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The Clinical Ethics Credentialing Project: Preliminary Notes from a Pilot Project to Establish Quality Measures for Ethics Consultation

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Abstract The Clinical Ethics Credentialing Project (CECP) was intiated in 2007 in response to the lack of uniform standards for both the training of clinical ethics consultants, and for evaluating their work as consultants. CECP participants, all practicing clinical ethics consultants, met monthly to apply a standard evaluation instrument, the "QI tool", to their consultation notes. This paper describes, from a qualitative perspective, how participants grappled with applying standards to their work. Although the process was marked by resistance and disagreement, it was also noteworthy for the sustained engagement by participants over the year of the project, and a high level of acceptance by its conclusion.

Keywords Clinical ethics consultation · Training · Standards · Ethics · Credentialing

Although clinical ethics consultation (CEC) very often occurs in the most complex clinical situations there has been a longstanding and ongoing debate about whether and how standards should be developed to train individuals to do this work. Although competencies have been developed (ASBH 1998), there is no agreement

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at a national level (except for the Veteran's Administration (2009)) about practitioner qualifications, practice standards, or valid and reliable measures to assess the quality of a consultation (Dubler and Blustein 2007; Spike and Greenlaw 2000), despite evidence of enormous diversity in the scope and organization of CEC practice across the United States (Fox and Myers 2007). Interestingly, as CEC practices have grown in number, the field as a whole has remained largely insulated from parallel developments in the areas of patient safety and quality improvement. While the debate continues, many argue that this lack of uniform minimum standards for the work of CEC has resulted in a marginalization of CEC services, and that the lack of uniform education and experience may expose patients and families to unintended harm at moments of high emotional and medical risk. In a response to these concerns, the Clinical Ethics Credentialing Project (CECP) was initiated in 2007 to pilot test an approach to training clinical ethics consultants and evaluating their work, with the goal of providing each participant with both a reliable credential to support their qualification as a clinical ethics consultant, and an ongoing method to perform quality assessment of the CEC practices in their institutions. This paper will describe, from a qualitative point of view, the reactions of project participants as they took part in this bold experiment. It is hoped that these examples will inform the debate around these issues and provide guidance for those who are seeking to develop similar programs.

Background

The CECP was a 2-year training program for practicing clinical ethics consultants in the New York Metropolitan Region. It enrolled 72 participants from 27 institutions across the region, including public, private, tertiary, ambulatory, and skilled nursing facilities of varying sizes. The organizational structures and practice arrangements for CEC among the institutions varied significantly. Participants represented many disciplines, including medicine, social work, chaplaincy, law, nursing, and psychology. Individuals had a wide range of experience, from very junior to very experienced, and varying levels of institutional support for their work in CEC. The majority of participants had completed the 1-year Montefiore/Einstein Certificate Program in Bioethics and Humanities or an equivalent program. Those few who did not have this preparation completed an examination to test their fluency in bioethics and the practice of CEC. Faculty members were drawn from the Divisions of Bioethics at Montefiore Medical Center (MMC), the Department of Epidemiology and Social Medicine at MMC, the Albert Einstein College of Medicine, and Bellevue Hospital (New York City Health and Hospitals Corporation).

The CECP trained participants to apply a quality improvement instrument (the "QI tool") to their consultation notes. The goal of this training was three-fold: (1) to help participants improve the quality of their consultation notes, (2) to develop a model for an on-going QI process to assist in peer review of consultation notes, and (3) to assist participants in developing a process for credentialing and privileging at their institutions. There are obvious limitations to using the written chart note as the object of analysis. First and foremost, not all consultation services use a written

chart note to document the consultation process. And for those that do, it is understood that the note may, or may not, reflect the quality of the consult itself. A very brief chart note does not mean that a high quality consultation did not take place. Similarly, an elegant note could shield an inadequate consultation. In addition, it must be acknowledged that any standardized template for documentation of a complex process such as a clinical ethics consultation runs the risk of becoming a "checklist": clinical ethics consultants could document as required, but this will do little if anything to improve the quality of the process itself. But there are significant advantages to using a chart note as a measure of quality. From a QI perspective, the chart note is the permanent record of the consultation. It should, therefore, accurately and appropriately document the important process aspects of the consultation. In addition, use of a standard tool to analyze notes would not require a large commitment of resources, could potentially be flexible across a wide array of institutions, and would be consistent with the quality assessment practices in other disciplines. These benefits were felt to make chart note analysis a good first step toward the establishment of standards for consultations, although not a substitute for a closer examination of the consultation when possible.

The QI tool used in the project was developed over a 2-year period at MMC by an iterative process. In 2005, as part of a quality improvement initiative, the Division of Bioethics of MMC requested an expert outside review of a sample of its consultation notes. Reviewers called for, among other points, (1) a more structured consultation note to ensure that all important information was included and (2) greater consistency in the written notes. Building on these suggestions, CECP faculty and a group of clinical ethics fellows at MMC met monthly for a year to discuss and refine a set of quality elements that were considered key to good consultations and that ideally should be documented in consultation notes. These elements, phrased as questions, were organized into 8 sections and fashioned into a one-page grid which ultimately developed into the QI tool used to analyze written chart notes.

This process, and the resulting QI tool, reflected consensus at an institutional level about the key quality elements that should be present in a chart note. The initial plan for the CECP process anticipated that all participants would submit original chart notes from their practices throughout the year, redacted for personal and institutional identifiers. The QI tool would be used to analyze the redacted notes, followed by a faculty-moderated discussion of the notes and the process of using the QI tool. This application of the QI tool by individuals from a variety of institutions across the region would, in part, informally test whether it could be used as an inter-institutional mechanism to develop a normative standard of practice at the regional level. This paper describes participant reactions to the QI tool itself, and to the process of submitting their work for scrutiny.

Lessons Learned

CECP participants were recruited by the project PI and by word of mouth. All were engaged in clinical ethics consultation at their home institutions. It is important to

note that participation was voluntary, and, in most cases, not formally sponsored by their institutions. Eager to improve their consultation skills, these participants represented a "living laboratory" of individuals attempting to apply uniform quality measures to the work of clinical ethics consultation in real time. What follows is a description of participant reactions to this process, organized around three themes: resistance, conflict, and engagement. Themes are summarized from process notes taken at the time of each CECP session and from in depth interviews with participants at the conclusion of the project.

Resistance

Participants were informed before the start of the project that they would be asked to submit original redacted notes for analysis by the project group using a standardized instrument, with a goal of three notes per trainee. Less than a third of the 72 participants submitted original notes at the start of the project. By the conclusion of the project about 100 original notes had been submitted, but the majority of these were submitted in the second half of the project. Although they offered many legitimate reasons for their slow pace in coming forward with their work, there were several probable sources for their resistance. It could mirror a theme present in the national debate: *should* the work of CEC, powerfully defined by the local culture of each institution, and dealing with unique and complex clinical situations, be scrutinized in an impersonal way? Project faculty accepted the continued voluntary participation of each individual over the 2 years of the project as an affirmative response to this question. Secondly, in the absence of a national consensus about standards, *can* such scrutiny really be fair? It took time for each individual to accept the QI tool that would be applied to their work, and the group process of peer evaluation that would be used to apply it. Not surprisingly, as participants became familiar with the QI tool, as group members came to know one another, and as the peer evaluation process became a known quantity so did individuals' wish to have their work evaluated. And finally, many participants were concerned about using the chart note as the object of assessment. As one participant noted, analysis of the note "…would have poor sensitivity and specificity to tell us anything about the quality of the consult itself." Interestingly, as discussed under the "Engagement" section below, peer discussion of chart notes actually led to discussion of the consult process, an aspect of the CECP process that was enthusiastically embraced by all participants. This was of course the implicit goal of CECP.

Conflict and Disagreement

CECP participants represented an impressively diverse array of practice styles. It is not surprising that they disagreed with faculty, and each other, about almost every aspect of the project. This section highlights three important areas of disagreement: (a) the necessary elements of a consult process, (b) the necessary elements of a consult note, and (c) semantics.

Consult Process

The QI tool aimed to define and assess the necessary elements in the consultation process. Consensus on those elements was reached by a deliberative process at one institution (MMC) over an entire year. Needless to say, it did not reflect consensus among the 27 institutions included in CECP. There was vigorous debate about the following aspects of the consultation process that had been deemed essential by the group that developed the QI tool:

1. Is it necessary to meet with the entire medical team, or simply the individual who called the consult?
2. Is it necessary to meet with the family?
3. Is a face-to-face with the patient essential?
4. What is the role of Risk Management and Legal Affairs in the ethics consultation process?
5. Must written notes include a mandatory educational component?
6. Must the consultation be documented by a written note? Should that note go into the medical record?
7. Who does the consultation (one person, a small group)? Should the consultant review what happened before the consult is finalized? If yes, with whom?
8. Is it necessary to follow up after the consultation?
9. Should the consultant be a "neutral party" in the process, or is it permissible to play a role when skills are needed (e.g., helping complete DNR forms)?

In these debates, participants strongly defended their particular practices initially, but a different picture emerged after several CECP meetings: individuals revealed that they had many questions and much uncertainty about their own practices, and were hoping to learn more about how others viewed the consult process. In response to this circumstance, faculty added a new component to the CECP process: role plays of standardized cases that were acted out by trainees in front of the group, moderated by the PI. This provided the opportunity for discussion and debate with both faculty and peers about consultation practice. This resulted in a group consensus by the conclusion of the project about many aspects of the consultation process.

Consult Notes

The majority of CECP participants documented their consultations with handwritten notes; most of these were incorporated into the medical record. But from this common starting point there was disagreement about many aspects of the structure of the note. The most important of these was length. If employed, the elements in the QI tool would produce a note of at least one to two pages. But few consultants were given protected time to perform consults and used available time to carry out the consult itself, documenting it only with a sentence or a brief paragraph describing the problem and its resolution. There were several additional aspects of the note that were disputed by members of the group:

1. Is it necessary to mention who initiated the consult?
2. Is it necessary to document the ethically relevant medical and social history? Most feel that since this information appears elsewhere in the record it does not need to be repeated.
3. Is it necessary to have a description of the process by which resolution was achieved? While many participants felt that this element should be documented, others objected to the length of time it would add to completing the note.

There was ongoing discussion about whether or not ethics consultation notes should serve an educational goal. The PI and CECP faculty, with roots in large academic medical centers containing mature clinical ethics consultation services, argued that all consultations offered important opportunities for education. Many participants felt that long notes would not be read by those who had requested consults, and that educational material was irrelevant.

Semantics

Participants spent considerable time debating the meaning of a number of items on the QI tool, at first in general discussion, and later when applying the QI tool to specific chart notes. For example, the instrument asked for distinction between "mediation as the focus of the consult", or "consultation" (defined as "clarification and analysis of relevant ethical principles and practices"). Although there was agreement that these models sometimes took place in pure form, most participants felt that the majority of consults that they performed were mixed, and could not reliably be coded as either "mediation" or "consult". There was similar disagreement about the meanings of terms under the "Identification of Ethical Issue" item and the "Ethical Analysis" item. Some took a broad, inclusive frame to identify the issues in a note, others a narrow one. Some wanted all issues listed, others argued for prioritizing. How could we be sure that "the relevant bioethical knowledge was integrated into the note"? What had seemed clear to the developers of the instrument became murky as a group of engaged participants attempted to put it to use.

Engagement and Acceptance

Deceptively simple on its face, the goal of CECP was ambitious: to see if consensus about normative standards for the documentation of clinical ethics consultations reached at one institution could be applied more widely to others. Given the diversity of practice represented by participants, the resistance and disagreement described above is not surprising. But equally important to note is the sustained level of engagement in the process over a period of 2 years and the level of acceptance that was reached by the group about many aspects of the QI tool and its use.

CECP participants may have been slow to provide their own original notes for scrutiny, and they may have disagreed vigorously about the QI tool and the notes that it produced. But they arrived for each session, month after month, ready to work, eager to debate. In part this could reflect a characteristic of clinical ethics

consultants everywhere: the desire to improve one's practice. But the process by which CECP was conducted is also undoubtedly responsible and deserves mention. It reflected what could be called a mediation approach, one that met conflict and resistance in a deliberative and inclusive manner. This flexible approach meant that participants' needs and concerns were incorporated into the design of the project as it went along. The role-play exercises described above are an example of this, as they were not originally part of the design of the training program.

Despite the initial resistance to using the QI tool to evaluate chart notes, most participants accepted its use in at least a limited fashion by the end of the project. Although it was clear that the project would not conclude with a "one size fits all" standard, there was a remarkable progression to a general acceptance of many of its elements. Several vignettes will illustrate this point:

- The consultant who objected most strenuously to the QI tool described in an exit interview how her practice had changed because of it: it reminded her to include certain information, she organized her notes according to its format, and she began adding "a line or two" of educational content to each note.
- A senior consultant on a very busy service also felt that it helped to strengthen her documentation in her notes; she also used the QI tool to approach the QI Committee in her hospital to develop a formal QI mechanism for her service.
- A junior consultant began carrying the QI tool with him as a vital "checklist" when performing consults.
- A group of consultants who operated within a network of ambulatory sites and began the project with no written chart notes used the tool as a template to begin developing a procedure for formal notes.

These are noteworthy examples, but almost all participants reported a positive effect of using the QI tool on their practices. Most important of all is the way in which the tool came to be used within the CECP sessions. By the final sessions of the project each group would analyze individual notes using the QI tool and then discuss them as a group. The QI tool provided a common foundation for the group to begin the discussion. What developed was a discussion of not only the notes but of the consult process itself. The author of the note was questioned about the particulars of the consult, what took place, the choices made in conducting the consult, and in writing the note. Participants found these discussions immensely profitable and were eager to have them continue.

Conclusions

Because the diversity of participants and their practices in CECP mirror the national scene in clinical ethics consultation in many ways, this qualitative description of the project provides data that could potentially be useful in the debate about the establishment of standards in CEC. The resistance and conflict that is documented illuminates the many differences that were present in one regional group of consultants and that would have to be negotiated if a common regional standard were to be established. The sustained engagement of the CECP participants

demonstrates that, at least in our sizable sample, participants felt a shared need to improve their work that motivated them to attempt to work through their differences. While it did not produce a consensus about how a clinical ethics consultation should be performed, documented or evaluated, it did start the conversation.

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