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Clinical ethics counseling: Therapeutic goals, the patient's will and decision-making problems in modern medicine

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1. Clinical ethics counseling and main currents in medical ethics

Changes in medicine and the role of the patient

The current significance of clinical ethics counseling has its origin in three essential currents of medicine today. For one, the nature of clinical practice has been changing fundamentally for the past 50 years or so. Secondly, the emerging status of the patient as a self-determined decision-making subject – a process initiated primarily in the Anglo-Saxon world – and thus also the concept of patient autonomy have become the pivot of medical problem-solving and decision-making processes and actions. And lastly, limits on resources accompanied by large-scope treatment indications generated by medical innovation have widened the “gap between the availability of expensive high-performance medicine and restricted access to it due to limits of financial means,” thus making it necessary to make ethically reflected allocation decisions in the face of the conflicting priorities of distributive justice and optimal care of the individual patient (STEINKAMP and GORDIJN 2003).

Changes in clinical medicine derive for the most part from scientifico-technical developments which have made even quite serious diseases more and more controllable. Our possibilities for shaping our lives technologically – whether at the beginning or the end of life – are constantly expanding and taking on previously unknown dimensions. Whereas on the one hand more and more options for medical intervention in cases of critical and infaust courses of disease have emerged, the constraint of having to reflect critically upon and provide sound justification for choices made between several therapeutic options – involving in part a considerable degree of invasiveness – has intensified decidedly.

Changes in clinical practices have been accompanied to quite a considerable extent by

changes in the role of the patient. Previously the addressee and object of professional medical decisions and actions, the patient has undergone a deep transformation under the banner of patient autonomy, becoming a subject engaged in decision-making processes with the physician on a basis of partnership. The uncertainties connected with this emancipation from the paternalism of the physician and the embracement of an ideal but also illusionary, because utopian, notion of farthest-reaching autonomy on the side of the patient, and finally the current model of partnership which characterizes the physician-patient relationship cannot be discussed in this article; they have been treated extensively by others, however (NOACK and FANGERAU 2006). Thus let it suffice to emphasize that clinical ethics differs from other forms of bio-or medico-ethical research and practice in particular in terms of a specific convergence with decisions and actions taken within the relationship of partnership entertained between the physician and the patient as well as their – only too frequently neglected – embeddedness in an historically developed and culturally contingent context (ILKILIC 2006; ILKILIC 2007).

Structural factors effecting the increased occurrence of ethical conflicts which physicians and nursing staff in particular perceive as a growing challenge are economic necessities and legal and organizational regulations in practice. At present external, non-medico-specific factors, i.e. **economization** and **juridification** of clinical practice, tend to intensify ethical conflicts (LABISCH and PAUL 1998). The question which poses itself to many medical caretakers is: should medical decision-making and action primarily be medically advisable, social and ethical or should it be predominantly oriented to pragmatic conditions (PAUL 1998)?

As far as allocation of medical resources is concerned, more is at stake than just money. Thus every debate about the affordability of medical treatments is informed by a second question of fundamental importance: how can intervention or omission thereof be justified and/or viewed as imperative? This immediately raises the following question: is this medically justifiable act/omission also imperative in regard to the **individual** patient in his or her own **specific** situation (MARCKMANN 2006)? Thus medical and patient-oriented criteria always form a joint point of departure for medical decision-making. They are constitutive for ethical and social clinical practice **lege artis** (HURST, HULL et al. 2005).

Before we address the tasks, problems and perspectives of clinical ethics, an albeit very schematic characterization of other forms and practices of medical ethics should be provided for purposes of differentiation.

Which form of ethics?

The ongoing formation of bio-and medical ethics since the 1970's has led, for one, to a differentiation of scientific approaches and on the other hand to the emergence of quite diverse forms of institutionalization. Medical ethics is a sub-type of applied ethics. It is devoted to the specific issues of justification and value conflicts in their fields of application, i.e. medicine. Medical ethics is pursued for one as a scientific teaching and research discipline and as such it is assigned to the faculty of medicine and/or philosophy. Its role within medicine is legitimized primarily by the fact that medical ethics, in collaboration with the history and theory of medicine, strives to establish orientational knowledge in medicine through critical reflection of medical developments, explanatory models and practices (PAUL 1997; PAUL 1998; PAUL 2006; PAUL 2006; PAUL 2006). Within the framework of medical training, such knowledge is acquired in the subject "History, theory and ethics of medicine," which is incorporated in the curriculum of the *Ärztliche Approbationsordnung* (Licency Regulations for Physicians). Research interests in this genuinely interdisciplinary field are as diverse as are the subject matter and practices of medicine. In the area of ethics in question here, they are not primarily oriented towards application at the patient's bedside, however, but rather directed towards attempts to reconstruct and render analyzable basic issues and problems of medicine within specific temporal, local and cultural contexts in regard to values and value conflicts. Questions of research ethics, historical, cultural and ethical questions concerning the way we deal with death and dying as well as problems concerning fair distribution of health resources and the social attainability of health are examples of issues addressed by this field of inquiry. In the case of highly application-oriented medico-ethical research, what can be achieved at best is the clarification of conditions for the morality or ethical justifiability of what are ultimately situational decisions and actions (SCHULZ, STEIGLEDER et al. 2006).

In contrast, as a form of practical ethics, clinical ethics argues from a situational perspective. In doing so, it either draws upon decision models used in clinical practice – in clinic and organizations, for example – which, from an ethical perspective, are viewed as requiring justification and frequently even being deficient, or it orients itself to clinical cases characterized by value and/or decision-making conflicts at the patient's bedside – for example in connection with changes in therapeutic goals in the course of a shift from curative to palliative health care. Thus clinical ethics differs from the exclusively professional or personal ethos of the physician primarily in the sense that ethical problems which arise within the framework of clinical treatment and patient care are not viewed solely in the context of the

physician-patient relationship but rather as questions which pose themselves within the clinic or the organization as a whole (STEINKAMP and GORDIJN 2003:66).

The first clinical ethics committees in the USA, established by recommendation of the "Catholic Hospital Organization" in that country, came into being early on, in 1949. In Germany, the impetus for an institutionalization of clinical ethics also came from the area of denominational health care. In 1997, a joint "Recommendation of Protestant and Catholic Hospital Associations" formulated the demand for institutionalized ethics counseling; thus, large denominational hospitals usually now have well-established facilities for clinical ethics counseling. Attempts to establish clinical ethics committees driven more or less by what Horkheimer termed "instrumental reason" have resulted within the framework of hospital certification processes, for example through the KTQ_ (Kooperation für Transparenz und Qualität im Krankenhaus; Cooperation for Transparency and Quality in Hospitals), with well-structured facilities for ethics counseling receiving positive evaluation in this context. And finally, in 2006 the Central Ethics Commission of the German Medical Association inquired into principal structures and work modes of clinical ethics committees and published a statement on clinical ethics counseling (ZENTRALE KOMMISSION ZUR WAHRUNG ETHISCHER GRUNDSÄTZE IN DER MEDIZIN UND IHREN GRENZGEBIETEN BEI DER BUNDESÄRZTEKAMMER 2006; Central Commission of the German Medical Association on Adherence to Ethical Principles in Medicine and Adjacent Fields, 2006).

Institutionalization

Theoretical as well as practical forms of ethical expertise are represented in teaching and research as well as in the areas of patient care, ethics counseling and ethical review. In schematic terms, the situation is as follows:

| Institution | Task field |
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| Non-university institutes and research facilities | Research in the areas of bio-and medico ethics, often with a designated task or on the basis of an ideological foundation. |
| University institutes and research facilities | Teaching and research in the areas of bio-and medical ethics; in medical faculties often in the interdisciplinary field "History, Theory and Ethics of Medicine"; in philosophy departments in the area of practical philosophy. |

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| Clinical ethics committees | Local facilities in hospitals and clinics with tasks concerning the development of general orientation and guidelines, quality assurance for processes and results and in individual ethics counseling. Trainings – beginning and advanced – for physicians and nursing personnel of institutions. |
| Ethics commissions in accordance with federal state law | Institutions commissioned with review of applications for conducting clinical studies (in particular in accordance with AMG [Pharmaceutical Law], MPG [Medical Devices Law]) and issue of opinions of a regulatory nature with considerable consequences for professional regulations. |
| Ethics commissions of professional associations and the German Medical Association | Formulation of principles and guidelines in individual disciplines and for application-specific questions pertaining to the medical profession in general. Circulation and discussion of basic ethical issues among members of the medical profession. |
| National Ethics Council / German Ethics Council and Bioethics Commission of Rhineland-Palatinate (as sole existing federal state commission) | Basic issues of bio-and medical ethics in regard to their pan-societal relevance as well as in regard to existing socio-political and/or legal need for clarification and regulation. Education and informing of public and establishment of a social discourse on basic questions of bioand medical ethics. |

In the following, the focus of this article will be on the practice of individual-case counseling by clinical ethics committees. This topic is important from the standpoint of increasingly far-reaching implementation of local clinical ethics committees – among other respects in the context of certification processes – and on the basis of specific systematic questions which are raised in individual cases of ethics counseling. To effect a keener understanding of the argument these questions, which are inherently complex from a scientifico-theoretical perspective, are to be treated in three short steps. The first question to

be addressed concerns the relationship between clinical ethics counseling and medicine. On the basis of this, the relationship to the actual discipline of reference, i.e., ethics, is to be discussed in order to examine the relationship between clinical ethics and the reality of patients' lives on the one hand and on the other, that of physicians and other medical caretakers.

2. Concerning the relationship between clinical ethics and medicine

What is the specific nature of clinico-ethical argumentation and how does it pertain to medical knowledge, decision-making and actions? This question must be illuminated primarily in light of the fact that as an applied ethics, clinical ethics is dependent upon the conditions of its area of application. An essential prerequisite of clinico-ethical argumentation is thus the reconstruction of the medical facts and circumstances in the case in question as well as current options for action given in the contingent context (PAUL 2006). Apart from medical expertise, this requires in particular criticohermeneutic treatment of the medical state of knowledge with the involvement of various disciplines and, particularly when it is not a matter of routine clinical cases, an extensive exploration of current research literature, medical professional literature and relevant guidelines. A thorough reconstruction of the individual case goes far beyond this, however. It comprises consultancies with medical and nursing staff as well as a visit to the patient and in particular – whenever possible – conferral with the patient him- or herself. Patients and their next-of-kin are often confronted with a large number of physicians and nursing staff when dealing with a critical disease so that scheduling an additional "ethics round" has proven to be disadvantageous for the communication system; initial interviews with patients and/or next-of-kin should thus be held in a context which is as personal as possible, but this is a demand which often enough fails to be met due to pragmatic circumstances.

The first analysis of values and value conflicts which follows a review of the medical facts and circumstances also refers to the specific options for action provided by clinical medicine to a strong degree. Principally indicated and feasible measures should be characterized in the context of well-reflected therapeutic goals. In principle, therapeutic strategies can be categorized according to the following four groups:

- 1.) Therapy maximization: this means exhausting all measures at one's disposal to obtain the nearest therapy goal and the best possible overall clinical results.
- 2.) Therapy limitation: this means avoidance of escalation of measures as well as adjustment

of currently administered therapy but without initiating new therapies.

- 3.) Therapy reduction: in contrast to therapy limitation this involves limitation of currently administered therapy to what is required to obtain the nearest therapeutic goal in the sense of basic health care appropriate to the condition of the disease.
- 4.) Therapy discontinuation: this means refraining completely from any further interventions while ensuring primary health care.

Generally speaking, a critical analysis of given option for action will include a search for alternatives in the sense of a modification of therapeutic goals. This holds in particular for such cases in which the patient's survival can only be ensured through long-term intensive care. The question as to which therapeutic goal should be pursued is a challenge for physicians and other medical caretakers as well as for those involved in ethical counseling. Reorientation from a curative to a palliative therapeutic goal which foregoes prolongation of life for the benefit of an improvement of the patient's quality of life is a frequent problem in the context of clinical medicine but it is seldom approached in any systematic, theoretical fashion outside the realm of palliative medicine and thus it is often subject to the circumstances of situational decision-making.

It must be clearly emphasized that the point in time and the way in which a therapeutic goal is changed should be clarified using an interdisciplinarily oriented approach capable of integrating medical, ethical, psychological, social-and cultural-scientific as well as theological aspects. It has proven advisable to set up ethics committees exhibiting the widest possible spectrum of professional orientations. Which specific competences and skills are required by the clinical case in question must be reevaluated each time; typical problems of divided competency can occur in such situations. A large part of the difficulties which arise during communication processes in interdisciplinary settings can be alleviated by moderated procedures and guidelines for clinical ethics counseling but ultimately the communicative competence of those involved is more decisive than employment of professional competence. Thus in regard to the quality of counseling it is absolutely advantageous to agree upon a standardized procedure for clinical ethics counseling and to reflect critically the corresponding methodological prerequisites for counseling practices within a clinical ethics committee.

3. The relationship between clinical ethics counseling and ethics

From an ethical perspective, the evaluation of therapeutic goals is always also oriented towards concepts of "desirability" and "applicability," which are put to the test in considerations

of bio-medical innovation (TEN HAVE 1995). Thus a procedure which is suitable and viable per se should be medically, ethically and socially desirable in respect to its use as well as the results which can plausibly be expected of it. In this connection the patient's will forms the pivotal point of the concept of desirability. It is important to distinguish very carefully between desires of the first and of higher order, however. Whereas desires of the first order constitute immediately expressed and often unexpected desires, desires of a higher order are principally guided by fundamental convictions of longer standing and critico-rational, "sensible" decisions of a preliminary nature. It is these desires of a higher order which are decisive for determining a patient's will and which – if they have not already been expressed in reflected form – must be explicated. Due to the uncertainty which this generates for patients, it has become increasingly common for individuals to formulate the wishes shaped by their own values and fundamental long-term convictions in regard to end-of-life medical treatment in the form of a living will. Even if a living will exists, the currently declared will of the patient or his or her guardian, caretaker or proxy always takes priority, however. Should no living will put in writing exist, then the presumed will must be determined. What is meant by presumed will is the will which a patient would express at the current point in time if he or she had the capacity to do so. In order to determine a patient's presumed will, caretakers and proxies as well as the medical team should make mutual efforts to gain an understanding of the patient's values on the basis of earlier utterances and life decisions.

When dealing with the issue of a patient's will, ethical decision-making conflicts arise time and again. The main source of ethical decision-making conflicts is the openness of the patient's will to interpretation. This emerges for one from the potential difficulty of relating the patient's will to a currently give situation demanding a decision with sufficient definitude (SAHM 2004; CRANE, WITTINK et al. 2005; BURT 2006; SAHM 2006). Secondly, openness to interpretation can also result from a patient's failure to express his or her will and goals with sufficient clarity. Many living wills produced today were drawn up with legal assistance and are usually not objectionable from a juridic standpoint (ROTH 2004). They often fail to meet expectations of sufficient specificity in terms of the medical circumstances under which the will of the patient is to apply, however.

Furthermore, it is not always possible to determine clearly what the course and outcome of a disease will be (PAUL 2006). Due to this uncertainty, which is characteristic of medical decision-making and action, conflicting assessments concerning the benefits of therapeutic measures in relation to the duress of the patient and the success of reaching the therapeutic goal with available resources are often made. In practice this leads to burdensome and serious

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problems concerning weighing of interests, which call for an increased degree of justification and ethical responsibility. This typically constitutes a situation in which clinical ethics counseling should be used to moderate a consensual decision-making process. Specific problems of weighing benefits and detriments also arise in cases where a patient alternates between possessing and losing the ability to reason and make decisions, and in the case of children and adolescents. Individuals who are principally able to reason but are still under age should be involved in decisions to the degree that they are capable of taking sensible consideration of their situation. The goal in dealing with decision-making conflicts must be to make such decisions which the patient capable of sensible consideration of the decision at hand would in all probability agree to.

Such explication tasks, which are often underestimated in their medical and ethical scope, frequently run a certain risk, namely that the interests of next-of-kin or those of the medical and nursing staff are projected onto the presumed will of the patient and interfere with it. A – more or less pragmatic – reliance on ethical principles can help reduce this danger of interfering interests considerably. In this context the four principles first discussed by Beauchamp and Childress (BEAUCHAMP and CHILDRESS 1994), i.e. **autonomy, non-maleficence, beneficence and justice**, provide preliminary orientation. It must be clearly emphasized that taking maximum care in reflecting upon the patient's declared will or the reconstruction of his or her presumed will and taking consideration of this when defining therapeutic goals is the key to an adequate perception of the patient and his or her **autonomy** as a decision-making subject engaged in a physician-patient relationship based on partnership. If this is ensured, the next task is to raise the following crucial questions concerning the principle of maleficence – first and foremost the general imperative to avoid detriment to the patient – in the concrete clinical situation in which decisions must be made while taking into consideration desirable and applicable therapeutic goals:

- Does detriment to the patient or suffering result primarily from the disease itself or from the intervention?
- Is there any way to avoid larger detriment to the patient or to reduce his or her suffering without causing the largest degree of detriment as a result?

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- Is it unavoidable to impact the patient's quality of life short-term or to increase his or her suffering temporarily in order to achieve greater benefit for him or her in the final scheme?

- Has it been ensured that detriment and benefit have been taken into consideration in the subjective sense and in that of cultural variants as well?

In regard to beneficence the following questions then raise themselves:

Which of the attainable *therapeutic* goals best matches the interests of the patient or corresponds to his or her will?

- Are the measures to be taken to achieve the therapeutic goal desirable and feasible and/or applicable to the case in question?
- How can optimal quality of life be obtained for the patient while pursuing an appropriate therapeutic goal?

As in every medical decision-making situation, it is also possible to opt for "nonaction" or "non-decision-making" when determining and implementing a therapeutic goal. Conscious omission, for example waiting to see if a complication arises, constitutes an action in the ethical sense of the word and requires explicit justification. Taking action and refraining from taking action thus call for justification to the same degree. Ideally, justification should always derive from a therapeutic goal based on the patient's will and be justified and feasible in terms

of disease, health and quality of life. But how can the criteria of justice be taken into consideration in situational clinico-ethical decision-making processes?

4. Clinical ethics and the problem of application

The main focus of clinical ethics counseling lies on normatively founded decisions in individual cases. Even though decisions for or against a medical measure can and should ultimately only be made for which the physician takes responsibility, clinical ethics cannot ignore its task of making a contribution to the implementation of therapeutic goals which have been determined and deemed to be desirable and attainable. In clinical ethics one typically encounters three different categories of problems at the level of application: economic problems, legal problems and communication problems.

In particular, economic considerations are brought forth time and again when therapeutic goals reached by consensus and their planned implementation are scrutinized in terms of affordability – often in reference to questions of distributive justice. It has frequently been pointed out that in the current situation, the ideal of a physician-patient relationship based on partnership is being called into question by fundamental changes in the structures of medicine which are transforming the role of the physician in his or her interaction with the patient from one of “advocacy to allocation” (MECHANIC 1986) (MCCULLOUGH 1999). What is meant is the economically stimulated effect that physicians increasingly find themselves in a situation of having to balance the needs of their patients against the necessity of cost control. This effect has resulted from processes of *rationalization* and *economization* taking place in many areas of treatment cost calculations on the basis of criteria which are unclear or at least inappropriate in the context of clinical practice, the consequence of which is uncontrolled and undesired *implicit bedside rationing* (YOUNG 2000; MARCKMANN 2006). *Explicit rationalization* which is ethically well-founded in terms of justice in the sense of need-based distribution of limited resources – preferably involving such medical measures whose benefit is undisputed (PORZSOLT 1996) – cannot occur at the bedside but rather must be negotiated at higher levels of meso- and macro-allocation.

In light of such problems, an expanded notion of benefit in medicine currently offers the most promising avenue towards sensible limitation and legitimization of curtailments in terms of types and extent of medical treatments. The concept of benefit presently used in its restricted sense operates on the assumption that medical decision-making could be represented in the form of general principles – or at least in the form of generally valid heuristic

rules (NUNES 2003; GERBER and LAUTERBACH 2005). Only in this way can standardization of diagnostic and/or therapeutic procedures on the basis of case groups and DRGs as well as the restriction of decision-making autonomy in the physician-patient relationship be justified. Linear and exclusive legitimization of individual clinical decisions and treatments on the basis of probabilistic knowledge is problematic in institutions providing supra-maximum care in any case, for this would in fact fail to take account of situational, patient-related criteria of benefit and the particular clinical severity of cases treated here which are demanded from a clinico-ethical perspective. The feat consists in establishing a **balanced** relationship between medical knowledge and expertise on the one hand and pragmatic conditions on the other in each individual case and making them the foundation of clinical decision-making and action (PAUL 2003; PAUL 2006; PAUL 2006) which balances out individual treatment goals and the overriding goals of sustainable medical care. Such a balance is not only endangered; it would already seem to have been forfeited to the disadvantage of patient-centered medical diagnosis and treatment, and pessimists are not the only ones who fear that this development is irreversible. In light of the issue concerning justice in meeting needs and facilitating treatment, efforts to influence medical care structures in the sense of improving the culture of medical care constitute a task which local clinical ethics committees should take upon themselves.

At the application level, clinical ethics – in particular when it is a matter of end-of-life decisions involving therapy reduction or minimization – also finds itself confronted with legal considerations time and again. In the context of clinico-ethical decisions, legal regulations should initially be viewed primarily under the aspect of upholding values and their positive normative effect in interactions between medical personnel, the patient and his or her next-of-kin. As regards this, there is a clear tendency, however, to value protection against misuse more highly than the autonomy of the physician and the patient. This is the attitude which has resulted in the full-fledged emergence of a defensive type of medicine in the widest sense of the word, in which the notion of patient-oriented therapeutic goal-setting in normal hospital wards comes under pressure and questions of therapy reduction and/or minimization are decided primarily in anticipation of "legal indications." In the clinical situation, this structural problem is very difficult to solve. It is nevertheless crucial within the framework of clinical ethics counseling to work initially in the direction of realizing medically purposeful and ethically justifiable therapeutic goals which are in keeping with the patient's will alone. In doing so, it is beneficial for legal expertise to be represented within the clinical ethics committee so as to capacitate, in cases of doubt, the implementation of decisions in such a way as to render them indisputable in legal terms.

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A last aspect which often proves to be the actual source of conflicts in practice should be discussed here briefly. Communication problems – often left unmentioned and frequently unacknowledged – within the medical team as well as between physicians and other medical caretakers on the one side and next-of-kin and patients on the other, are often what prevent desirable and applicable therapeutic goals from being implemented (REDDER 1994). To be sure, clinical ethics committees can offer trainings designed to address this problem, but improvement of communication is dependent to such a considerable degree on pragmatic circumstances and conditions – space, time, hierarchies, professional interests, etc. – that it is very difficult to estimate the contribution clinical ethics can make in this situation.

The tenet that there can be no science of the individual has its philosophico-historical roots in the proposition “De singularibus non est scientia.” According to this, clinical ethics is by its very nature a *practice* which is completely reliant on the theoretical foundations of its disciplines of reference. Here the circle closes, for clinical ethics which maintains no connection to the history, theory and ethics of medicine fails by far to meet the demands of well-justified and understandable decisions and actions – demands which medicine is always obligated to fulfill in practice – and it would ultimately prove to be intuitionistic and primarily reliant on the individual social and moral competence of the persons involved. This does not seem appropriate for any contemporary clinical ethics, however (COHN, GOODMAN-CREWS et al. 2007).

5. Conclusion and perspectives

In Germany, clinical ethics counseling was initially established in denominational hospitals and was motivated later on by procedures of hospital certification as well. As a rule, its tasks consist in providing clinical ethics counseling, engaging in the formulation of guidelines as well as offering trainings for physicians and nursing staffs concerning ethical issues. Furthermore, some hospitals exist in which ethics committees are involved in individual cases or even in fundamental decisions which affect the clinic as a whole.

In light of the broad spectrum of tasks which clinical ethics is to fulfill and the dimensions of the individual task fields merely sketched out by this article, it is necessary to reconsider, time and again, the relationship between clinical ethics (as a practice) and the methods and foundations of its disciplines of reference, i.e. practical philosophy on the one hand and the interdisciplinary field History, Theory and Ethics of Medicine on the other. In institutions far removed from the arena of university teaching and research in particular, critical reflection on

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the standards of medical ethics and the methods and procedures one feels obligated to use for whatever reasons must take place. In university clinics it must also be clear, however, that clinical ethics which is to meet high standards cannot be built on the foundation of individual competence alone; the prerequisite for clinical ethics counseling is for one a close networking with disciplines of reference and ongoing medical and medico-ethical training for members of ethics commissions. Furthermore, in the interest of quality assurance a systematic framework for procedures used in counseling and well-structured documentation and critical evaluation of the activities of clinical ethics committees should be given. This seems to be quite urgent, for as studies show, carrying out clinical ethics counseling has a significant effect on the lengths of patients' stays in the hospital, in particular in intensive care units, with these periods of time usually being shortened considerably as a result of counseling (SCHNEIDERMAN, GILMER et al. 2000; SCHNEIDERMAN, GILMER et al. 2003; SCHNEIDERMAN 2006).

In view of its clinical efficacy, the perspective of clinical ethics counseling must be to increase its degree of professionalism even more. Clinics which establish ethics committees must ask themselves if they are willing to provide the necessary resources for professional clinical ethics. Members of clinical ethics committees should subject themselves to self-scrutiny, asking themselves whether their own professional and structural prerequisites suffice in order to engage in the area of clinical ethics which meets the necessary professional standards. In the area of clinical ethics, there is still an enormous need for teaching and research. The bridge from the history, theory and ethics of medicine and practical philosophy to the practice of clinical ethics remains to be clarified scientifically-theoretically as well as -practically (HUCKLENBROICH 2005). To be sure, isolated efforts have been made to change this (KETTNER 2005), but there has yet to be any impact on the activities of clinical ethics committees, including those at university clinics.

On the whole, the importance of clinical ethics is increasing all the time – and this goes for Germany as well. By its very nature and in terms of what occasions it, clinical ethics is a practice. Thus resources for clinical ethics should be provided by the area of medical care to such an extent as to allow for professional accomplishment of tasks. At the same time, the closest possible connection to the disciplines of reference – practical philosophy and History, Theory and Ethics of Medicine – at the teaching and research level should be established so as to be able to reclarify and scrutinize the methodological and systematic foundations of situational ethical decision-making on an ongoing basis. One can only hope that in Germany, clinical ethics attains the status it deserves – not only in denominational hospitals and the context of certification measures – and that it establishes quality standards suitable for dealing

with the scope of decision-making processes in question.

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Bibliography

- BEAUCHAMP, T. L. and J. F. CHILDRESS (1994). Principles of Biomedical Ethics, 4th edition. New York, Oxford University Press
- BURT, R. A. (2006). "Law's Effect on the Quality of End-of-life Care: Lessons from the Schiavo Case." *Crit Care Med* 34(11 Suppl): 348-354
- COHN, F., P. GOODMAN-CREWS, et al. (2007). "Proactive ethics consultation in the ICU: a comparison of value perceived by healthcare professionals and recipients." *J Clin Ethics* 18(2): 140-7
- CRANE, M. K., M. WITTINK, et al. (2005). "Respecting End-of-life Treatment Preferences." *Am Fam Physician* 72(7): 1263-1268
- GERBER, A. and K. W. LAUTERBACH (2005). "Evidence-based Medicine: Why do Opponents and Proponents use the Same Arguments?" *Health Care Anal* 13(1): 59-71
- HUCKLENBROICH, P. (2005). "Wie die Theorie medizinethischer Beratungsorgane in die Theorie der Medizin eingebettet werden kann." *Erwägen, Wissen, Ethik* 16(1): 35-38
- HURST, S. A., S. C. HULL, et al. (2005). "Physicians' Responses to Resource Constraints." *Arch Intern Med* 165(6): 639-44
- ILKILIC, I. (2006). Zum Bedarf an „Kulturoffenheit“ in der Medizinethik am Beispiel von muslimischen Patienten in einer wertpluralen Gesellschaft. In: *Biomedizin im Kontext*.
- S. GRAUMANN and K. GRÜBER, eds., Berlin: 51-65 ILKILIC, I. (2007). "Medizinethische Aspekte im Umgang mit muslimischen Patienten." *Deutsche Medizinische Wochenschrift* 132(30)
- KETTNER, M. (2005). "Ethik-Komitees. Ihre Organisationsform und ihr moralischer Anspruch." *Erwägen, Wissen, Ethik* 16(1): 3-16
- LABISCH, A. and N. W. PAUL (1998). *Medizin (zum Problemstand)*. In: *Lexikon der Bioethik Bd 2*. W. KORFF, ed., Gütersloh, Gütersloher Verl.-Haus: 631-642
- MARCKMANN, G. (2006). Verteilungsgerechtigkeit in der Gesundheitsversorgung. In:

- Geschichte, Theorie und Ethik der Medizin: Eine Einführung. S. SCHULZ, K. STEIGLEDER, H. FANGERAU and N. W. PAUL, eds., Frankfurt/M., Suhrkamp
- MCCULLOUGH, L. B. (1999). "Laying medicine open: understanding major turning points in the history of medical ethics." *Kennedy Inst Ethics J* 9(1): 7-23.
- MECHANIC, D. (1986). *From Advocacy To Allocation: The Evolving American Health Care System*. New York, Free Press/Collier Macmillan
- NOACK, T. and H. FANGERAU (2006). Zur Geschichte des Verhältnisses von Arzt und Patient in Deutschland. In: *Geschichte, Theorie und Ethik der Medizin: Eine Einführung*. S. SCHULZ, K. STEIGLEDER, H. FANGERAU and N. W. PAUL, eds., Frankfurt/M., Suhrkamp
- NUNES, R. (2003). "Evidence-based Medicine: A New tool for Resource Allocation?" *Med Health Care Philos* 6(3): 297-301
- PAUL, N. W. (1997). Von der medizinethischen Reichweite strukturhistorischer Erklärungsmodelle in der Medizingeschichte. In: *Geschichte und Ethik in der Medizin. Von den Schwierigkeiten einer Kooperation*. R. TOELLNER and U. WIESING, eds., Stuttgart, Fischer: 49-65
- PAUL, N. W. (1998). "Incurable Suffering from the "hiatus theoreticus"? Some Epistemological Problems in Modern Medicine and the Clinical Relevance of Philosophy of Medicine." *Theoretical Medicine and Bioethics* 19(3): 229-251
- PAUL, N. W. (1998). "Wider besseres Wissen? Historische, theoretische und ethische Überlegungen zur primären Allokation unter wachsendem Kostendruck." *Der Gynäkologe* 31(7): 608-615
- PAUL, N. W. (2003). The Representational Framework of Health and Disease. In: *Traditions of Pathology in Western Europe. Theories, Institutions and their Cultural Setting*. C. R. PRÜLL, ed., Pfaffenweiler, Centaurus: 123-138
- PAUL, N. W. (2006). Diagnose und Prognose. In: *Geschichte, Theorie und Ethik der Medizin: Eine Einführung*. S. SCHULZ, K. STEIGLEDER, H. FANGERAU and N. W. PAUL, eds., Frankfurt/M., Suhrkamp: 143-152
- PAUL, N. W. (2006). Gesundheit und Krankheit. In: *Geschichte, Theorie und Ethik der Medizin: Eine Einführung*. S. SCHULZ, K. STEIGLEDER, H. FANGERAU and N. W. PAUL, eds., Frankfurt/M., Suhrkamp: 131-142
- PAUL, N. W. (2006). Medizintheorie. In: *Geschichte, Theorie und Ethik der Medizin: Eine Einführung*. S. SCHULZ, K. STEIGLEDER, H. FANGERAU and N. W. PAUL, eds., Frankfurt/M., Suhrkamp: 59-73

- PAUL, N. W. (2006). Wissenschaftstheoretische Aspekte medizinischer Forschung. In: Geschichte, Theorie und Ethik der Medizin: Eine Einführung. S. SCHULZ, K. STEIGLEDER, H. FANGERAU and N. W. PAUL, eds., Frankfurt/M., Suhrkamp: 268-282
- PORZSOLT, F. (1996). "Rationalisierung und Rationierung im Gesundheitssystem." Münchener Medizinische Wochenschrift 138 608-611
- REDDER, A., ed. (1994). Medizinische Kommunikation: Diskurspraxis, Diskursethik, Diskursanalyse. Opladen
- ROTH, A. (2004). "Die Verbindlichkeit der Patientenverfügung und der Schutz des Selbstbestimmungsrechts." Juristenzeitung(10): 494-502
- SAHM, S. (2004). "Selbstbestimmung am Lebensende im Spannungsfeld zwischen Medizin, Ethik und Recht." Ethik in der Medizin 16(2): 133-147
- SAHM, S. (2006). Sterbebegleitung und Patientenverfügung: Ärztliches Handeln an den Grenzen von Ethik und Recht. Frankfurt, Campus Verlag
- SCHNEIDERMAN, L. J. (2006). "Effect of ethics consultations in the intensive care unit." Crit Care Med 34(11 Suppl): S359-63
- SCHNEIDERMAN, L. J., T. GILMER, et al. (2000). "Impact of ethics consultations in the intensive care setting: a randomized, controlled trial." Crit Care Med 28(12): 3920-4
- SCHNEIDERMAN, L. J., T. GILMER, et al. (2003). "Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial." Jama 290(9): 1166-72
- SCHULZ, S., K. STEIGLEDER, et al., eds. (2006). Geschichte, Theorie und Ethik der Medizin: Eine Einführung. Frankfurt/M., Suhrkamp
- STEINKAMP, N. and B. GORDIEN (2003). "Ethik zwischen Leitbild und Stationsalltag. Das Zweilagennmodell der Ethik in der Klinik." Zeitschrift für Medizinische Ethik(49): 6575
- TEN HAVE, H. (1995). "Medical Technology Assessment and Ethics -Ambivalent Relations." Hastings Center Report 25(5): 13-19
- YOUNG, E. W. (2000). "Changing Economics and Clinical Ethical Decision-making: A View from the Trenches." Camb Q Healthc Ethics 9(2): 284-7
- ZENTRALE KOMMISSION ZUR WAHRUNG ETHISCHER GRUNDSÄTZE IN DER MEDIZIN UND IHREN GRENZGEBIETEN BEI DER BUNDESÄRZTEKAMMER (2006). "Stellungnahme der Zentralen Ethikkommission der Bundesärztekammer zur Ethikberatung in der Medizin vom 24.01.2006." Deutsches Ärzteblatt(103): A1703A1707

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