

Original Articles

Utilization of a Pediatric Ethics Committee by Certified Child Life Specialists: Barriers and Opportunities

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Objective:

The aims of this study are to understand the perspectives and experiences of CCLSs within the Pediatrics Ethics Committee and to explore the role of CCLSs in requesting ethics consults.

Method:

The study was conducted at Yale New Haven Children's Hospital between July 2019 to December 2019 and received IRB exemption from the Yale University (HIC 2000025771) as data were collected via a voluntary, anonymous survey Utilization of a Pediatric Ethics Committee by Certified Child Life Specialists: Barriers and Opportunities and a voluntary, confidential focus group.

Results:

The results suggest that CCLSs in this institution are less likely to utilize the ethics committee than attending physicians due to lack of prior involvement with and knowledge of the committee, supporting the study's initial hypothesis, and that CCLSs do face ethical dilemmas and moral distress in patient care.

Conclusion:

Although the policy at Yale New Haven Children's Hospital is that anyone involved in the care of the patient in question can call a consult, CCLSs report being wary of bringing up ethics consults for fear of disapproval from the team. However, CCLSs are well-positioned to advocate for patients and should be encouraged to call and participate in ethics consults to enhance communication between parties. Future follow-up studies involving larger populations and including attending physician focus groups should build on these initial findings to work towards a system where the voices of all care team members and patients are represented in morally distressing situations.

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Certified Child Life Specialists (CCLSs) play an integral role in the care of pediatric patients, providing support to increase coping and cooperation in stressful healthcare settings and bridging the gap between families and providers (Romito et al., 2021). CCLSs are trained professionals who use techniques such as "play, preparation, active coping strategies, education, and expressive activities" to help children cope with the stress of the hospital setting and help parents learn to soothe their children (Humphreys & LeBlanc, 2016, p. 153).

CCLSs have an opportunity to assume an important role in ethics discussions and conflict mediation between pediatric providers and patients and their caregivers. CCLSs are well-equipped to navigate these discussions because of the close connections they form with patients and families. One aspect of this "closeness" develops when CCLSs engage in therapeutic play with pediatric patients – an activity that calms children and helps them understand medical experiences (Romito et al., 2021). CCLSs also offer support to caregivers by helping families develop strategies to

comfort the child and adjust to the child's illness (Carter et al., 2018). Through these interactions, CCLSs are able to "develop therapeutic alliances, monitor reactions to events, and provide timely information" (American Academy of Pediatrics, 2000).

These close connections heighten CCLSs' sensitivity to burgeoning signs of moral distress in patients and caregivers. CCLSs are well-positioned to bring up ethical concerns and offer clarity on behalf of both families and providers in ethics committee deliberations. Yet, despite the likely benefit from CCLSs' potential involvement in ethics discussions, no literature exists on the role they play in initiating or participating in ethics consults. While some institutions may limit who is allowed to make an ethics consult, at Yale New Haven Children's Hospital, anyone involved in the care of the patient, including CCLSs, can initiate a consult to the Pediatrics Ethics Committee (PEC) through a simple phone call. Thus, the goals of this study are twofold: 1) understand perspectives and experiences of CCLSs with the PEC within this institution and 2) contribute to a preliminary methodology for exploring the role of CCLSs in requesting ethics consults.

Generally, pediatrics ethics consults are infrequently utilized, with each hospital averaging one consult per month or less, despite a variety of ethically challenging situations in pediatrics (C. Brown et al., 2014; Kesselheim et al., 2010; Thomas et al., 2015; Winter et al., 2019). In contrast, non-pediatric ethics committees saw on average 19.5 consults per year in 2009 (Courtwright & Jurchak, 2016). Some studies have examined factors contributing to low ethics committee utilization among physicians (C. Brown et al., 2014; Gacki-Smith & Gordon, 2005; Kesselheim et al., 2010; Thomas et al., 2015). However, these studies are few, and there is even less literature on the role of multidisciplinary care team members in calling (i.e. requesting) pediatric ethics consults. Specifically, there is no literature on CCLSs' experience in calling ethics consults.

Medical care is increasingly performed in the context of a team of providers and support staff, typically with an understood hierarchy amongst these providers (Lancaster et al., 2015). In most cases, the attending physician is the designated team leader at the top of the hierarchy. This establishes a power dynamic within the team which, depending upon the attitude and approach of the attending physician, may diminish voices of other team members (J. Brown et al., 2011; Foronda et al., 2016; Lancaster et al., 2015). The hierarchy may also create the impression that a team leader needs to sign-off on all patient-care decisions, including the decision to initiate an ethics consultation (Foronda et al., 2016).

In this exploratory study of CCLSs' participation in ethics consults, the team of researchers hypothesized that CCLSs call ethics consults less often than attending physicians and that a significant reason for this is the hierarchical dynamics between CCLSs and attending physicians. To assess this hypothesis, this study surveyed attendings and CCLSs to gauge relative awareness of the PEC at Yale New Haven Children's Hospital and assess understanding of ethically challenging situations and consultation procedures.

This survey was followed by explanatory focus groups of CCLSs to gain greater insight into their attitudes towards and participation in ethics consults.

Method

Setting

The study was conducted at Yale New Haven Children's Hospital between July 2019 to December 2019 and received IRB exemption from the Yale University (HIC 2000025771) as data were collected via a voluntary, anonymous survey and a voluntary, confidential focus group.

Survey Development

The survey (Supplemental Figure 1) was developed by a multidisciplinary research team which included medical students, attending physician members of the pediatric ethics committee, a pediatric resident physician, and CCLSs. The research team designed questions to elicit a general idea of respondents' experiences with the PEC, including participating in and calling ethics consults. Questions also sought to identify barriers to calling ethics consults and to understand situations that could prompt such consults. Two members of the research team who did not participate in the question building piloted the survey by completing it and providing feedback afterwards. Slight changes in phrasing for clarity resulted from the pilot. The survey (Supplemental Figure 1) was generated on the Qualtrics® platform.

Recruitment

All 22 Certified Child Life Specialists in this hospital were invited to voluntarily participate in the study. All 61 attending physicians from the Neonatology, Pediatric Critical Care, Pediatric Hematology/Oncology, and Pediatric Hospital Medicine groups were specifically invited due to the historically higher incidences of consults arising from these specialties at this institution. The invitations were distributed via email containing a link to the survey (Supplemental Figure 2). The survey data collection occurred over two months, with periodic reminders to encourage responses. Participation was voluntary and anonymous, with no compensation for participation. Any survey that did not have responses to every question was deemed incomplete.

Following survey data collection and analysis, CCLSs were invited to participate in a focus group to further explore and contextualize survey results. A convenience sample of five participants was drawn by emailing all 22 CCLSs in the hospital, regardless of survey completion status, and seeking volunteers. As this portion of the study aimed to better elicit and understand perspectives of CCLSs, attending physician focus groups were not conducted.

Survey Statistical Analysis

Frequencies and percentages were calculated for all discrete and nominal values. All survey data was analyzed using R version 3.1.2 (R Foundation for Statistical Computing,

Vienna, Austria). Bidirectional chi-squared tests were used to compare categorical variables. Results were presented as odds ratios (ORs) with 95% confidence intervals (CIs).

Additionally, bivariate and multivariate logistic regression was performed to identify predictors for variables associated with having called an ethics consult. For regression, the variables were numerically coded (Supplemental Table 1). For “Position,” attending physicians were coded with value zero while CCLSs were coded with value one. For all applicable questions, a response of “no” was coded as zero and a response of “yes” as one.

Focus Group Process and Analysis

An explanatory mixed-method approach enabled us to further explore the results of the quantitative data through a detailed focus group (Schifferdecker & Reed, 2009). Focus group questions (Supplemental Figure 3) were based on survey results that would benefit from further exploration. For example, upon noting that several survey respondents were uncertain about the existence of a designated pediatric ethics committee and over half of respondents did not know how to call an ethics consult, focus group questions were designed to further explore the details of what participants knew and did not know about the ethics committee and how to call a consult. The focus group began with a broad question (“What do you know about the pediatric ethics committee?”) and gradually introduced guiding questions exploring participants’ understanding of the process of calling an ethics consult, their comfort with calling ethics consults, barriers surrounding the process, and suggestions for improvement. Given the nature of these questions, the qualitative design of this portion of the study was phenomenological with the goal to “understand the nature of a phenomenon, incident, or circumstance through those who experienced it” (Chen & Teherani, 2016).

Two members of the research team were present for the focus group, one of whom was the primary facilitator and the other as a co-facilitator and note-taker. After informed consent, the focus group was recorded and transcribed. Any uncertainty about transcription content (e.g., inaudible portions) was resolved by the investigators using handwritten notes taken during the focus group. Coding was performed according to conventional content analysis methodology (Hsieh & Shannon, 2005) and informed by levels of coding (Charmaz, 2006). Two investigators independently conducted first-level, open coding. They first identified the passages that described the phenomena in question—respondents’ understanding of and experience with calling ethics consults—and wrote words or phrases that captured the phenomena. After coding the transcript, each of the coders reviewed these words and phrases and refined them to best represent the respective phenomena and capture the respondents’ own words (*in vivo* coding). These words and phrases formed the set of 47 “initial codes” per investigator. After independently coding, the investigators met to compare codes, and there was complete consensus between reviewers on the most important passages that represented the phenomena in question. There

were slight differences in words and passages chosen as codes for these phenomena, but these differences were semantical rather than conceptual. A third investigator participated in consensus discussions and consulted in instances where there were slight differences to reach consensus. Coders reached consensus on the best phraseology of the codes, resulting in 40 distinct codes. One of the primary investigators then recoded the transcripts as needed using the agreed-on scheme.

In a separate session, codes were then regrouped into broader categories and major themes from the focus group as identified and agreed on by coders. Two overarching themes emerged, with more distinct sub-themes within each. Throughout the process, NVivo 12 Pro® (QRS International, Melbourne, Australia), a qualitative analysis software package, was used to store transcripts, perform coding, and manage final code categories.

Results

Survey

Of the 45 surveys returned, six were incomplete, resulting in 39 being included in the final analysis. The survey response rate was 41% ($n = 25$) for attending physicians and 63.6% ($n = 14$) for CCLSs (Table 1). Ninety-six percent of the attending physicians who responded worked in inpatient settings, while 71.4% of the CCLSs who responded ($n = 10$) worked in outpatient settings. Over half of responding CCLSs worked at this institution for fewer than six years, whereas, over 60% of responding attending physicians worked at this institution for more than 5 years.

CCLSs were significantly less likely to have called an ethics consult (OR = 0.14, $p < 0.01$), know how to call a consult (OR = 0.2, $p = 0.03$), or know an ethics committee member (OR = 0.15, $p < 0.02$) when compared with attending physicians (Table 2). They were also less likely to know that this institution has a dedicated pediatric ethics committee or to have participated in an ethics consult, though these differences were not statistically significant.

To further examine factors that influence calling an ethics consult, bivariate analyses were performed (Table 3). The analyses demonstrate that “position” is inversely correlated with having called an ethics consult ($\beta = -0.37$, $p < 0.01$), suggesting that attending physicians are more likely to call consults than CCLSs. The variables “knows how to call a consult” ($\beta = 1.82$, $p < 0.01$), “knows PEC member” ($\beta = 1.36$, $p = 0.03$), “has been a part of a consult” ($\beta = 1.83$, $p < 0.01$), and “total time at this institution” ($\beta = 0.38$, $p = 0.02$) were all positively correlated with having called an ethics consult.

Following bivariate analyses, multivariate regressions were then performed to assess the most significant variables related to “having called an ethics consult” (Table 3). Position was kept as a variable in all multivariate regressions. When combined with “time at this institution,” only position remained a significant factor in the regression ($\beta = -0.32$, $p = 0.02$). With involvement of multiple variables, only “having been part of ethics consults” remained a consistently significant variable ($\beta = 1.31$, $p < 0.01$).

Table 1. Descriptive Table of Demographics

	Attending Physicians	Child Life Specialists
Number of Responses	25/61	14/22
Response Rate	41%	63.6%
Unit		
Outpatient	4%	71.4%
Main Hospital	0%	28.6%
Off-Site/Affiliated Branch	4%	28.6%
ED	0%	14.3%
Inpatient	96%	28.6%
General Medical Unit	20%	14.3%
Surgical Unit	0%	7.14%
NICU	36%	7.14%
PICU	36%	0%
Well-newborn Nursery	4%	0%
Years Worked Here		
< 1	12%	28.6%
1-5	20%	28.6%
6-10	20%	14.3%
11-15	32%	14.3%
16+	16%	14.3%

Table 2. Comparing Knowledge of PEC, Know-How, Times Called, Knowing Committee Member, and Having Been Part of Consult. With Odds Ratios and CI

CCLSs compared to	Have called a consult?	Know about dedicated PEC?	Know how to call a consult?	Have been part of a consult	Know PEC member?
Attending Physicians	0.14 (0.02, 0.71) $p < 0.01^{**}$	0.33 (0.02, 3.31) $p = 0.33$	0.2 (0.03, 1.06) $p = 0.03^{*}$	0.38 (0.08-1.72) $p = 0.19$	0.15 (0.02-0.84) $p = 0.02^{*}$

* $p < 0.05^{*}$. ** $p < 0.01$.

Table 3. Variables Associated with Calling an Ethics Consult, Identified Through Bivariate Regression

Predictors	Beta	SE	p-value
Position*	-0.37	0.13	<0.01
Total Time at YNHH*	0.38	0.16	0.02
Knows dedicated PEC	0.35	0.82	0.67
Knows how to call a consult**	1.82	0.53	0.001
Knows PEC member*	1.36	0.59	0.03
Has been part of consult***	1.83	0.46	0.0003

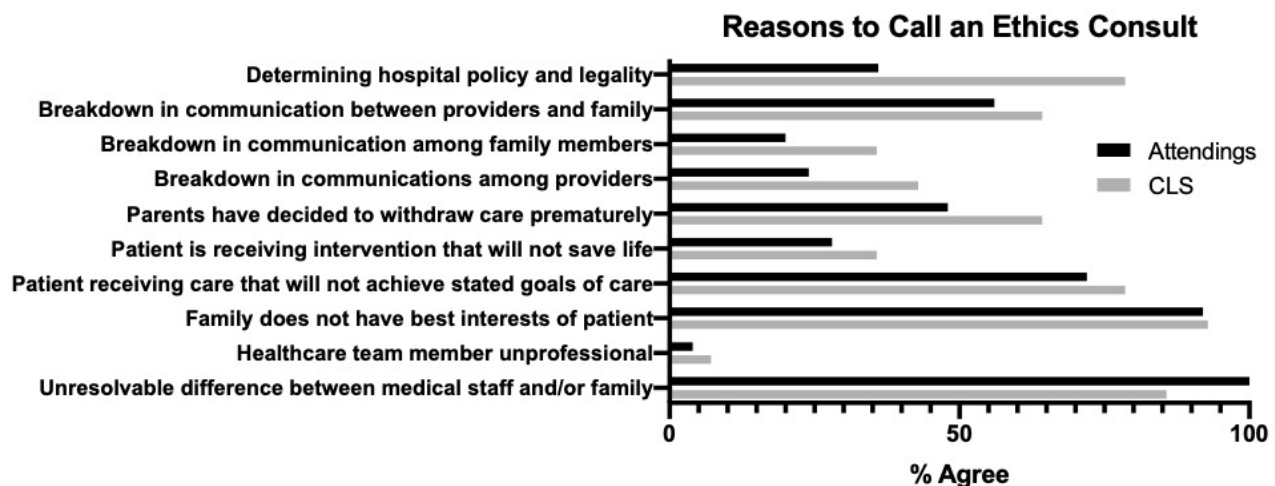
* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$

Finally, one survey question sought to elicit reasons for not calling ethics consults if an individual believed one was necessary (Figure 1). Reasons shared by both CCLSs and attending physicians for not calling consults were: “someone else made the official call,” “the situation resolved before making the consult,” “decided as a team to not call,” “discouraged from calling,” and “never considered calling.” However, a higher percentage of CCLSs reported the rea-

sons as “someone else making the call” and “never considered calling.” One reason unique to CCLSs was being unaware that they could call an ethics consult. Reasons unique to attending physicians not calling were: “a prior consult was not helpful,” “believed the process would take too long,” and “uncertainty about how to call.” Almost 24% of attending physicians stated that they always called when

Table 4. Multivariate Regression Models for Most Significant Variables Associated with Calling an Ethics Consult

Models	Beta	SE	p-value
Model 1			
Position*	-0.32	0.13	0.02
Total Time at YNHH	0.3	0.16	0.06
Model 2:			
Position	-0.29	0.13	0.06
Knows how to call a consult*	1.44	0.55	0.01
Model 3:			
Position*	-0.29	0.14	0.04
Knows PEC member	0.82	0.62	0.19
Model 4:			
Position*	-0.27	0.12	0.02
Has been part of consult**	1.59	0.43	0.001
Model 5:			
Position	-0.22	0.12	0.08
Knows how to call a consult	0.88	0.54	0.11
Has been part of a consult**	1.31	0.47	0.008

* $p < 0.05$. ** $p < 0.01$.**Figure 1. Specific Reasons for Not Calling an Ethics Consult**

they believed necessary, whereas no CCLSs gave that answer.

Focus Group

Focus groups illuminated the reasons and circumstances behind CCLSs' decisions to call or not call an ethics consult. Of the five focus group members, four had participated in ethics consults at this institution, and one had experience calling an ethics consult. They described a variety of reasons that an ethics consult might be called, including conflict between medical staff and families, deciding on "compassionate" care for the patient, and when "staff and staff [are] in conflict... feeling like we're not sure what the [attending] physician's plan is." Over the course of the conversation, CCLSs repeatedly emphasized discomfort with call-

ing ethics consults and the need to use ethics consults to empower patients and families. The following themes and sub-themes emerged.

Theme 1: Child Life Staff Perceive Nurses' and Their Own Reluctance to Call Ethics Consults Due to Hierarchical Dynamics within the Medical Team

Sub-Theme 1a. Fear of Consequences Related to Calling an Ethics Consult

In discussing barriers to pursuing ethics consults, all CCLSs mentioned fear of the consequences from calling such a consult, amongst both CCLSs and nursing staff with whom they work. One CCLS stated, "I've had nursing staff say like 'X, Y, Z happened, I wanted to call an ethics con-

sult,' but felt like there would be repercussions if she kind of brought that to the attention, and so she didn't." Another agreed, adding, "I think people sometimes think there's repercussions...what if somebody knows I called it...do they think I'm stepping out of my boundaries as a child life specialist or as a nurse by calling this?" Another participant simply said, "I have not felt like it was in my right to make that consult."

Sub-Theme 1b. Calling Ethics Consults is Perceived to be a Team Decision

Participants agreed that ethics consults involve a "team decision," and consults would often not be called if some team members did not want it. In response to this, one participant wondered why teams might not agree to a consult and hypothesized that members might be "offended...especially if it's (a CCLSs). We are not a medical decision maker, so we're basically saying you guys aren't communicating very well, and I'm identifying that for you, and then they're going to say well who are you to say that we are not communicating well?" One CCLS also specifically mentioned that a nurse was "nervous to approach the attendings that were on [service]" to broach this question.

Sub-Theme 1c. Evolving Attitudes in All Staff Over Recent Years are Improving Willingness to Call Ethics Consults

Despite the lingering uncertainty regarding calling ethics consults, one participant did endorse that she felt more comfortable in her role recently. According to this CCLS:

I'd say in general our role is viewed differently in the 8 years that I've been here, that whether it's a confidence of the staff understanding who we are as individuals and what we bring to the table, whether it's our job becoming more intertwined with the clinical aspects as opposed to the play aspects, that like we're seen more part of the medical team as opposed to the periphery.

Other participants also cited a change in the head of the pediatric ethics committee to someone who they work with more closely as an encouragement to CCLSs making ethics consults. They noted that they have increased access to this person because "he respects our job" and "comes into our office a lot."

Theme 2: Perceptions of Ethics Consults as Empowering for Families and Aligned with Child Life Staff's Advocacy Role

Sub-Theme 2a. CCLSs Experience Discomfort on the Behalf of Patients and Families

CCLSs considered calling ethics consults in situations where they felt discomfort with the patients' and families' understanding of the medical care. One participant explained, "I think we ask questions a lot – is this appropriate for the ethics committee, the formal committee... I think that we kind of throw that thought out there a lot, because

we work with a lot of families where we're like this doesn't sit quite right." Another CCLS specifically mentioned, "I've been uncomfortable with the direction that the care is going in terms of feeling like the family didn't really understand how terminal their child really was or the physician kept offering phase I trials when I don't know that the family understood that a phase I trial is not a cure." In fact, one CCLS went further to describe feeling that she was "advocating for what the parents, caregiver, family is wanting, but [her] voice is the only one." Another CCLS remarked that she was "the representative of the patient and family... their voice to make that consult" and eventually called an ethics consult despite disagreement from the rest of the medical team.

Sub-Theme 2b. CCLSs Suggest Empowering Families to Call Ethics Consults

In their suggestions for improving ethics consults, a CCLS mentioned that "I don't see many families calling ethics consults, a lot of families are afraid to even ask questions" and advised that the committee "empower them [families] to actually feel like they could call." Among the suggestions was the request to have the ethics committee brought up to families as "services that are offered to you," to present it "neutrally" to avoid the conception of the ethics committee as punitive. They also added that, prior to calling the ethics committee, many families should have more frequent team meetings because "if we communicated in the beginning, we wouldn't be in the position of calling an ethics consult."

Discussion

The results suggest that CCLSs in this institution are less likely to utilize the ethics committee than attending physicians due to lack of prior involvement with and knowledge of the committee, supporting the study's initial hypothesis, and that CCLSs do face ethical dilemmas and moral distress in patient care.

Of the four variables that were identified as significant predictors for having called an ethics consult (position, knowing how to call an ethics consult, having been part of a consult, and knowing a PEC member), three have logical relationships to calling consults. First, knowing how to call an ethics consult is a prerequisite to calling a consult, thus a correlation is expected. The significant relationship between "having been a part of a consult" and "having called a consult" can be explained by the fact that one is almost certainly to be a part of a consult that one called. Furthermore, partaking in past consults may familiarize participants with the process and utility of an ethics consult and encourage future engagement of the PEC. Knowing a PEC member could also increase knowledge of the role of the PEC, potentially leading to increased utilization of ethics consults. Position is the only variable that should not inherently result in differences in use of the PEC in an institution where anyone is allowed to call an ethics consult.

This result is further explored in initial survey data that provides an overview of some specific barriers that CCLSs

may face when deciding to make an ethics consult. Approximately one quarter of responding physicians stated that they would always call an ethics consult when considered, but none of the CCLSs responded similarly, suggesting that CCLSs face unique barriers to calling ethics consults. The most common reason for not calling consults among CCLSs respondents was that someone else would make the official call, suggesting that perhaps CCLSs discuss the option of calling ethics consults with attending physicians and/or other team members rather than individually making a consult. Responses also showed that some CCLSs were not aware that they could call ethics consults, which implies a lack of CCLSs training in the utilization of the PEC or an assumption that CCLSs could not call an ethics consult. Previous literature on advanced practice practitioners' and nurses' experiences calling ethics consults also shows that the most common reason for these groups to refrain from calling an ethics consult was not knowing how (Cederquist et al., 2021). These findings suggest that there are educational disparities between attending physicians and other care team members in the usage of ethics committees, which may disempower other team members.

Focus group data clarified CCLSs attitudes towards ethics consults. One theme that emerged supports survey findings that CCLSs call fewer ethics consults as a result of team hierarchies. The concern that they would be perceived as overstepping their positions or would face repercussions is possibly an engrained pattern from traditional medical decision-making in which attending physicians make ultimate determinations (Foronda et al., 2016; Lancaster et al., 2015). A previous study of barriers to ethics consults among nurses and physicians found that nurses were also concerned about the team hierarchy (Gaudine et al., 2011). Of note, this fear of a poor reaction to proposing an ethics consult also implies a negative connotation towards ethics consults among team members, which should be further explored, as ethics consults are not meant to be punitive or judgmental but rather an opportunity for open discussion.

Another emergent theme from the focus group concerned the advocacy role of CCLSs vis-a-vis patients and families. The Child Life Code of Ethics states that CCLSs are responsible for "minimizing the potential stress and trauma children and their families may experience," which in some scenarios may involve calling ethics consults (*Child Life Code of Ethics*, 2020). However, CCLSs reported that they often feel alone speaking on behalf of the patients. Additionally, CCLSs described the desire to call ethics consults due to discomfort of families, testifying to their unique understanding of patients' and families' experiences. Many suggestions CCLSs proposed focused on improving access to ethics consults for families and enabling families to address their uncertainties or discomfort with the medical team. These comments support the role of CCLSs as a bridge between medical teams and families, providing information that should be more widely utilized to gauge whether an ethics consult is needed.

Limitations

This is exploratory study, and its chief limitations are the relatively small sample size and sample demographics. The convenience sample obtained may have attracted participants who have had more engagement with the PEC and most likely produced participants who could offer more insights regarding ethics consults. The findings of this study cannot be generalized to the larger child life profession. Additionally, more attending physicians who responded are inpatient providers and have been at the children's hospital longer, as compared with the CCLSs respondents. A possible alternate explanation for physicians' greater participation in calling ethics consults might be that their longer tenure at the institution offered them more opportunities to learn about and call ethics consults. However, this explanation was not supported by regression analysis as "time at this institution," when included with "position" as a variable, was not a significant predictor of calling an ethics consult. Another discrepancy between the physicians and CCLSs surveyed is that the majority of CCLS respondents worked in outpatient settings and perhaps had not been as exposed to ethics consults. However, focus group findings suggest that CCLSs working in both environments have encountered scenarios in which ethics consults are warranted; moreover, the setting in which they worked was not identified by CCLSs as creating a barrier to calling consults. While future studies should seek to better control for and explain these demographic differences, at this time they appear unlikely to be the primary contributing factors in the differences in involvement in ethics consults.

Conclusion

The survey and focus group findings offer complementary explanations of why CCLSs at this institution do not utilize ethics consults as often as attending physicians and suggest that CCLSs have insights into patient and family concerns that should be valued in deciding to consult the PEC. Although the policy at Yale New Haven Children's Hospital is that anyone involved in the care of the patient in question can call a consult, CCLSs report being wary of bringing up ethics consults for fear of disapproval from the team. However, CCLSs are well-positioned to advocate for patients and should be encouraged to call and participate in ethics consults to enhance communication between parties. Future follow-up studies involving larger populations and including attending physician focus groups should build on these initial findings to work towards a system where the voices of all care team members and patients are represented in morally distressing situations.

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Supplementary Materials

Supplemental Figure 1. Survey

Download: <https://childlife.scholasticahq.com/article/33127-utilization-of-a-pediatric-ethics-committee-by-certified-child-life-specialists-barriers-and-opportunities/attachment/83913.docx>

Supplemental Figure 2. Recruitment Email

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Supplemental Figure 3. Focus Group Questions Outline

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Supplemental Table 1. Coding Schema

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