Ethics Consultants' Recommendations for Life-Prolonging Treatment of Patients in a Persistent Vegetative State

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Objective.—Surprisingly little is known about the content of ethics consultants' recommendations. We chose to study this issue using hypothetical persistent vegetative state (PVS) cases. We addressed four questions: What recommendations do ethics consultants give regarding life-prolonging treatment (LPT) in PVS cases? To what degree is there consensus? What factors influence recommendations? Do recommendations conform to established guidelines?

Design.—Questionnaire survey. Our questionnaire asked subjects what they would recommend for seven hypothetical vignettes involving a PVS patient that varied with respect to advance directives and family wishes. We also questioned subjects about demographic characteristics, ethics consultation experience, and personal preference for LPT in PVS.

Subjects.—Attendees at an annual meeting of the Society for Bioethics Consultation (n=154).

Results.—The response rate was 77%. Eighty-one percent of respondents were ethics committee members and 62% were ethics consultants. There was general agreement among respondents for only one of seven vignettes: in the case of a PVS patient whose advance directive and family agree that LPT be stopped, 93% recommended stopping all LPT. Responses to other vignettes varied considerably. Although patient wishes were an important factor influencing recommendations, none of the respondents adhered invariably to the patient's advance directive. Recommendations were also influenced by family wishes, resource allocation considerations, legal constraints, and personal preference for LPT in PVS. Guidelines we examined were generally too equivocal to be useful for evaluating ethics consultants' recommendations.

Conclusions.—The finding of wide variability in ethics consultants' recommendations suggests a need to clarify standards for ethics consultation.

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ALTHOUGH ethics consultants are increasingly being employed by hospitals and other institutions to assist in clinical decision making, the literature contains relatively few empirical studies on ethics consultation. There is a handful of descriptive studies summarizing, for example, background and training of consultants, reasons for consultation requests, and characteristics of patients.[1-6] A few studies have also attempted to evaluate the success or failure of the ethics consultation process[3,4,6] or to explore the theoretical foundations of consultants' ethical decision making.[7] However, little is known about the substantive content of ethics consultations—that is, for a given clinical case, what specifically would ethics consultants advise?

We were particularly interested in studying two aspects of ethics consultants' advice. First, we wondered to what extent recommendations by different consultants presented with the same clinical information would be consistent. Second, we wanted to know how closely ethics consultants' recommendations would conform to well-known consensus statements and guidelines. These two questions are especially timely in light of recent discussions about credentialing ethics consultants and the related issue of developing standards to evaluate ethics consultations.[8,9]

To study ethics consultants' recommendations, we administered a questionnaire to a group of individuals attending a professional meeting of bioethics consultants. We asked subjects what they would recommend as ethics consultants for a series of clinical case vignettes. We chose to focus the questionnaire on decisions about life-prolonging treatment (LPT) because these are the most commonly raised issues for clinical ethics consultants[1,3-6] and because no area in medical ethics has a richer literature. Numerous articles have been written on this topic,[10] survey studies have described the attitudes of physicians,[11-17] nurses,[17] or lay people,[18,19] and guidelines have been endorsed by professional organizations.[18,20-26]

In an effort to make the clinical cases realistic and straightforward, we described a patient in a persistent vegetative state (PVS). Persistent vegetative state is a clinical entity that has been the subject of famous court cases, such as *In re Quinlan*, 355 A. 2nd 647 (NJSC 1976) and *Cruzan v Director, Missouri Department of Health*, 110 SCt 2841 (1990). Recently, PVS has received a great deal of attention in professional journals and the popular press, including several sets of ethical guidelines devoted exclusively to the condition.[27-30] Ethics consultants probably have as much familiarity with PVS as with any other single diagnosis. In addition, many of the subjective determinations that typically complicate ethics consultation are absent from PVS cases. Decision-making capacity, a pivotal concept in many ethics cases, is never at issue with patients in PVS. Compared with most other medical conditions, the prognosis of PVS is known with a great deal of certainty. The condition is easy to describe, as it is relatively well defined and consistent from case to case. The PVS patient's situation is generally static, so time is rarely a factor, and because PVS patients are considered unable to experience pain and suffering, quality-of-life assessments become irrelevant. The relative simplicity of PVS makes it ideally suited to our multiple vignette format.

METHODS

Subjects

We surveyed the group of individuals who attended the sixth annual meeting of the Society for Bioethics Consultation in Toronto, Ontario, in September 1991. One of us (E.F.) attended the meeting and obtained a list of 154 people who checked in at the registration desk. Questionnaires

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were distributed to 144 people at the conference; the remaining 10 subjects were sent questionnaires by mail. Subjects were asked to return their questionnaires at the conference or in the mail. Those who did not initially respond were sent two follow-up mailings.

Questionnaire

The 10-page questionnaire (available on request) took approximately 15 minutes to complete and consisted of two parts. The first part presented eight variations on the following hypothetical case:

> You are consulted about limiting treatment for an unconscious patient who, in the opinion of the attending physician, a neurologist, and multiple other consultants, has virtually no chance of ever regaining consciousness and no known awareness of the outside world. Currently the only treatments the patient is receiving are fluid and nutrition through artificial means and routine nursing care; the patient does not require any other life-prolonging treatments (eg, mechanical ventilation, antibiotics, etc).

The case description was intended to convey simply yet accurately the condition of a typical patient in PVS. We deliberately avoided using the label "persistent vegetative state" or technical data such as the duration of unconsciousness to minimize the possibility that differences in medical knowledge might lead to varying interpretations.

For the first seven vignettes, subjects were asked to indicate what they would recommend if they were the ethics consultant. These vignettes differed as to whether the patient's prior wishes were known, whether family or friends were available, and the content of the advance directive and family wishes. The eighth vignette asked what the subject would want for him- or herself in the circumstance described. The eight vignettes comprised the following:

1. Patient did not want to be kept alive; family wants to stop all LPT.
2. Patient did not want to be kept alive; family wants to do "everything possible" to prolong life.
3. Patient wanted to be kept alive as long as possible; family wants to do "everything possible" to prolong life.
4. Patient wanted to be kept alive as long as possible; family wants to stop all LPT.
5. No verbal or written advance directive of any kind regarding patient wishes; family wants to stop all LPT.
6. No verbal or written advance directive of any kind regarding patient wishes; family wants to do "everything possible" to prolong life.
7. No verbal or written advance directive of any kind regarding patient wishes; patient has no known family or friends.
8. If you were the patient described above, what would you want for yourself?

After each vignette, the following five possible responses were listed:

A. Continue routine nursing care, but stop all treatments necessary for prolonging life, including artificial fluid and nutrition.

B. Continue fluid and nutrition through artificial means as well as routine nursing care, but do not add any additional procedures or treatments.

C. Continue fluid and nutrition through artificial means as well as routine nursing care, and in addition add the following procedures or treatments if they become necessary for prolonging life (circle as many as apply): antibiotics, simple diagnostic tests, blood or blood product transfusions, transfer to intensive care unit, dialysis, chemotherapy for cancer, minor surgery, major surgery, mechanical ventilation, cardiopulmonary resuscitation, organ transplantation.

D. Do everything possible to prolong life, including but not limited to the procedures and treatments listed in C.

E. Other (specify).

Subjects were then asked to explain or qualify each recommendation and to indicate whether the recommendation would change if all legal and bureaucratic constraints were removed.

In the second portion of the questionnaire, we collected demographic data including age, sex, religion, education, and professional background. Subjects were also questioned about their experience as members of ethics committees and as ethics consultants and whether they had completed advance directives for themselves.

Data Analysis

Categorical variables were compared using the χ^2 test of association. In addition to testing coded questionnaire responses, we constructed a variable, "active consultants," to distinguish respondents who indicated that in their role as ethics consultants they had made one or more recommendations about treatment withdrawal in the last 3 years. Similarly, we constructed a variable, "very active consultants," for respondents who had made at least 20 such recommendations.

The degree of consensus regarding each case scenario was expressed as the proportion of agreeing pairs.[31] We also calculated an "intensity of LPT" variable by assigning numeric scores of 1 through 4 to the ordinal responses A through D, then summing responses across the seven vignettes. Higher scores represented more intensive treatment. We examined associations between intensity of LPT and respondent characteristic variables using either Spearman's rank correlation coefficient or the Mann-Whitney test. Written comments and responses to open-ended questions were transcribed and later grouped into categories.

Table 1.—Demographic Characteristics of the Respondents

Characteristic	No. (%)
Sex	
M	71 (61)
F	46 (39)
Country of residence	
United States	80 (70)
Canada	34 (30)
Age, y	
≤40	33 (28)
41-60	69 (58)
>60	16 (14)
Religion	
Catholic	30 (26)
Protestant	40 (34)
Jewish	14 (12)
Agnostic/atheist/other	32 (28)
How religious	
Very	45 (38)
Somewhat	45 (38)
Not at all	28 (24)
Professional background*	
Physician	45 (38)
Nurse or other clinical	20 (17)
Philosopher	27 (23)
Theologian or minister	28 (24)
Administrator	10 (8)
Attorney	7 (6)
Ethicist	21 (18)
Other	22 (18)

*Percentages exceed 100 due to overlap.

RESULTS

Characteristics of Respondents

Of the 154 questionnaires that were distributed, 118 were returned for a response rate of 77%. Demographic characteristics of respondents are summarized in Table 1. In the last 3 years, 81% (95 of 117 respondents who answered this question) had been members of ethics committees, while 62% (72/117) had acted as individual ethics consultants (of these, 61% had consulted in university hospitals, 33% in private hospitals, 21% in public hospitals, 4% in health maintenance organizations, and 11% in other institutions). Forty-six percent (54/117) of all respondents indicated that as consultants they had made one or more recommendations about treatment withdrawal in the last 3 years (active consultants). The median number of times active consultants had made such recommendations was 10 (range, one to 200). Eighteen percent of respondents (21/117) had made 20 or more recommendations (very active consultants). The median number of recommendations for this group was 55.

Forty-seven percent of respondents had a written advance directive expressing their personal wishes about continuing or limiting treatment in the event of their inability to make health care decisions (treatment directive), while 50% had a written advance directive designating another person to act as proxy decision maker (proxy directive). Forty-six per-

Table 2.—Responses to the Vignettes

			Recommendation					
Variation (No. of Responses)	Patient's Wishes*	Family's Wishes†	A—Routine Nursing Care Only	B—Continue Fluid and Nutrition	C—Additional Treatments (Specify)	D—Everything Possible	E—Other (Specify)	Proportion of Agreeing Pairs
1 (115)	No LPT	No LPT	107 (93)	6 (5)	1 (1)	0 (0)	1 (1)	0.87
2 (114)	No LPT	All LPT	57 (50)	27 (24)	7 (6)	0 (0)	23 (20)	0.34
3 (116)	All LPT	All LPT	4 (3)	44 (38)	42 (36)	7 (6)	19 (16)	0.30
4 (116)	All LPT	No LPT	23 (20)	43 (37)	30 (26)	4 (3)	16 (14)	0.26
5 (115)	Not known	No LPT	78 (68)	23 (20)	4 (3)	0 (0)	10 (9)	0.50
6 (112)	Not known	All LPT	14 (12)	48 (43)	27 (24)	2 (2)	21 (19)	0.29
7 (115)	Not known	Not known	64 (56)	25 (22)	11 (10)	0 (0)	15 (13)	0.38
8 (114)	Personal preference‡		95 (83)	12 (10)	2 (2)	0 (0)	5 (4)	0.71

*Persistently vegetative state (PVS) patient's wish for life-prolonging treatment (LPT) as expressed in an advance directive.
†Wishes of the PVS patient's family regarding LPT for the patient.
‡The LPT respondents would want for themselves if they were in PVS.

cent of respondents had neither type of directive.

When we compared the demographic characteristics of active consultants (n=54) with those of other respondents (n=64), the active consultant group contained a higher percentage of males (76% vs 48%; $P=.002$) and US residents (83% vs 58%; $P=.004$), but a lower percentage of health care professionals (44% vs 66%; $P=.02$). Active consultants were also more likely to have written advance directives (74% vs 36%; $P<.001$).

Recommendations of Respondents

Table 2 shows the responses to the eight case vignettes along with the proportion of agreeing pairs for each vignette. The proportion of agreeing pairs statistic[31] can be understood as follows. Let a randomly chosen respondent make a recommendation for variation 5. The chance that a second randomly selected respondent would agree with the first is 50%, because the proportion of agreeing pairs is 0.50 for that vignette. Although the proportion of agreeing pairs statistic does not adjust for chance agreement, it is clear that no strong consensus exists when there is only a 50/50 chance that two people will agree. Thus, of the seven patient vignettes, there is strong consensus regarding only variation 1, for which the proportion of agreeing pairs is 0.87. Notably, agreement about variation 1 is stronger than agreement about personal wishes for LPT in PVS.

The specific responses to the vignettes are also interesting. In variation 1, when a PVS patient's prior wishes (expressed in an advance directive) and family wishes agree that LPT should be stopped, 93% of respondents would recommend stopping treatment, 5% would recommend tube feedings only, and 1% would add other necessary treatments. Variation 2 is identical to variation 1 in that the advance directive contains instructions to stop all LPT, but it differs from variation 1 in that the family disagrees with the advance directive and wants "everything possible" done to prolong the patient's life. In variation 2, 50% of respondents would advise stopping all LPT, while 30% would advise providing at least food and fluid despite the patient's advance directive. Notably, a substantial percentage (20%) of respondents chose the "other" response for this case and all subsequent patient cases (9% to 19%).

In variation 3, the PVS patient's prior wishes and family wishes agree that everything possible should be done to prolong life. For this variation, 83% of respondents would recommend continuing some form of LPT, but only 6% would recommend wholly acceding to the request that all necessary LPT be given. Of respondents who selected option C, most (80% to 90%) would support providing antibiotics and simple diagnostic tests, a sizable minority (about 30%) would recommend blood transfusions, invasive tests, mechanical ventilation, or cardiopulmonary resuscitation, but very few (<10%) would support providing dialysis or major surgery.

Variation 4 is similar to variation 3 in that the PVS patient wanted life to be prolonged as long as possible, but it differs from variation 3 in that the family disagrees with the advance directive and wants LPT stopped. In this case, 20% of respondents would disregard the advance directive by choosing option A, compared with 3% in the previous case.

In the case of the PVS patient who left no advance directive but whose family asks that LPT be stopped (variation 5), 68% of respondents would recommend following the family's request, and no one would suggest giving maximal LPT. When the family of a PVS patient without an advance directive asks that everything possible be done (variation 6), 12% of respondents would still suggest stopping all LPT. Finally, when the PVS patient has no advance directive and no available surrogate (variation 7), 56% of respondents would recommend cessation of all LPT including tube feedings.

Ninety-two percent of respondents wrote comments in response to one or more open-ended questions. The most common entries associated with option E responses involved resolving conflicts through discussion, attempting to change family members' views, working out a compromise, and withdrawing LPT after a delay. In response to the question, "Please explain or qualify your recommendation," entries commonly concerned patient wishes (ie, autonomy and self-determination), family wishes, futility, quality of life, and cost.

Factors Influencing Responses

Only one respondent characteristic, personal preference for LPT in PVS, was significantly related to intensity of LPT (respondents who would choose LPT for themselves in PVS were more likely to recommend LPT for others in PVS) ($r=.43$; $P<.001$). Active consultants and other respondents did not differ overall in the intensity of LPT they would recommend, but outliers for the intensity of LPT variable were never active consultants—no active consultant would recommend stopping all LPT in every vignette or in no vignettes, whereas 5% of other respondents would stop LPT in every vignette and 12% would stop LPT in no vignettes. Intensity of LPT was not associated with age, gender, country of residence, professional background, religion, level of religiosity, or use of advance directives.

Although patient wishes were the most commonly cited factor in responses to open-ended questions, none of the respondents adhered literally and invariably to PVS patients' advance directives in their categorical responses. Only 49% of respondents consistently recommended withdrawal of LPT in cases involving PVS patients who had asked that life not be prolonged (variations 1 and 2). For cases involving PVS patients whose prior wishes were to be kept alive as long as possible (variations 3 and 4), only 3% consistently recommended providing all necessary LPT.

The strong influence of family wishes on decision making is highlighted by a comparison of responses between paired vignettes involving identical advance directives but discrepant family wishes. Fifty-two percent of respondents changed their recommendations at least once between these pairs.

Another factor that evidently influenced respondents' choices was concern for appropriate resource allocation. Most respondents would deny a PVS patient treatments such as blood transfusions, dialysis, chemotherapy, or major surgery even if the patient and the family both desired maximal LPT, yet they would endorse providing treatments such as artificial fluid and nutrition, antibiotics, or simple diagnostic tests.

Removal of all legal and bureaucratic constraints would cause 36% of respondents to change their responses to at least one vignette. For individual vignettes, 2% to 17% of respondents would change in the absence of legal and bureaucratic constraints.

Conformity to Guidelines

In recent years, a number of consensus statements of expert panels and ethical guidelines by professional organizations have been published in the medical literature. Some authors have suggested that adherence to these guidelines might serve as a useful outcome measure for evaluating ethics consultations.[32] To better understand the overall variability of responses we observed in our data, we carefully examined 12 well-known consensus statements and guidelines[18,20-30] and attempted to determine the extent to which recommendations in this study were consistent with them. Critical evaluation of the 12 documents confirmed our impression that even for simplified cases involving PVS patients, existing guidelines are seldom useful in distinguishing acceptable from unacceptable courses of action. In fact, the guidelines offer little practical advice for handling any of the cases described in our questionnaire with the exception of variation 1. For this case, guidelines provide abundant justification for recommending that LPT be stopped and very little justification for any other recommendation, though their style is predominantly permissive rather than prescriptive. In keeping with the guidelines, the vast majority of ethics consultants in this study indicated that they would recommend stopping all LPT for variation 1. Considering the prevailing attitudes of only a few years ago, when ethicists hotly debated whether denying food and fluid was ever permissible,[33] the finding that general agreement now exists in this area is remarkable in itself.

On the other hand, regarding comparatively difficult cases like those described in variations 2 through 7, guidelines are so permissive and ambiguous that any of several recommendations could be supported. For example, the President's Commission[22] offers the following advice for dealing with cases in which decisions made by surrogates conflict with advance directives:

> Provision may have to be made for an administrative mechanism to decide situations in which a health care professional challenges a proxy's decision on the ground that it is [not] based on . . . a reasonable interpretation of the patient's instructions.

Similarly, for an incompetent patient with no advance directive or surrogate decision maker, the Appleton Consensus suggests the following:

> If the now-incompetent patient has no family or friends, the physician has an especially weighty obligation to ensure that decisions are made well. Not all such patients need personal advocates (for example, guardianships, ombudspersons, public officials), but the physician should consult widely with other direct care givers, consultants, and relevant religious advisors. Some cases may merit formal review either by intra-institutional or extra-institutional authorities before the decision is made by the physician.

Thus, existing guidelines only specify clear standards for the simplest of cases. For more difficult cases, such as those ethics consultants are most likely to face, guidelines provide little direction for ethics consultants, although they may narrow the range of acceptable possibilities. The guidelines' lack of specificity is understandable considering that ethical guidelines are primarily intended to assist practicing physicians rather than ethics consultants. But insofar as these same guidelines are the best standards available for ethics consultants, it is hardly surprising that ethics consultants' recommendations are divergent.

LIMITATIONS

The findings of this study are limited in several respects. Although our response rate of 77% is fairly high for a survey study, our respondents were self-selected in that they all attended the same professional meeting, and therefore our results may not be generalizable to all ethics consultants. On the other hand, members of the Society for Bioethics Consultation probably constitute a sizable proportion of ethics consultants in the United States.

A second limitation of this study stems from its format. Written responses to hypothetical cases cannot be expected to perfectly mirror actual behavior. For example, some people may be more eager to advise treatment withdrawal when they respond anonymously to a questionnaire than when they perform consultations in real life. Others may equivocate when cases are presented as simplified vignettes but react decisively to cases presented in a richer, more tangible narrative. Such limitations are inevitable consequences of all survey research. In designing our questionnaire, we attempted to minimize these effects, eg, by including an open-ended "other" category among the multiple-choice options and by inviting subjects to explain or qualify their categorical responses. After examining the written comments, we consider that our data give a reasonable first approximation of what ethics consultants would recommend for PVS patients.

COMMENT

In this study, we demonstrate considerable variability in what ethics consultants say they would recommend for specific hypothetical PVS patients. Even though our cases were specifically designed to be simple and unambiguous and were therefore more straightforward than the cases an ethics consultant typically encounters, we observed little consensus among recommendations for six of seven patient vignettes. In fact, for more than half of the vignettes, there was not even a majority response.

This degree of variability in recommendations by ethics consultants may be troubling at first, especially to ethics consultants. But it would be a mistake to construe our results as evidence condemning ethics consultants or the consultation process. The mere presence of variation among ethics consultants does not imply a lack of expertise, nor does it imply that ethics consultation is without value.

Let us compare ethics consultation with another, quite different type of consultation, that performed by infectious disease specialists. It would not be uncommon for two well-respected infectious disease specialists consulting on the same patient to disagree on the optimal combination of antibiotics. Few would regard such a disagreement as material evidence for lack of expertise on the part of either specialist. Instead, such disagreements are commonly considered matters of style. Analogously, then, ethics consultants might also be allowed a certain latitude in their recommendations.

Extending our analogy, however, it is obvious that not all antibiotic choices are equally appropriate. If some antibiotics are clearly inferior to others, certain recommendations might be sufficiently inappropriate to call a specialist's expertise into question. Therefore, even though consultants cannot be expected to agree about everything, they must surely agree about some things if we are to respect their role-specific expertise. Unfortunately, determination of standards is somewhat subjective even for a field as scientifically based as infectious diseases. Rarely is there a single source that is universally held as a gold standard. Instead, standards exist as more or less formalized opinions based on bodies of knowledge composed of several overlapping and potentially contradictory sources (eg, peer-reviewed literature, recognized experts, professional organizations, and textbooks).

Still, despite the subjective nature of standards, agreement within a field is ordinarily sufficient to make standards meaningful. In infectious diseases, for instance, there is agreement about desirable outcomes—patient survival, eradication of organisms, abatement of symptoms, and so forth. These outcomes are all readily measurable. In addition, the infectious disease literature contains countless empirical studies specifically designed to test how desired outcomes are best achieved. Thus, standards are objectified by appealing to the scientific method.

Of course, the field of infectious diseases differs from the field of medical ethics in several important respects. Whereas activities of infectious disease consultants are expected to maximize the chances of achieving certain measurable, agreed-upon outcomes, there is considerable debate over appropriate goals for ethics consultants, and few empirical studies have tested the effects of ethics consultations on outcomes. One can expect published guidelines to be ambiguous and specialists' recommendations to be diverse when available data are insufficient to establish a single best standard of care.[34]

CONCLUSIONS

In the field of clinical ethics, controversy remains over such fundamental questions as what is the nature of ethical expertise, is clinical ethics a profession, and should ethics consultants give advice? The current study adds to the growing evidence for lack of agreement in the field. Our data show that even the substantive content of ethics consultations in response to specific cases is far from uniform. A widespread ethical consensus has emerged only for the easiest case (a PVS patient whose advance directive and surrogate decision makers agree that LPT should be stopped). For more difficult cases, including cases in which a PVS patient has an advance directive requesting maximal LPT, a family disagrees with a PVS patient's advance directive, or a PVS patient has no advance directive, widespread consensus has yet to develop.

How can we define standards by which ethics consultants' recommendations should be judged? We propose the following. In developing standards for ethics consultants, care should be taken not to overestimate the degree to which consensus exists, because consensus in ethics is exceptional and often illusory. For rare cases that are virtually uncontroversial, a strong consensus opinion of experts can be viewed as defining a standard of care. However, absent a consensus, a unique standard of care has yet to evolve. In other clinical realms, convergence of expert opinion tends to accompany the accumulation of empirical data favoring a particular intervention,[34] but for many of the questions ethics consultants are asked to consider, it is hard to imagine how databased studies will ever yield definitive answers. For challenging ethics cases, consensus may be a pipe dream.

We suggest, therefore, that ethics consultants should aim not only to make recommendations that fall within a range of ethically acceptable alternatives, but also to bring about solutions that are harmonious. As this study demonstrates, ethics consultants use a variety of strategies, including discussion, negotiation, persuasion, compromise, and delay, to resolve conflicts. Apparently, many ethics consultants recognize that they are less effective when they attempt to impose their personal conceptions of an external ethical consensus on the participants in a case than they are when they delicately orchestrate an internal ethical consensus among those participants. If this is so, then a major implication of this study may be that the value of ethics consultation often lies as much in its reconciliatory process as in its prescriptive content.

We agree with others who have suggested that appropriate outcome measures for ethics consultation include objective measures of conflict resolution and subjective measures of satisfaction among patients, family members, physicians, and nurses.[6,8,30] We also applaud the efforts of those members of the Society for Bioethics Consultation and the Society for Health and Human Values who are forming a joint task force on standards for ethics consultation.[9] However, if their plan is to achieve consensus among ethics consultants, they may have a formidable task ahead of them.

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