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Credentials for Clinical Ethics Consultation – Are We There Yet?

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Most everyone would agree that people doing the work of clinical ethics consultation (CEC) should be qualified. Relevant stakeholders in situations where a CEC is requested are often at their most vulnerable, emotionally, physically, spiritually. Typically, the stakes are high. The last thing we would want is for someone without the requisite qualifications, however well-meaning, to make the situation worse, or even to simply fail to help.

Fox and colleagues' estimated that 29,000 individuals devote more than 314,000 hours to performing CEC in U.S. hospitals each year (Fox et al., 2007). According to survey findings, 41% of clinical ethics (CE) consultants reported learning how to perform CEC via formal, direct supervision by an experienced member of an ethics consultation service, and 45% via independent learning, without formal, direct supervision. Only 5% completed a fellowship or graduate degree program in bioethics. This mirrors findings from a survey of Maryland hospital ethics committees, which showed that the majority of ethics committee members had little formal education and training in ethics (Hoffmann et al., 2000). Yet, currently, there is no available evidence that any particular training model (i.e., formal graduate training, direct supervision, and/or independent learning) prepares an individual to effectively perform CEC.

Concerns along these lines are creating momentum to "professionalize" the field of CEC. When a field is fully professionalized, it self-regulates its membership and educational institutions in the name of a public good, and ensures that formal standards (e.g., standards of practice and a code of ethics) are upheld by practitioners and taught by programs that educate and train those practitioners (i.e., through accreditation, certificates and/or diplomas) (Baker, 2009). Proponents argue that professionalization is needed to ensure quality and accountability of those responding to ethics questions, concerns, and conflicts in health care settings. Others focus more on

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ensuring the competency of CE consultants, rather than promoting "professionalization" of the CEC field per se. The Veterans Health Administration's (VHA) IntegratedEthics program provides an example of the latter (Fox, Berkowitz, Chanko, & Powell, 2006). However, while the VHA's resources provide a method of ensuring CEC quality without promoting CEC "professionalization" per se, they also present a challenge to those who point to a lack of agreed-upon CEC quality standards as a major barrier to professionalizing the field of CEC.

In addition to the standards identified in the VHA's IntegratedEthics CEC primer (Fox et al., 2006), other recognized standards for the CEC field are delineated in the American Society for Bioethics and Humanities' (ASBH) *Core Competencies for Health Care Ethics Consultation* (1998, currently under revision – hereafter "*Core Competencies*"). Yet, there is currently no credentialing process by which CE consultants can demonstrate that they possess these *Core Competencies*, nor any accreditation process by which to judge graduate programs as meeting minimum standards for educating and training CE consultants. Moreover, there is no code of ethics for the field. Efforts to identify the scope of CEC services and possibilities for credentialing CE consultants include Nancy Dubler's Clinical Ethics Credentialing Project (Dubler & Blustein, 2007; Dubler, et al., under review), and ASBH's newly formed Clinical Ethics Consultation Affairs standing committee. Yet, any effort to explore credentialing of CE consultants must begin with refining the scope of interest.

CEC – Definition and Scope

CEC refers to "services provided by an individual or a group to help patients, families, surrogates, health care providers, or other involved parties address uncertainty or conflict regarding value-laden concerns that emerge in health care" (ASBH, under revision). Innovations in medicine have expanded health care options while increasing the complexity of medical decision-making. Our fragmented U.S. health care system, rising health care costs, and growing numbers of under-insured and un-insured, are just some of the contributors to ethics questions being encountered daily in health care settings across the country. Health care ethics committees and, more specifically, CEC services have evolved as one way of addressing these issues.

However, the activity of performing CEC is but one of several services that a clinical ethicist or clinical ethics consultant (hereafter CE consultant) may provide. The *Core Competencies* focused on CEC (more accurately entitled "health care ethics consultation") rather than the broader scope of

services a CE consultant may provide. Other activities may include giving ethics lectures, teaching/mentoring students in ethics, engaging in research and scholarship, and so forth. Some CE consultants also function as *bioethicists*, providing opinions, theoretical analyses, and scholarship on ethical issues in the life sciences (i.e., not only as applied in health care settings). Coming to agreement on standards for a more narrowly defined scope of activities (such as CEC) is one way of negotiating consensus in fields such as *clinical ethics* and *bioethics*, which are notoriously diverse and wide-ranging in scope. Indeed, this will likely present a challenge to the development of a code of ethics for CE consultants. However, given that CEC may be considered the "highest stakes" activity of a CE consultant, and that the skills and knowledge competencies necessary to effectively provide CEC overlap to a large degree with competencies needed to engage in other CE consultant activities, demonstrable proficiency in CEC may serve as emblematic of the general competency of a CE consultant.

CEC – Evidence of Benefit?

Evidence that qualified CEC services produce a valued benefit may be extrapolated from the fact that high-volume, well-functioning CEC services attract repeat requests for these services (Fox et al., 2007). This assumes that individuals at health care facilities with a well-functioning CEC service learn to recognize ethics questions/concerns and request that the CEC service help answer their questions and address their concerns. One approach toward CEC within an institution is that CE consultants' specialized knowledge and skills are essential to effectively address these questions and concerns. Another approach is that, in addition to contributing specialized CEC knowledge and skills, a CEC service helps to carve out needed time for health care staff working in our fast-paced health care settings to engage in ethical reflection (Walker, 1993). For both approaches, under-qualified CE consultants most likely fail to demonstrate the full potential of CEC because they lack the specialized knowledge or skills to effectively address ethics concerns, and to distinguish CEC from other types of consultations (e.g., medicine, chaplaincy, palliative care, social work). However, objective methods of demonstrating the value of CEC, and the impact of qualified versus unqualified CE consultants, would benefit efforts to establish credentials for CE consultants.

CE Consultant Minimum Standards

The *Core Competencies* lists *basic* skills and knowledge competencies that

everyone involved in a consultation must possess, as well as *advanced* skills and knowledge competencies that at least one person involved in a consult must possess. For example, everyone involved in a CEC should have a basic ability to analyze the value uncertainty or conflict in the case or question brought to them, but at least one individual should have advanced skills in this area. An example of the latter would be the ability to handle conflict among involved stakeholders in more complex cases where skills in mediation are needed. To advance the goal of professionalizing the field of CEC, the minimum standards for a CE professional would be set at the level of an advanced practitioner – that is, someone who demonstrates all the identified skills and knowledge competencies in the *Core Competencies*, and any other recognized "standards of practice" for an advanced CEC practitioner. An example of other standards of practice that may emerge include adequate intake procedures for ethics consultation requests, an established approach for formal CEC case consultation meetings, and proper documentation in the consultation service records and (for CEC involving a patient), the patient's medical record) (Dubler et al., under review).

This admittedly leaves out other individuals performing CEC who only possess *some* of the required competencies. For example, in the *Core Competencies,* the basic skills and knowledge that every individual taking part in an ethics consultation must possess represents an alternative set of minimum standards. This could reflect one of two situations: (1) a team CEC approach is being used to respond to CEC requests, in which all members of the team possess the required basic competencies, and some individual members possess the required advanced competencies (but no one individual possesses *all* the basic and advanced competencies), or (2) a qualified CE consultant with advanced CEC knowledge and skills leads each CEC, and others who have at least basic competency are also involved.

Identifying a method to demonstrate only *basic* CEC knowledge and skills competencies would not address the issue at hand, since the basic competencies are necessary but not sufficient to effectively perform CEC. Notwithstanding situation #1 above in which the necessary advanced knowledge and skills are found at the collective level of the team rather than in one individual, a move toward professionalizing CEC is a way to ensure that at least one individual responding to a consultation request has the requisite advanced CEC knowledge and skills.

Accrediting or Credentialing?

Methods by which individuals could demonstrate meeting necessary expert CEC competencies include *accrediting training programs* and *credentialing*

individuals.[1] Accreditation involves an external body ensuring that standards for training competent CE consultants have been met, similar to how the Liaison Committee on Medical Education accredits medical schools. Such efforts would ensure consistency across graduate bioethics programs, which currently vary considerably in their ability to prepare qualified CE consultants. One criticism of such programs is their lack of a mandatory clinical practicum, particularly for individuals with no prior clinical background. This author has heard accounts from several individuals who have attempted to hire a CE consultant with a degree from a bioethics graduate program, only to find that the majority of candidates they interviewed were not sufficiently competent at CEC to function effectively without substantial additional training.

One concern with the program accreditation approach is that it will squelch innovation and diversity in CEC approaches due to the need to endorse common standards. Another concern is that individuals who have not met competency benchmarks might still graduate from a program and thus be recognized as a professional CE consultant despite failing to meet minimum standards. Furthermore, the program accreditation method would not address how to recognize those currently functioning as expert CE consultants.

Given that, according to Fox et al.'s estimate, 95% of individuals currently doing CEC have no formal training, and the remaining 5% have received formal training from a non-accredited program, we can assume that some of these individuals do possess expert CEC knowledge and skills. The question of how to "grandfather" these individuals must be addressed. Such an approach could take the form of credentialing them by formally evaluating their CEC knowledge and skills competencies. A "professional" CE consultant would thus have to demonstrate all basic and advanced competencies, whereas a "non-professional CE consultant" (i.e., member of a CEC service who needs only basic competencies as part of a team approach) might undergo a different form of credentialing or certification.

Regardless of whether an accreditation or credentialing approach is implemented to identify qualified CE consultants, adequate evaluation methods will be needed.

Valid & Reliable Evaluation Methods

Measuring a CE consultant's qualifications to perform CEC will unavoidably involve limiting formal evaluation to a subset of CEC activities that can be objectively measured. Tools currently in use to evaluate the proficiency of CE consultants include self-report measures, such as the

VHA's *Ethics Consultant Proficiency Assessment Tool* (available at http://www.ethics.va.gov/ethics/integratedethics/index.asp). This tool, which was developed using the ASBH's *Core Competencies*, asks questions of the CE Consultant, such as: "Rate your ability to educate the participants regarding the ethical dimensions of the case." Possible responses include: "not skilled," "somewhat skilled," "skilled," "very skilled," "expert."

While self-perception tools provide some information regarding an individual's CEC knowledge and skills, they are not robust measures of *actual* skills and knowledge. Having a mentor or supervisor who has observed the CE consultant rate that individual's skill level using such a tool would be a more robust approach. However, producing valid and reliable methods to effectively evaluate CEC competencies across institutions is a formidable endeavor. Knowledge is easier to objectively test than are skills, which typically require resource intensive observations. Yet, testing objective knowledge alone (e.g., in a board-type exam) would fail to demonstrate that an individual had the requisite skills to practice CEC at the expert level. Furthermore, objectively testing expert ethics knowledge is difficult, given that ethical analyses often produce more than one "right answer," and that legal standards that inform ethical analyses vary from state to state. However, the same set of challenges applied in other credentialing efforts, such as in hospice and palliative medicine. Yet, the American Board of Medical Specialties has succeeded in creating a certification exam for hospice and palliative medicine.

Most likely, as stated above, a CE consultant credentialing exam would only test a subset of CEC knowledge and skills competencies, and would rely on other proxy measures to demonstrate expertise. For example, applicants could provide evidence of having performed a minimum required number of CECs, or could present examples of their own CEC documentation.

Conclusion

Those favoring staffing a CEC service with at least one professional, qualified CE consultant argue that relying on all-volunteer, under-qualified staff to perform CEC as an "add-on" to their other work, without compensation or protected professional time, contributes to poor CEC outcomes (Spike & Greenlaw, 2000). Such individuals may unwittingly cut corners in the CEC process, or conduct ethics consultations based on their own professional bent, with little appreciation for how their approach falls short (Spike, 2009). Advocates for professionalization argue that the time has come to identify expert CE practitioners, hold them accountable to

standards of practice in their field, and devote the requisite resources to allow CEC services to flourish. Given findings that CEC may reduce health care costs spent on non-beneficial services (Gilmer, et al., 2005), one could argue that employing a CE consultant with demonstrated advanced knowledge and skills competencies would be self-funding within a health care institution, and would provide better CEC outcomes than a CEC service with no professional, qualified CE consultant. An alternative view is that individuals providing CEC should have the required knowledge and skills competencies, regardless of whether they provide those services as a professional CE consultant or as a member of a CEC service staffed by volunteers within the institution.

Consensus is building that some method of demonstrating competency of individuals performing CEC is needed. What has yet to be determined is which specific standards of competency to endorse, and which methods of demonstrating competency to employ.

NOTE

[1] In this issue, Ken Kipnis defines "certification" as the process by which a professional field recognizes competent practitioners, and "credentialing" as a process by which health care facilities assess a staff member's competency to perform specific tasks. I am using "credentialing" here as a broader term to represent any formal demonstration of an individual's CEC competency.

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