CHARTING THE FUTURE

Credentialing, Privileging, Quality, and Evaluation in Clinical Ethics Consultation

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Clinical ethics consultation has become an important resource, but unlike other health care disciplines, it has no accreditation or accepted curriculum for training programs, no standards for practice, and no way to measure effectiveness. The Clinical Ethics Credentialing Project was launched to pilot-test approaches to train, credential, privilege, and evaluate consultants.

When difficult decisions must be made about health care, clinical ethics consultation provides an additional resource and a conduit for complex communication among patients, their families (including relatives, significant others, close friends, and appointed surrogates), and the care team. CE consultants address some of the most divisive and contentious issues in American society. While other disciplines, such as chaplaincy and palliative medicine, have developed training standards[1] and become viable, funded disciplines within the medical center, clinical ethics consultation (CEC) has yet to mature. Although there are stipulated competencies for consultants,[2] there is no agreement on (1) standards for practice (outside of the Veterans Administration system),[3] (2) qualifications for practitioners,[4] or (3) valid and reliable measures to rate the quality and effectiveness of the CEC process.[5] There is neither accreditation for training programs nor an accepted curriculum for what such programs should teach. Finally, there has been no agreement that these clinicians must be credentialed and privileged in order to practice, in contrast to what is required for all other health care professionals.

Nancy Neveloff Dubler, Mayris P. Webber, Deborah M. Swiderski, and the Faculty and the National Working Group for the Clinical Ethics Credentialing Project, "Charting the Future: Credentialing, Privileging, Quality, and Evaluation in Clinical Ethics Consultation," *Hastings Center Report* 39, no. 6 (2009): 23-33.

The patient safety movement and quality improvement practices in health care have changed how insurers, the federal government, and patients rate and measure excellence in health care delivery, and increasingly they will determine how care is reimbursed. CEC has remained insulated from these evaluations, however—a fact that must change if its full potential is to be realized. It was precisely to bring about this change that the Clinical Ethics Credentialing Project (CECP) was launched. The project aimed to pilot-test possible approaches to training, credentialing, and privileging clinical ethics consultants and evaluating their work. It enrolled twenty-eight professionals, previously trained in the Montefiore-Einstein Certificate Program in Bioethics and Medical Humanities, who worked at the New York City Health and Hospitals Corporation, and forty-two previously trained professionals from a variety of hospitals surrounding New York City. Some applicants to the program who had not graduated from the Montefiore-Einstein certificate program were tested to gauge their fluency with health care ethics topics. The faculty—who were recruited from Bellevue Hospital and from Montefiore Medical Center—designed the program, taught the participants, and reviewed written assignments. For privacy reasons, HHC and non-HHC hospitals were grouped separately for teaching and discussion, although all case materials were redacted.

In November 2008, a working group of nationally recognized experts in bioethics and CEC convened to critique the project and advise the CECP on its products and processes. The goal of the meeting was to examine the project's experience and see if consensus was possible among these experts on standards for the organization and practice of CEC. Given the group's depth and diversity, its findings should reflect the current state of CEC in the United States.

The working group identified the following salient characteristics of a CEC service, comparable to other clinical services:

- The CEC service should be staffed by professionals whose education, experience, and present ability receive a high level of scrutiny.
- The CEC service should have a clear and transparent process.
- CE consultants should have the respect and support of clinical and corporate authorities in their institutions.
- CE consultants should be adequately compensated for their expertise and contribution to the clinical care environment and should be supported in ongoing educational activities.
- The processes and products of a CEC service should be subject to regular evaluation and peer review and to a rigorous quality improvement process, comparable to other clinical services.

Even though the issues of CEC may be similar, every health care institution is different. Because of the emotional, professional, and moral content of the dilemmas, misunderstandings, disagreements, and dis-

Listed below are the members of the National Working Group of the CECP (faculty members are marked with an asterisk), who met in November 2008 to review the work of the project, critique its products, and arrive at a consensus statement to provide standards for CEC and guidance for consultants and institutions. These individuals participated as authors for this article. Their affiliations are given only for identification and do not assume support from their organizations for this article's conclusions.

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putes that they address, CE consultants may challenge the power structure, settled assumptions, and modes of professional practice in the institution.[6] Thus, if CEC is to be effective, its place must be negotiated, supported, and secured within each institution. In many institutions, CEC is an add-on to the already assigned clinical duties of busy health care professionals who are trained in other primary disciplines. Without adequate dedicated and compensated time, access to developing literature, and ongoing educational support, CEC is unable to fulfill its potential as a resource to promote high-quality patient care and encourage self-reflective clinical and institutional ethics practices.

What follows are the working group's recommendations for the organization of CE consultations, for ensuring the qualifications and competency of CE consultants, and for a quality improvement process.

Definition of Clinical Ethics Consultation

One widely accepted definition of CEC is that it is a service provided by an individual, consultant team, or committee to address the ethical issues involved in a specific clinical case. Its central purpose is to improve the process and outcomes of patient care by helping to identify, analyze, and resolve ethical problems.[7] (See Figure 1.) While CEC services may do other things to promote an institutional environment that supports ethical discourse on many levels, we focus on CEC activities involving individual patient cases.

We recognize the following components of successful CEC: informed discussion of the relevant content and history of bioethics—the principles, practices, and shared civil mores of American law, medicine, and ethics;[8] facilitating understanding of the ethical dimensions in clinical practice—navigating discussion of uncertainty, articulating ethical issues, elucidating ethical viability of options, and negotiating decision-making in complex

Figure 1. Fundamental Elements of Clinical Ethics Consultation

Clinical ethics consultation is an intervention in which a trained clinical ethics professional:

- responds in a timely fashion to the request for a CEC from any member of the medical care team, patient, or family member;
- reviews the patient's medical record;
- either interviews relevant medical stakeholders or gathers the clinical care team and other consultants to discuss the case;
- visits the patient and family whenever possible;
- as a preliminary matter, identifies the ethical issues at play and any sources of conflict;
- involves the patient or family with care providers to promote communication, explore options, and seek consensus, when appropriate;
- employs expert discussion of bioethical principles, practices, and norms and uses reason, facilitation, negotiation, or mediation to seek a common judgment regarding a plan of care going forward;
- attends to the social, psychological, and spiritual issues that are often at play in disagreements about the proper course of care;
- triggers a further process with hospital medical leaders or a bioethics committee to resolve the situation, if a resolution is not reached;
- follows up with a patient and family after the initial consultation (although this feature of CEC varies, since in some systems follow-up is a task solely for the medical team);
- records the process and substance of the consultation, including the consultant's recommendations and their justification, as part of the patient's medical record;
- reviews the consultation with others on the CEC service as a basic level of evaluation and peer review; and
- utilizes a formal and rigorous quality improvement process.

This description incorporates elements frequently mentioned in the literature and reflected in the practices of the clinical ethics consultation services of working group members. For sources in the literature, see American Society for Bioethics and Humanities, *Core Competencies for Health Care Ethics Consultation* (ASBH, 1998); Nancy N. Dubler and Carol B. Liebman, *Bioethics Mediation: A Guide to Shaping Shared Solutions* (United Hospital Fund Press, 2003), 10; Arthur L. Caplan and Edward J. Bergman, "Beyond Schiavo," *Journal of Clinical Ethics* 18, no. 4 (2007): 340-45; Kenneth Berkowitz and Nancy N. Dubler, "Approaches to Ethics Consultation," in *Handbook for Health Care Ethics Committees*, ed. Linda Farber Post, Jeffrey Blustein, and Nancy N. Dubler (Johns Hopkins University Press, 2007), 147-49; Mark P. Ausilio, Robert M. Arnold, and Stuart J. Youngner, *Ethics Consultation: From Theory to Practice* (Johns Hopkins University Press, 2003); Veterans Administration Integrated Ethics, "Document the Consultation in the Health Record," http://www.ethics.va.gov/docs/integratedethics/Ethics_Consultation_Responding_to_Ethics_Questions_in_Health_Care_20070808.pdf, at 38; and Elizabeth G. Nilson et al., "Clinical Ethics and the Quality Initiative: A Pilot Study for the Empirical Evaluation of Ethics Case Consultation," *American Journal of Medical Quality* 23, no. 5 (2008): 356-64.

medical situations;[9] and, whenever appropriate, mediating conflicts between staff members or among staff, patient, and family.[10] The CE consultant must strive to help those who are involved in a case to understand and resolve—in a timely fashion and on terms that are ethically sound—the problem that led to the consultation request. However, mindful of the danger of solutions imposed by powerful institutional professionals, if resolution is precluded by the nature of the facts or by virtue of the participants' characteristics, the CE consultant must work quickly, clearly, and constructively with the particular process stipulated in that institution for resolving "unsolvable" situations. These may include referral to the institutional ethics committee or presentation to the medical director or corporate leadership.

Many assume that CEC is limited to interventions that seek to resolve classical ethics dilemmas, such as the beneficent obligation of the physician to do good versus the desire of a patient to exercise his or her autonomy. However, experience indicates that CEC can be required in a variety of circumstances that fall well beyond the typical "clash of relevant principles."[11] The underlying situations requiring CEC may include, among other issues, questions about whether the voice of the patient has been adequately sought or attended to in the process of choosing a path for care;[12] conflict between and among care providers[13] or among providers, patient, or family;[14] questions about ethical interpretation[15] or analysis of alternative care plans;[16] and the clarification of institutional ethics policies.[17]

Standards for Clinical Ethics Consultation

Easy access to CEC and a plan for responding to requests for CEC from staff, patients, and family members (or other patient representatives). The system for responding to requests for CEC must be well publicized, easily accessible, and broadly based to address patient care concerns related to uncertainty about values or relevant ethical and legal principles, or conflicts between and among stakeholders. The ethics consultation service must be able to triage, assign a lead consultant (if a team is involved in the consultation), and coordinate among the patient, family members, and the relevant clinical services, such as palliative care, pastoral care, consultation-liaison psychiatry, and the involved medical services.

The CEC office is not the proper location for complaints, allegations, or investigations (concerning, for example, alleged physician error or malpractice, health care worker misbehavior, or billing and scheduling dysfunctions). CEC staff may analyze institutional systems as part of their role in enhancing organizational ethics, but they should refer investigations of individual behavior to another resource. Events are appropriate for CEC when they reflect a clash of values, present ethical uncertainty, or raise ethical-legal questions at the boundaries of each domain, and when they pose conflicts or the potential for conflict in the clinical decision-making process.

A clear process for gathering information and making appropriate arrangements to make sure all relevant stakeholders are heard. Respect for the patient requires that the CE consultant see the patient whenever possible. This visit may only confirm the report that the patient is on a ventilator and unresponsive. Yet the visual imagery of this patient is critical to later professional and family discussion. This visit serves a number of purposes: First, it shows respect for information-gathering and respect for the patient. Second, it permits verification and facilitates insight into how the patient's appearance factors into the family's perspective. Third, it helps the consultant resist any tendency to treat the patient as an abstraction.

Many CEC services encourage formal meetings of the multidisciplinary care team at the outset as a way of airing different medical interpretations of patient data. When care providers convey opposing opinions to patient and family, confusion and conflict may result. Although some patients and families may appreciate communication of uncertainty, others may be distressed and upset by such ambiguity. A CEC meeting attended by all of the attending physicians, fellows, house staff, social workers, nurses, and other relevant team members may be the first opportunity for subspecialty providers and the team to meet and share their opinions and perspectives. Such a meeting may help to clarify the patient's status and prognosis and may circumvent breakdowns in communication based on medical politics and hierarchical power structures within the health care team.[18] This greater clarity may facilitate subsequent discussion with the patient and family stakeholders.

Discussions with the family should attend to the grief and fear of loved ones experiencing anticipatory bereavement, suffering, and loss and requiring comfort and support. It often helps to begin with a question about the family's personal experiences with the health care system or with the patient—"Tell me about Mama," for example.[19] The medical team is the expert on illness and disease, but the family is the expert on "Mama." Plumbing their perceptions and encouraging them to tell their stories helps to bring the patient to the center of the discussion and gives voice to and empowers the family amidst the alien discourse of medicine.

A formal note in the medical record. A formal note in the medical record, such as a typed note in the chart, is the standard method care providers use to communicate about all aspects of the patient's care. An ethics consultation summary note should be entered into the medical record of every patient for whom a CEC has been completed. It is the

legal record of what has occurred, the intellectual repository of discussion and deliberation about the care options, and the rationale for actions taken. When appropriate, the note should contain a recommendation and its ethical justification. The chart language must always be professional and respectful. Professionals must be approved by the appropriate institutional committee in order to write a note in the medical record.

Ideally, the chart note presents the patient's story and provides insight into it, identifying the characters, sharing the patient's perspective, presenting the plot (including the CEC request), and identifying paths taken and abandoned.[20] This linear thread proceeds while specifying, clarifying, and assessing the ethical contours of possible options by discussing and referencing the relevant ethics literature and demonstrating consideration of the possibility of multiple morally acceptable outcomes.[21] When appropriate, the note should make clear recommendations. It should always demonstrate sound reasoning. The chart note is evidence of the transparent, collaborative, inclusive, and empowering nature of the CEC process.

It is the convention at some sites for copies of the chart note to be sent by e-mail to all staff who participated in the consultation. This practice, when confidentiality measures are assured, serves five purposes: (1) it facilitates an initial level of quality improvement—a check for *accuracy*—by subjecting the chart note to review by others present; (2) it promotes *transparency*; (3) it permits the participants in the conference to review how the issues discussed were relayed to the naive chart reader—that is, the newly arriving staff—and helps ensure *consistency* of understanding; (4) it supports *staff education* by concisely describing and analyzing the ethical dilemma in case material that, once redacted, can be used for institutional teaching; and (5) it ensures *closure*, as many of the participants in a CEC are in different locations in the institution and will not naturally encounter the chart. Proper measures must be taken to prevent confidentiality breaches, such as e-mail encryption.

There are still some institutions that maintain a policy barring CEC notes from the patient's chart.[22] Most are relying on risk-management advice that these notes are somehow more dangerous to the institution as possible evidence for malpractice suits than other sorts of patient care observations are. But an institution that has carefully selected the CE consultant or consultant service leader and is aware of her practice in regard to chart notes should be comfortable that the note will thoughtfully reflect the interests of the relevant parties, sound ethics analysis, and appropriate recommendations.

In addition to written notes in the patient's chart reflecting full consultations (augmented by an early progress note of response to the consultation request), some record should also be kept of all advice and analysis given over the telephone, by e-mail, and in informal settings. However, informal discussions, such as "curb-side" consultations, should be avoided if they go beyond providing general information. Patient-specific recommendations must not be offered; they risk missing important information or steps in the consultation process that could negatively affect subsequent patient care decisions.

These records will give a full picture of the CEC service's breadth of expertise and depth of penetration into the institution and provide an important step in developing a system that responds to all consultations in a thorough, high-quality manner. When possible, all of these materials should be included in the institution's quality improvement process since, in almost all jurisdictions, this protects requests from disclosure during litigation.

The chart note is always an opportunity both for education and for quality improvement. The CECP faculty created a library of short paragraphs that discuss ethical issues in a way suitable for editing and integration into chart note analyses. (See Figure 2 for some examples.) The CECP paragraphs summarize the literature regarding common areas of concern. For any person reading the chart note, they provide an introduction to the basic ethical reasoning of CEC. A high-quality consultation note, structured according to a standard format, may be an excellent proxy for real-time participation in the consultation itself and may be used when assessing the quality of the CEC through a systematic quality improvement process.

A standard format for writing in the chart. A clear format should govern a first intake note, the body of the chart note, and a final summary note, if required. If the chart note format tracks the elements of an established quality improvement tool, it will provide readily available material for later organizational evaluation.

In order to be authorized by a health care organization, clinical ethics consultants should successfully complete both a formal bioethics program and an apprenticeship that includes observation, participation in debriefing of cases, and supervised leadership of consultations.

FIGURE 2.
Sample Concept Paragraphs

Every participant in the Clinical Ethics Credentialing Project received a file with possibly relevant concept paragraphs to be used as reminders for analysis and as drafts for inclusion into chart notes (for a complete list of topics covered, see Figure 3, section D2). Individuals and institutions were encouraged to revise as desired.

Two examples of the draft paragraphs (written by Jeffrey Blustein) are as follows:

ADVANCE DIRECTIVES

Advance Directives provide documentation of an individual's wishes in relation to health care and end-of-life care in the event that he/she is no longer able to make such decisions for himself/herself. The Living Will and the Health Care Proxy are the two most commonly used advance directives. A Living Will is a written document that expresses the patient's specific instructions about care. These instructions often include the patient's stated choices for or against certain interventions such as artificial hydration and nutrition, ventilatory support, cardiopulmonary resuscitation, and control of pain at the end of life. As a legal document, a Living Will can be recognized as an indication of a patient's wishes regarding care at the end of life. The Health Care Proxy is a legal document that allows a patient to designate an individual ("Health Care Agent") to make medical decisions on his/her behalf in the event that he/she lacks the capacity to do so for himself/herself. A Health Care Agent has legal authority to make medical decisions on the patient's behalf regarding end-of-life care. Appointment of a Health Care Agent generally allows for a more flexible and more responsive approach to the nuances of medical conditions than the written directions expressed in a Living Will.

SUBSTITUTED JUDGMENT

Proxy decision-making for incapacitated patients must place particular emphasis on respecting the wishes and values of the patient when he or she had capacity. The prior wishes of the patient, however, may not be known, or were never expressed. Under these circumstances, proxies should consider whether a substituted judgment standard can be applied to the case at hand. A substituted judgment is a decision by others based on the patient's inferred wishes. The question to ask here is, "Knowing what you know about this individual's values, behavior, and decision history, what do you think he/she would decide in this grave situation?" It may also be helpful to pose the question this way: "Suppose that the patient were lying here now, capable of making decisions, listening to this conversation and knowing his/her grave medical condition and end-of-life prognosis. What do you think he/she would tell us to do for him/her?" Persons who know the patient well and are familiar with his/her values and beliefs, such as close friends or family members, are in the best position to make substituted judgments. It is particularly important to stress that decisions should be based on what it is believed *the patient* would want, not what *they would want* for the patient.

A clear format for a CEC chart note will be recognizable and will encourage the reader to expect a detailed ethical analysis that is applicable both to this case and to similar cases in the future. Treating like cases alike is one of the important bases of justice and fairness that a carefully crafted chart note can promote.

Recognition of CEC as one of many collaborating services that must be integrated and transparent in its functioning. In the increasingly complex world of health care institutions, many voices are present in conversations about troubling situations where ethics questions or concerns arise. These perspectives may include those of the patient, family, care team, and CE consultant, as well as those of the medical director, risk manager, and the office of legal affairs. If organizational ethics issues emerge, or if the patient situation is particularly distressing, the chief executive officer, members of the financial management group, or other top administrators may also be involved. All of these professionals have different, important, and valid perspectives. None should dominate at all times, yet some have the power, in some cases, to dictate the outcome.

American case law (and scholarly comment on it) and American bioethics adhere to similar modes of analysis. But the tasks of legal counsel and of risk management are to protect against possible future liability and legal challenge in an extraordinarily adversarial system. The task of the CE consultant is to identify, clarify, and analyze the ethical issues in the case and the interests and rights of patients, family members, providers, and administrators, and—where they clash—to facilitate or mediate a "principled resolution: a plan that falls clearly within accepted ethical principles, legal stipulations, and moral rules defined by ethical discourse, legislatures, and courts and that facilitates a clear plan for future intervention."[23] These are generally similar goals and usually converge. However, given the state of the law, the litigious nature of American society, the lack of justice in access to care, and the scarcity of health care re-

sources, ethics and law may occasionally diverge. This can be healthy and instructive for a robust discussion of professional and institutional values. Understanding the unique role of CEC in the landscape of institutional responsibilities and understanding the roles of the offices of legal counsel and risk management is a critical bridging component of the CE consultant. It will frequently require recognizing their differences, and sometimes, agreeing to disagree and to proceed by understanding whose view prevails and why. However, it is also the case that many attorneys in offices of legal counsel judge it to be helpful, in a difficult case, to have a well-crafted and carefully argued ethics note.

The only productive route for approaching the multiplicity of tasks and perspectives in any organization is to consciously recognize and acknowledge difference and create a respectful and transparent process for identifying and resolving conflicting perspectives. For example, a chart note and analysis that may raise issues for the institution's office of legal counsel or risk management could be brought to the attention of these professionals as part of the ongoing process of respectful dialogue, both to alert them to generic issues and to warn them about cases that might require their attention. In a case that may be the subject of legal action, the chart note must be crafted with special sensitivity and precision. Conversely, we hope that a perceptive office of legal counsel would refer to the CEC cases that would be better served by a less rules-based process than the one legal counsel is likely to follow. It is often useful for CE consultants, members of the offices of legal counsel and risk management, and relevant clinicians from the consultation psychiatry liaison service to meet together to discuss difficult cases and sharpen commonly agreed-upon concepts and processes. These complex, interdisciplinary discussions will be more likely in large academic medical centers or teaching hospitals, where authority and responsibility must be carefully parsed and disciplinary boundaries tested in pursuit of optimal care.

Institutional and peer oversight. The CEC service should reflect the diversity of the medical institution. It will address the most vulnerable patients and families, in times of emotional stress, and perhaps help to avoid a developing crisis. At a minimum, it should report to the institutional ethics committee, which should review consultations and chart notes and report to the medical board or governing body. It may also be part of the governing body. In either role, the CEC should not only report on individual cases but also identify troubling policy and process issues that have broad applicability to the medical institution and deserve attention, discussion, and perhaps revision. The CEC service should, in all of these forums, promote institutional self-reflection and systems-level quality improvement to address reforms that might prevent similar ethics concerns in the future.

Institutional reporting structures vary widely. An informal survey of the working group members reveals that some directors of a CEC service, as chairpersons of the hospital's ethics committee, are also members of the hospital's executive committee. Some CEC directors report to hospital medical directors or to a committee of the medical staff. One study reported that most CEC services were primarily accountable either to the hospital administration (36 percent) or the medical staff (29 percent).[24]

The CEC service should create a regular process for consultants' peer review of cases. This ongoing review is central to accountability and professional development. In the absence of a formal network (such as the CECP established) or an institutional ethics committee, lone clinical ethics consultants should develop a peer review supervision structure similar to that created by therapists and various other counseling professionals. A group of hospitals might create a consortium to structure peer review and quality improvement for CEC. Whatever structure is created, the responsible hospital authority should review the process to be certain that it receives maximal legal protection.

CONSULTANTS must be subjected to the same level of transparency, accountability, scrutiny, and oversight as other staff members who see patients, and like other members, they must write notes in the chart.

Ensuring the qualifications and competency of CE consultants. The Joint Commission, which accredits and certifies health care organizations and programs in the United States, now requires that professionals who intervene in patient care have their required qualifications and competency defined and periodically evaluated, either through formal credentialing and privileging or through other processes.[25] As has been demonstrated at some institutions, this rule can and should apply to CEC.[26] In order to be authorized by a health care organization to serve as a CE consultant, an individual should satisfy a number of criteria in three core domains: knowledge, skills, and clinical capacity. CE consultants must be trained to engage in finding information; interviewing the stakeholders; amplifying the voices of the patient and family; explaining, facilitating, and when appropriate mediating solutions; documenting the process appropriately; engaging in

a quality improvement process; serving as an educational resource; and demonstrating diligence in one's professional education and professional development. They must have basic preparation, augmented each year by journal reviews and participation in continuing education, all of which need to be supported financially by their institutions. Finally, as with many other health care professionals, they must have personal references that attest to their character and integrity.

Credentialing and privileging might not be the only institutional option for ensuring the qualifications and competency of CE consultants. For example, an institution might provide oversight of CE consultants through scope of practice agreements. Understanding the laws and regulatory requirements that apply in a given jurisdiction is an important component of developing an institutional system.

An institution seeking to establish a policy for ensuring the qualifications and competency of CE consultants should address specific questions in its jurisdiction, including at least the following:

- As the Joint Commission requires reprivileging every two years, how often will qualifications and competency be assessed, how will that process proceed, and where can professionals turn to acquire the necessary continuing education (or alternative) credits?

- Under the laws of the jurisdiction, are those who are credentialed and privileged more difficult to dismiss for cause? Might they face any unintended adverse effects from the credentialing and privileging process?

Figure 3. Initial Clinical Ethics Consultation Chart Review

The Clinical Ethics Credentialing Project found that a structured tool was useful in assessing the quality of the consultation and in evaluating change in quality over time. It also provided a checklist for those carrying out and documenting a CEC. The members of the CECP developed the following set of questions for assessing quality. The questions were listed on the left-hand side of a table, and each question could be answered by indicating "yes/most," "some/part," "no," or "not applicable." The table also provided space to comment on each answer.

A. Participants

1. Was it clear who requested the consultation? (specify in comment field)
2. If it was not the attending physician, was s/he informed in person or by telephone?
3. Were important care providers involved?
4. Was the patient cognitively able to participate?
5. Was there a face-to-face patient visit?
6. Were important family stakeholders involved?

B. Relevant history

1. Ethically relevant medical history?
2. Ethically relevant social history?

C. Consult implementation

1. Was the consult largely mediation—that is, dispute resolution among care providers, family, or patient?
2. Was the consult largely consultation—that is, clarification and analysis of relevant ethical principles and practices?
3. Were there meetings/discussions with care providers only?
4. Were there meetings/discussions with family only?
5. Was there a joint meeting/discussion with care providers and family?

D. Ethical problem

1. Was the ethical/mediation issue(s) well identified?
2. Which of the following issues most apply (indicate "yes" to all that apply, or rank them 1–3 according to importance)
   * allocation of scarce resources
   * benefit/burden analysis in care options
   * best interest of the patient
   * confidentiality
   * cultural values and treatment
   * decision-specific capacity
   * doctrine of double effect
   * end-of-life balance of acute and palliative care interventions

• Are there alternative means for securing the right of CE consultants to write in the chart and to have their practice insured that would not require credentialing and privileging, but could proceed through human resources, the medical staff office, or another department?

• Would designation of authority to practice from within human resources or other departments be sufficiently rigorous for identification, training, and supervision without involving the institution's medical staff office, as is required by the Joint Commission for credentialing and privileging?

• Would the institution's bylaws need to be changed to permit this new process?

• Should the CEC program be designated a separate clinical department—affiliated with, but independent of, the hospital ethics committee?

• How would the credentialing and privileging or other process for ensuring the qualifications and competency of the CE consultants relate to the status of the ethics committee chairpersons and members?

• How will informal experience ("grandparenting"), formal training, and ongoing learning all be valued, supported, and monitored as qualification processes change?

Measures for credentialing CE consultants. For credentialing, the institution should require the following or a similar plan, while keeping in

* failure of the medical team to assume "responsibility" for difficult medical choices
* informed consent
* withdrawing and withholding treatment
* justice in the context of American medicine
* medical futility
* patient autonomy
* prior directives and delegation of authority
* proposing 'false choices' to patient and family
* treatment refusal
* religious values and treatment
* setting boundaries for care
* special pediatric issues: best interest for neonates, children, and adolescents
* substituted judgment
* truth-telling
* other (describe)

E. Ethical analysis

1. Was relevant bioethics knowledge integrated into the note?
2. Was the chart note sufficient for educational purposes?

F. Process

1. Does the note give a clear description of the dynamic of the discussion?
2. Was the voice of the patient clear?
3. Were the voices of the family stakeholders clear?
4. Were the positions of the care providers clear?
5. If there was disagreement among health care team members, was consensus achieved?
6. If there was disagreement among family members, was consensus achieved?
7. If there was disagreement among health team and family members, was consensus achieved?

G. Recommendations

1. If consensus was achieved, were the recommendations clear?
2. If consensus was not achieved, was it clear what should happen next?

H. Style

1. Is appropriate medical language used throughout?
2. Is neutral language used throughout?

mind the need to allow existing competent clinicians who have operated effectively under prior arrangements to continue to practice.

• *Participation in a formal training program and verification of qualifications.* CE consultants should successfully complete a substantial, formal program in bioethics, including material specifically addressing clinical ethics. Any such program should emphasize the development of core competencies in the following areas:

- *Knowledge:* CE consultants must know the vocabulary and nomenclature of clinical medicine. In addition they should know (a) the central concepts, principles, and theories of bioethics; (b) common clinical ethical issues; (c) relevant health law; (d) codes of professional ethics; and (e) institutional policies and practices.

- *Interpersonal skills:* Consultants should have training and proficiency in recognizing and managing the social, psychological, and spiritual aspects of CEC, and in the techniques of facilitation, negotiation, or mediation in order to gather and communicate information, address issues of uncertainty, and help resolve disagreements.

- *Educational background:* Consultants should have participated in a formal training program to assure that they have the knowledge described above. The candidate's teachers or mentors must provide written evaluations of his or her performance and fitness to do CEC.

• *Completion of an apprenticeship.* CE consultants should also complete an apprenticeship—a supervised period of practice similar to a clinical fellowship for medical specialties, although flexible in regard to time. The supervisor should have the leeway to state, after a specified period, that the person is qualified to perform CEC. The apprenticeship should consist of the following elements:

- participation as an observer in CEC performed by experienced consultants (for example, at least ten case consultations, although viable standards will need to await empirical data);

- attendance at a monthly multidisciplinary chart review, ethics committee meeting, or quality improvement meeting to debrief past and ongoing cases that raise ethical issues; and

- successful completion and documentation of three consultations as lead consultant, under the supervision of experienced mentors.

These requirements will be difficult for many health care institutions to meet at present. Many excellent consultants will have had sufficient education and "on the job" training to be "grandparented" into an officially sanctioned status. For many institutions, the requirements outlined here will define future goals rather than reflect a present reality and will help to fashion a plan of phased-in training. Until programs that address these requirements in a comprehensive manner become readily accessible and adopt universal criteria, institutions must identify alternative methods of training and apprenticeship that CE consultants seeking to become credentialed or sanctioned must complete. This is an area ripe for systematic study.

A robust quality improvement process. Quality improvement is mandatory in all subspecialties of health care. As CEC moves into the mainstream, it must be judged by mainstream standards. CEC and CE consultants must be subjected to the same level of transparency, accountability, scrutiny, and oversight as other members of the staff who see patients, and, like other members of the staff, they must write notes in the chart. This next step would be easier if there were clear standards for accrediting these professionals, but even without this platform, the obligation of hospitals to ensure quality mandates that they take responsibility for quality improvement efforts in CEC services.

The CECP has found that a structured quality improvement tool, based in reviews of the CEC summary notes, is not only useful for retrospective quality analyses, but also serves as an educational tool, a checklist for the key interventions needed in a CEC, and a template for the chart note. (See Figure 3 for a sample quality improvement tool.) An ethics case consultation that documents all of the data required by the quality improvement tool is likely to meet a high quality standard.

Any quality improvement program for CEC will likely need to be incrementally employed. For many institutions, observation of consultations, regular case review by the ethics committee, and peer review processes will be the first efforts in quality improvement. Reviews of quality by colleagues—now required to maintain the privilege to practice at many hospitals—may be useful. (The "360-degree" review is an example of this kind of quality review.) Reviews of process and outcome are basic to a quality improvement plan. A gradually maturing process of quality improvement will embed CEC in the quality culture of the institution. As a formal CEC service evolves along with a quality improvement program, work may include research that identifies outcomes that inform the practice of CEC and yield significant learning opportunities for the profession.[27]

CEC in Context

Ultimately, securing excellence in clinical ethics consultation hinges on four overarching principles identified by the CECP working group: providing institutional support for the CEC service, overseeing the qualifications and expertise of

consultants, compensating the critical CEC services, and evaluating the quality of CEC service. Institutions that support a CEC service will have the potential for enhanced quality of patient care in the context of more robust intellectual analysis of clinical decision-making and institutional policy. Creating a quality improvement model that improves over time in order to evaluate whether CEC interventions meet established and evolving standards will ensure that this service merits its place in the institution.

The CEC standards articulated in this consensus document are one way to enable a CEC service to function effectively and accountably in health care settings and to negotiate ethically justifiable solutions when values uncertainties or conflicts arise regarding a patient's plan of care. These CEC standards recognize that the best possible decision arises from a process that includes the perspectives of all interested parties, provides robust ethical reasoning, recognizes the range of values that influence beliefs and behaviors in a morally pluralistic society, and supports a resolution that integrates all the parties' perspectives. A quality CEC service must be nested in an institutional environment that values the voice of CEC as a champion for transparent, quality patient care, and serves as a conduit for building trust in clinical medicine through deliberate, inclusive action.

Acknowledgments

The Clinical Ethics Credentialing Project (CECP) was funded by FJC, A Foundation of Philanthropic Funds; the HHC Foundation; the United Hospital Fund of New York; and the New York Community Trust. We would also like to thank four individuals who as leaders of Montefiore Medical Center supported the development of this model: Elaine Brennan, Spencer Foreman, Gary Kalkut, and Steven M. Safyer.

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