | | Experiences with ethical issues | | | | Have asked for counselling in the past | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Reasons for the use of ethical counseling** | Male | Female | p-value | Nurses | Physicians | p-value | Yes | No | p-value | Low | Medium | High | p-value | Yes | No | p-value |
| | *(Mean agreement)* | | | *(Mean agreement)* | | | *(Mean agreement)* | | | *(Mean agreement)* | | | | *(Mean agreement)* | | |
| To solve and avoid legal problems | 3.73 | 3.56 | 0.26 | 3.62 | 3.69 | 0.55 | 3.62 | 3.69 | 0.77 | 3.57 | 3.41 | 4.00 | <0.001 | 3.89 | 3.55 | 0.03 |
| To compare and exchange opinions different from mine | 3.84 | 3.83 | 0.87 | 3.84 | 3.81 | 0.83 | 3.86 | 3.75 | 0.31 | 3.66 | 3.72 | 4.16 | <0.001 | 4.09 | 3.75 | 0.01 |
| To understand ethical involvement in health care activities | 3.79 | 3.86 | 0.67 | 3.86 | 3.82 | 0.62 | 3.90 | 3.72 | 0.15 | 3.72 | 3.79 | 4.03 | 0.05 | 4.04 | 3.79 | 0.09 |
| To behave appropriately in conflicts with the patient's family | 3.74 | 3.97 | 0.19 | 3.95 | 3.90 | 0.55 | 3.96 | 3.90 | 0.73 | 3.69 | 3.94 | 4.20 | <0.001 | 4.06 | 3.89 | 0.08 |
| To get psychological support in facing ethical problems | 3.58 | 3.83 | 0.19 | 3.90 | 3.54 | <0.001 | 3.75 | 3.84 | 0.83 | 3.48 | 3.87 | 4.11 | <0.001 | 4.06 | 3.71 | 0.01 |
| To find suitable answers to terminal patients' requests | 4.10 | 4.11 | 0.63 | 4.15 | 4.05 | 0.33 | 4.13 | 4.08 | 0.45 | 3.81 | 4.23 | 4.35 | <0.001 | 4.39 | 4.04 | 0.01 |

ethical issues and their correct management cannot be simply delegated to the individual initiative. Although a high percentage of the sample declared to have a good knowledge of ethical issues, a very low percentage of the respondents had actually attended a specific training. In this regard, the self-perception of knowledge in this work seems to be a "soft indicator" compared with the objective and indirect dimensions that were considered most reliable to outline the profile of potential users of an ECS. The importance both of content knowledge about ethical issues and of the available instruments to face them was highlighted by the greater importance that the respondents who had asked for counselling in the past acknowledged to the potential activities of an ECS compared to respondents who had never requested counselling *(Table 2)*. Therefore, a key role in raising awareness of the ethical dimension in healthcare practice can be played by education in ethics, which is often referred to as an ECS competency [14, 20, 28].

One aspect highlighted by the results of this study, investigated both as an aid that would have been useful in situations experienced in the past *(Table 2)* and as a potential demand for counselling *(Table 3)*, is the need of psychological support, especially for Nurses. The comparison between the expectations of Physicians and Nurses regarding the services provided by ECS introduces a further element of analysis to the current debate, as highlighted in previous studies [20]. The high frequency of ethical difficulties in nursing care has already been documented, and some recurring issues have been highlighted [24]. A context characterized by moral distress caused by difficult relationships with the patients and their family and conflicts with other Healthcare Professionals due to poorly shared care choices has been widely described [18, 29-32].

Other specific issues were of particular interest for the overall sample, such as the counselling for "individual cases" about "end-of-life", and advice regarding how to behave during conflicts with patients/families. In the literature, "end-of-life" cases are considered as the major reason to get ECS advice [6, 8, 9, 33]. Indeed, during these situations Healthcare Professionals must make decisions in a context of technological development and enhanced possibilities of therapeutic pathways that may conflict with the ethical dimension. Situations related to "end-of-life" can generate conflicts between healthcare providers and patients and/or their relatives [24, 33-35], especially in the case of disagreement with family's demands of "medically inappropriate treatment" [24, 34, 36], also defined as "futility". The "futility" aspect may create conflicts between family's expectations on the care and Healthcare Professional's decisions, often complicated by a lack of communication between them [8, 33, 35, 37-39]. Moreover, ethically difficult end-of-life situations exacerbate Nurse's discomfort in facing patients' suffering, appropriateness of treatment, and communication problems with relatives that can be worsened by the lack of specific training in the ethical field [2, 6, 8]. Ethical counselling during contrasts between Healthcare Professionals and patients or families could provide explanations to the patients and/or their families about the under-lying reasons for clinical decisions related to the conflict, thus contributing to shared clinical decisions [29, 30]. Besides, it could improve the relationship between Healthcare Professionals and the patients/families focusing the attention on the communication [40].

Education should also play a role in supporting Healthcare Professionals: upgrading study curricula can provide Nurses with tools to deal with other Healthcare Professionals about healthcare choices and with experts about ethical difficulties. In this way, it is possible to create the conditions for overcoming the sense of powerlessness caused by both the perception of poor ability to affect complex ethical situations and a sense of inadequacy in the relationship with experts, aspects that can cause resistance to requesting counselling [2, 6, 8, 14, 18-20, 23, 24, 28-39, 41]. Moreover, the respondents, particularly those who had asked for counselling in the past and those with higher experiences with ethical issues, considered to have counselling to orient themselves in the ethical dimension of healthcare issues as more important (e.g. definition of the ethical aspects of healthcare situations, information on regulations and exchange of views with experts), thus delineating central competences for an ECS. This higher sensitivity to ethical issues also leads some Healthcare Professionals to have greater awareness than others about potential risks that may arise from not being able to recognize the ethical implications in clinical and healthcare decisions. Therefore, rather than being used as a legal shield to avoid legal problems, an ECS support model should help and reassure Healthcare Professionals in decision-making and raise their awareness of the potential ethical content of care [5].

In the technological healthcare reality, ECS, where they are spread, play a specific role in supporting decision-making by providing guidance for patient care. Along with the ECS spread and the growth in demand for their performance, especially by Healthcare Professionals, suggestions have been made for their organization, and competences that extend to the promotion of policy initiatives and training of ethical operators have been defined. Ethical counselling in the healthcare field is increasingly becoming a resource for healthcare systems with a recognized potential in the process of improving performance quality, especially for the dedication shown by Healthcare Professionals in dealing with increasingly frequent ethical difficulties [3-6] and in using ECS [8, 9, 13, 14].

The competences attributed to the ECS arise from both reflection on the current ethical challenges in healthcare and analysis of the demand for counselling for services that work in hospital facilities within the health systems where ethics counselling has been established [34, 36].

The results presented here highlight the expectations of potential users regarding ECS competences from a twofold perspective, which were already identified by the Italian National Committee for Bioethics [22]:

- Healthcare Professionals' perception of their need for ethical advice arising from their real everyday situations encountered in healthcare;
- motivations that are the basis of a potential demand for ethical support.

For both these perspectives, the responses given by the sample lead us to consider the following as the principal functions of ECS:

• to suggest hospital policy and develop ethical guidelines;

• to provide counselling activities for individual cases in response to questions from clinicians, patients, and family members.

The expectations of potential ECS users lead to a thought on the role and skills of counsellors and the process of their recruiting [14]. In particular, the need to determine the method for counsellor recruitment, which has to be based on specific experience and training requirements, continues to be one of the most critical issues in organizing ECS [6, 41]. In this regard, although mediating and not prescriptive attitudes are required to ECS in order to solve ethical problems, it should particularly deal with the definition, interpretation, and application of guidelines [27, 40]. Hence, working according to the best practice criteria is the way to develop and improve the quality of ethical debate, guaranteeing greater acknowledgement for the counselling activity and adequacy of the answers to Healthcare Professionals who request them. If the request for advice is not met, both the quality of care and the possibility of development and establishment of ECS within healthcare facilities may be compromised [6, 7, 14].

## STRENGTHS AND LIMITATIONS

This study was carried out in a local context using a convenience sample. Therefore, the results are not generalizable to a national stage.

To our knowledge, this is the first Italian study in which Healthcare Professionals (Nurses and Physicians) were indirectly asked about the contents of potential requests of ECS starting from their experiences and opinions in ethical difficulties. The lack of ECS distresses Healthcare Professionals who often perceive the need for ethical consultation due to the increase of ethical difficulties encountered during daily clinical practice.

## CONCLUSIONS

Studies on the presence of ethical difficulties in clinical and nursing activities are consistent in detecting the growth of ethically sensitive situations that Healthcare Professionals are faced with. Because of this emerging reality, health systems in many countries have promoted the spread of ECS in healthcare facilities. Therefore, stakeholders are currently discussing regarding the needs of potential users, the more appropriate types of performances to offer, the organizational models, and the regulatory systems. Reflection, however, besides relying on the debate and experiences of other countries and on recent indication of the Italian National Bioethics Committee [22], should consider the prospect of potential users who, more than others, can contribute to defining the competencies of an ECS. Expected performances should focus on counselling and support in clinical and healthcare decisions in complex ethical situations. However, this activity on individual clinical cases is desirable to be conducted under institutional policies and guidelines so that the Service should become a promoter. In this context, attention to recruitment and training of components is of fundamental importance. An ECS composed of experienced and authoritative members can provide a valuable tool to stimulate debate on the ethical dimension of care, promoting the training of Healthcare Professionals on these issues.

The ECS role could expand to define institutional solutions to ethical issues by providing input for organizational guidelines and putting itself as a service of policy proposition at local level. Thereby, it could represent the guarantor of quality standards in responses to ethically sensitive situations, supporting, not replacing, Healthcare Professionals and managers in care decisions. It is desirable that future research deepens the needs of Healthcare Professionals regarding to ethical issues, for example by performing focus groups. Possible organisational evolutions could be the development of ECS and task forces within healthcare authorities that could support and sensitize Healthcare Professionals.

## REFERENCES

1. Slowther AM, McClimans L, Price C. Development of clinical ethics services in the UK: a national survey. J Med Ethics. 2012;38(4):210-4. DOI: 10.1136/medethics-2011-100173

2. Tapper EB, Vercler CJ, Cruze D, Sexson W. Ethics consultation at a large urban public teaching hospital. *Mayo Clin Proc*. 2010;85(5):433-8. DOI: 10.4065/mcp.2009.0324

3. Slowther AM, Hope T. Clinical ethics committees. BMJ. (Clinical research ed.). 2000;321(7262):649-50. DOI: 10.1136/bmj.321.7262.649

4. Tapper EB. Consults for conflict: the history of ethics consultation. Proc Bay Univ Med Cent. 2013;26(4):417-22.

5. Slowther A, Johnston C, Goodall J, Hope T. Development of clinical ethics committees. BMJ. (Clinical research ed.). 2004;328(7445):950-2. DOI: 10.1136/bmj.328.7445.950

6. Fox E, Myers S, Pearlman RA. Ethics consultation in United States hospitals: a national survey. Am J Bioeth. 2007;7(2):13-25. DOI: 10.1080/15265160601109085

7. van der Kloot Meijburg HH, ter Meulen RH. Developing standards for institutional ethics committees: lessons from The Netherlands. J Med Ethics. 2001;27 Suppl

1:i36-40. DOI: org/10.1136/jme.27.suppl_1.i36

8. Moeller JR, Albanese TH, Garchar K, Aultman JM, Radwany S, Frate D. Functions and outcomes of a clinical medical ethics committee: a review of 100 consults. HEC Forum. 2012;24(2):99-114. DOI: 10.1007/s10730-011-9170-9

9. Romano ME, Wahlander SB, Lang BH, Li G, Prager KM. Mandatory ethics consultation policy. Mayo Clin Proc. 2009;84(7):581-5. DOI: 10.1016/s0025-6196(11)60746-5

10. Orlowski JP, Hein S, Christensen JA, Meinke R, Sincich T. Why doctors use or do not use ethics consultation. J Med Ethics. 2006;32(9):499-502. DOI: 10.1136/jme.2005.014464

11. Bramstedt KA, Jonsen AR, Andereck WS, McGaughey JW, Neidich AB. Optimising the documentation practices of an Ethics Consultation Service. J Med Ethics. 2009;35(1):47-50. DOI: 10.1136/jme.2008.024265

12. Campbell AV. Clinical governance--watchword or buzzword? J Med Ethics. 2001;27 Suppl 1:i54-6. DOI: org/10.1136/jme.27.suppl_1.i54

13. Dauwerse L, Abma T, Molewijk B, Widdershoven G. Need for ethics support in healthcare institutions: views of Dutch board members and ethics support staff. J Med Ethics. 2011;37(8):456-60. DOI: 10.1136/jme.2010.040626

14. Chwang E, Landy DC, Sharp RR. Views regarding the training of ethics consultants: a survey of physicians caring for patients in ICU. J Med Ethics. 2007;33(6):320-4. DOI: 10.1136/jme.2006.016287

15. Comitato Nazionale per la Bioetica. I comitati etici. Roma: Presidenza del Consiglio dei Ministri; 1992.

16. Comitato Nazionale per la Bioetica. I comitati etici in Italia: problematiche recenti. Roma: Presidenza del Consiglio dei Ministri; 1997.

17. Italia. Decreto del Ministero della Salute 8 febbraio 2013. Criteri per la composizione e il funzionamento dei comitati etici. Gazzetta Ufficiale – Serie Generale n. 96, 24 aprile 2013.

18. Pavlish C, Brown-Saltzman K, Hersh M, Shirk M, Nudelman O. Early indicators and risk factors for ethical issues in clinical practice. J Nurs Scholarsh. 2011;43(1):13-21. DOI: 10.1111/j.1547-5069.2010.01380.x

19. Godkin MD, Faith K, Upshur RE, Macrae SK, Tracy CS. Project examining effectiveness in clinical ethics (PEECE): phase 1-- descriptive analysis of nine clinical ethics services. J Med Ethics. 2005;31(9):505-12. DOI: 10.1136/jme.2004.010595

20. Leuter C, Petrucci C, Lancia L, di Orio F. Request for ethics support in healthcare practices. Reasons and characteristics of Ethics Consultation Service users. Ann Ig. 2013;25(6):539-52. DOI: 10.7416/ai.2013.1954

21. Leuter C, Altobelli E, di Orio F. Research Ethics Committees in Abruzzo: criticisms and prospects for developments. Ann Ig. 2010;22(3):263-72.

22. Comitato Nazionale per la Bioetica. I comitati per l'etica nella clinica. Roma: Presidenza del Consiglio dei Ministri; 2017.

23. Leuter C, La Cerra C, Calisse S, Dosa D, Petrucci C, Lancia L. Ethical difficulties in healthcare: A comparison between physicians and nurses. Nurs Ethics. 2017:969733016687158. DOI: 10.1177/0969733016687158

24. Leuter C, Petrucci C, Mattei A, Tabassi G, Lancia L. Ethical difficulties in nursing, educational needs and attitudes about using ethics resources. Nurs Ethics. 2013;20(3):348-58. DOI: 10.1177/0969733012455565

25. Italia. Legge 22 Dicembre, n. 219. Norme in materia di consenso informato e di disposizioni anticipate di trattamento. Gazzetta Ufficiale – Serie Generale n. 12, 16 gennaio 2018.

26. Hurst SA, Perrier A, Pegoraro R, Reiter-Theil S, Forde R, Slowther AM, et al. Ethical difficulties in clinical practice: experiences of European doctors. J Med Ethics. 2007;33(1):51-7. DOI: 10.1136/jme.2005.014266

27. Marcus BS, Carlson JN, Hegde GG, Shang J, Venkat A. Evaluation of Viewpoints of Health Care Professionals on the Role of Ethics Committees and Hospitals in the Resolution of Clinical Ethical Dilemmas Based on Practice Environment. HEC Forum. 2016;28(1):35-52. DOI: 10.1007/s10730-014-9262-4

28. Lachman VD. Clinical ethics committees: organizational support for ethical practice. Medsurg Nurs. 2010;19(6):351-3.

29. Goethals S, Gastmans C, de Casterle BD. Nurses' ethical reasoning and behaviour: a literature review. Int J Nurs Stud. 2010;47(5):635-50. DOI: 10.1016/j.ijnurstu.2009.12.010

30. Pavlish C, Brown-Saltzman K, Fine A, Jakel P. A culture of avoidance: voices from inside ethically difficult clinical situations. Clin J Oncol Nurs. 2015;19(2):159-65. DOI: 10.1188/15.cjon.19-02ap

31. Ulrich C, O'Donnell P, Taylor C, Farrar A, Danis M, Grady C. Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. Soc Sci Med. 2007;65(8):1708-19. DOI: 10.1016/j.socscimed.2007.05.050

32. Ulrich CM, Taylor C, Soeken K, O'Donnell P, Farrar A, Danis M, et al. Everyday ethics: ethical issues and stress in nursing practice. J Adv Nurs. 2010;66(11):2510-9. DOI: 10.1111/j.1365-2648.2010.05425

33. Breslin JM, MacRae SK, Bell J, Singer PA. Top 10 health care ethics challenges facing the public: views of Toronto bioethicists. BMC Med Ethics. 2005;6:E5. DOI: 10.1186/1472-6939-6-5

34. Williamson L. Empirical assessments of clinical ethics services: implications for clinical ethics committees. Clin Ethics. 2007;2(4):187-92. DOI: 10.1258/147775007783560184

35. Mitnick S, Leffler C, Hood VL. Family caregivers, patients and physicians: ethical guidance to optimize relationships. J Gen Inter Med. 2010;25(3):255-60. DOI: 10.1007/s11606-009-1206-3

36. Carrese JA, McDonald EL, Moon M, Taylor HA, Khaira K, Catherine Beach M, et al. Everyday ethics in internal medicine resident clinic: an opportunity to teach. Med Educ. 2011;45(7):712-21. DOI: 10.1111/j.1365-2923.2011.03931.x

37. Piers RD, Azoulay E, Ricou B, Dekeyser Ganz F, Decruyenaere J, Max A, et al. Perceptions of appropriateness of care among European and Israeli intensive care unit nurses and physicians. JAMA. 2011;306(24):2694-703. DOI: 10.1001/jama.2011.1888

38. Wilkinson DJ, Savulescu J. Knowing when to stop: futility in the ICU. Curr Opin Anaesthesiol. 2011;24(2):160-5. DOI: 10.1097/ACO.0b013e328343c5af

39. Gallagher CM, Holmes RF. Handling cases of 'medical futility'. HEC Forum 2012;24(2):91-8. DOI: 10.1007/s10730-011-9168-3

40. Petrini C, Ricciardi W. Clinical ethics and the role of clinical ethics committees: proposals for a revival. Commentary. Ann Ist Super Sanità. 2017;53(3):183-4. DOI: 10.4415/ANN_17_03_01

41. Gaudine A, Thorne L, LeFort SM, Lamb M. Evolution of hospital clinical ethics committees in Canada. J Med Ethics. 2010;36(3):132-7. DOI: 10.1136/jme.2009.032607