CLINICAL ETHICS CONSULTATION AFFAIRS (CECA) COMMITTEE AGENDA OCTOBER 18, 2009

Members Present		Members Excused
Armand Antommaria	Nneka Mokwunye	Mark Aulisio
Autumn Fiester	John Moskop	Jeffrey Berger
Joseph Carrese	Kayhan Parsi	Nancy Berlinger
Ellen Fox	Bob Pearlman	Art Derse
Colleen Gallagher	Marty Smith	Millie Solomon
John (Jack) Gallagher	Jeffrey Spike	
Paula Goodman-Crews	Terry Rosell	
Tracy Koogler	Anita Tarzian (Chair)	
Steve Latham	Lucia Wocial	
Christine Mitchell		

The meeting was called to order at 12:30 PM by the Chair.

EXECUTIVE SUMMARY

The CECA committee met for approximately five hours on Sunday, October 18, 2009, following the close of the ASBH Annual Conference. After introductions, the committee members discussed their goals for the coming year. The Committee's broad goal is to improve the quality of health care ethics consultation. The Committee chose to use the Core Competencies as a starting point in recognizing that individual consultants, consult team members, and ethics committee members have different needs. Given the diversity of consultants' backgrounds, among other considerations, it was believed preferable to focus first on certifying consultants rather than accrediting training programs. Drawing on models from other disciplines such as chaplaincy, the Committee will consider the benefits and detriments of different methods and levels of certification. The Committee members recognized that the efforts to develop a certification process may demonstrate the lack of/need for measurable standards for the practice. The Committee will also seek to provide resources to improve the skills of team and committee members providing ethics consultation. The Committee reformed its subcommittees along these lines with Anita chairing the subcommittee on basic competencies and Colleen the subcommittee on advanced competencies. The subcommittees will teleconference monthly and the Committee quarterly.

The Committee also discussed its role relative to the development of a code of ethics for clinical ethics consultation and the selection of program material on clinical ethics consultation for the Annual Meeting. The Committee will review the code being developed by Ken Kipnis and Bob Baker prior to its submission to the board, and will ask Ken and Bob to update the full Committee on their progress at its next teleconference. The Committee recommended reestablishing a competitive general submission and review process for the selection of preconference workshops. The proposals should be consistent with the Core Competencies and interactive, and the presenters should present evidence of their teaching success in this format. The Committee will encourage the incorporation of sessions about consultation in the general program, and agreed that individuals with clinical ethics consultation expertise review these submissions.

DETAILED MEETING MINUTES

Anita began by reviewing the goals of the meeting being threefold: (1) to discuss and agree on what we will accomplish in the upcoming year, (2) discuss how the group is structured and whether the sub-committee structure of the group needs to be changed, and (3) decide how to divide the workload and timeline for accomplishing tasks.

1. What the Committee plans to accomplish in the upcoming year (by next Annual Meeting)

Measurable standards (certification/accreditation)

We initially discussed the following approaches to ensuring that individuals providing clinical/health care ethics consultation (HCEC) are competent:

Targeted at the individual: certifying, hospital credentialing/privileging, licensing
Targeted at the institution: accrediting a bioethics educational program

We discussed the goal of this Committee being to increase the quality of HCEC in U.S. health care institutions. We agreed

that poor quality is a problem, although one member wondered whether the lack of outcomes data is of concern (related to evidence of poor quality or evidence of HCEC benefit). Others pointed out that there is value in focusing on individual competency, and that once you establish competency of individuals doing HCEC and improve quality across the board, you can more effectively measure outcomes. We discussed the perception of a wide variance of competence and quality among those performing HCEC; that there seems to be a minority representing an advanced level and then a huge segment in the middle (basic/intermediate) or bottom (poor). One member pointed out that if we only focus at the top level, we'll be accused of elitism. We discussed the concern that a move toward certification would be perceived as endorsing a move to "professionalize" everyone doing clinical ethics (the broader scope of activities), rather than an effort to ensure quality of HCEC.

We considered perhaps focusing on how to do HCEC in ways that harm stakeholders. That is, do we need to consider a "minimum" standard for HCEC certification? One member pointed out that what is really bothering people is what's being done *wrong.* Could we address that? Perhaps propose the "Top 10 Quality Gaps in HCEC." Another member agreed, and felt that Clinical Pastoral Education (CPE) represents a high standard, whereas the alternative proposal of pursuing a less ambitious, more achievable goal would be more feasible (i.e., to pursue some "lower hanging fruit" that will advance HCEC quality and be doable within the next year). Another member suggested developing or promoting a functional peer review system.

One member asked if we have consensus on detailed standards. We agreed that we have some general skills and knowledge standards in the *Core Competencies* report, but not adequate methods of evaluating them. Establishing the tools and methods needed to certify an individual as competent would be of value whether or not we actually are able to produce a certification, accreditation, or credentialing method, because of what we would learn along the way.

One member pointed out that those around the table represent experts in the HCEC field, and that the less expert people doing this are not represented. One member responded that he represents such individuals (i.e., a constituency of community hospitals), and that HCEC is the only thing going on in hospitals that can harm people, but for which those performing the service are not shown to be competent. There is a requirement for an ethics service at these hospitals, but often, for example, physicians doing HCEC are giving medical opinions, not ethics consults. He advised keeping a focus on this concern and the need to do something about it.

Another member pointed out that the ASBH Board will likely be endorsing an updated *Core Competencies* (CC) within the next 6 months. She proposed that we build off of that. One particular concept there is the basic versus advanced level of skills/knowledge competencies. We could use that as a starting point in moving forward. But we shouldn't move too quickly toward *how* before we establish the *what*. Our overall goal is to improve the quality of HCEC in this country. One way to do that is to measure the competency of individuals performing HCEC. Another way of improving quality of HCEC is to establish standards. That's another goal of this committee. Veteran's Health Administration (VHA) system is a good representation of the many people doing HCEC out there with little or no advanced ethics training. The tools developed by the VHA to address this lack of training appealed to those at VHA hospitals and various other hospital systems are now using them because they were developed to meet the needs of the intended audience. We don't necessarily have to certify individuals to have them improve their practice. If the bar is set too low, it doesn't accomplish its goal. If the bar is set too high, we exclude too many people. Moreover, establishing a valid method for high level skill assessment is difficult.

One member pointed out that many people are calling themselves HCE consultants, and we shouldn't ignore them. This member favors addressing what's going on in the bulk of hospitals while also setting standards for more advanced practice, and pointed to the CC and *Education Guide* as standards to uphold. Another member pointed out that the CC has been tested by time and should be considered the more accepted standard, whereas the Education Guide, being fairly new, is still being vetted and should not be considered a standard.

Regarding accreditation of programs, one member pointed out that there are many HCEC practitioners in the field, and that program accreditation may, in the long-run, be a more efficient way of establishing more uniform competency among HCEC practitioners. Another member cautioned that training programs may have a conflict of interest in terms of credentialing their own graduates. Yet another member suggested that there may be a perceived conflict of interest among those on the Committee who represent bioethics programs, and that we should recognize that no bioethics graduate program in the U.S. currently trains its students to be competent HCEC practitioners. (He believes there may be clinical

ethics training programs that do, but not bioethics graduate programs.) Another member stated that, as director of a department that hires clinical ethicists, she wants to know that the candidate has what's needed to do the job. She has found that graduates of bioethics programs or those with experience teaching ethics to health care professionals need to be rounded out in other areas (e.g., clinical skills) before being able to practice competently. Another member suggested that if we made headway on certification of individuals, then we could move toward accrediting programs; we should consider the end user, and if we established minimum standards, the training programs would pay attention to make sure their students would be prepared to meet those standards.

We agreed that, although the charge of the Committee was to explore options for certifying individuals and accrediting graduate programs, we would focus on different options for certifying individuals who function as advanced-level HCE consultants, and different options for improving the quality of those functioning at the basic HCE consultant level (see Table below).

One member proposed that a rationale for ASBH certifying individuals performing HCEC could be that this would act as a form of peer review, an endorsement by experts in the field that an individual is competent to perform this activity, somewhat like a letter of recommendation. She pointed out that newly graduated nurses are not competent to practice without further orientation and training, and that evaluation of their competence is ongoing. Subjective evaluation is unavoidable, it can't be totally objective, but it can, and should, be *fair*. We should accept that we have experts that aren't yet certified for HCEC, but could be, and that if we establish a fair process of endorsement of their abilities by colleagues with similar expertise, this would be of value.

One member described how the National Association for Teachers certifies teachers by, in part, videotaping them teaching a class. Another member described the system for social workers that requires an internship. She cautioned against assuming that clinicians (e.g., nurses, physicians) are qualified to do HCEC just because they have clinical experience. Another member pointed out that, pragmatically, we have to consider feasibility based on volume. For example, chaplains and social workers support a system of certification/licensing based on high numbers of those professionals supporting the process and associated costs. We have to consider what is financially feasible. We need to get a good estimate of the volume of who would seek certification. Another member pointed out that no matter what we do, we can't make it mandatory. Who would come? People like those in the room. However, if we started a certification program, although we would have low numbers at first, this might move the Joint Commission or the American Hospital Association to require that hospitals have at least one certified HCE consultant.

One member pointed to Marty's (& Kodish, Ford, Sharp, & Wiese's) presentation at ASBH about their grant to develop a 4-part HCEC certification process comprised of a written exam, consultation experience/case portfolio, interpersonal skills assessment, and oral examination. He wondered whether this process could be used at the graduate bioethics program level to accredit those programs (for those programs educating and training individuals to be competent at HCEC), rather than using them to certify individuals. Another member pointed out that certification and accreditation don't have to all happen at once, that if we identify standards and tools to certify individuals, these could be adopted by graduate programs, and the issue of program accreditation could be something re-examined later. We could consider certification as a "proof of concept" by coming up with a process and using it to evaluate a small number of individuals in the first year. The numbers would go up from year to year and we could evaluate and tweak the process moving forward.

One member pointed out that there seemed to be an assumption that programs educating and training individuals for HCEC are academic programs. He suggested that qualified pastoral care professionals and their CPE model might be instructive, as the focus is on ensuring that chaplains have the requisite skills to function in health care facilities—skills that overlap to some degree with those in the CC. Another member concurred, and described one of the oldest CPE programs at her institution. In the CPE model, individuals with a Master of Divinity go through an extensive process of supervised training, and can choose to function at a "basic" level of pastoral care provider or an "advanced" level of CPE supervisor. Another member pointed out that there is a lot of volume in the CPE model, which might not be the case with HCEC.

We discussed ideas to explore and "next steps" related to individual HCEC certification, and ideas for improving basic core competencies, summarized here:

Certifying Individuals with Advanced CCs	Improving Basic CCs
Measuring knowledge (We agreed that knowledge test alone is insufficient.) Evaluating write-ups of case analyses. Work with psychometricians who develop other licensing board tests (e.g., define measurable knowledge standards in CC and weight each for percentage of questions); there are companies that would help develop a body of questions, float in new questions, it's an ongoing process (Colleen to explore) Measuring skills Present a range of options & costs of each. Minimum time doing HCEC, being mentored, evaluation by mentor, letters of recommendation, self-assessment with improvement plan, observed structured clinical examination (OSCE), observation of HCEC with Standardized Patients; Specific HCEC-related education, a portfolio, (Clinical experience necessary, but must be supervised for HCEC) Must include good communication skills. If minimum # consults required, need to address feasibility given low average # consults performed per hospital (e.g., satellite training hospitals) Certification models Present different models of certification & costs of each CPE (Terry & Nneka will explore); Family Mediation Canada, transformative mediation (Armand will explore); Fellow American College of Health Care Executives (Colleen will explore) HC compliance officer program (Steve to explore) Financial Planners (more knowledge than skill) Ombuds health care mediator certification (Paula will explore) VHA training for advanced certificate for leadership in nursing; someone else certifies you've completed tasks (Ellen will explore) Requirement for keeping current with ongoing continuing professional education – we would have to explore methods of making such education available. Other things to do Ask members who would be interested in getting certified. Find out who else would pursue this. Get more info on specific evaluation methods, particularly skills evaluation, standardized patients (e.g., Devra Cohen-Tigor). Figure out how to make hospitals value HCEC certification (e.g., quality control angle). May need to work with Joint Commission or AHA. Probably need something to show first. "Have to take the first step".	Develop problem-based interviewing guide - identify certain skills that an individual performing HCEC should have and how to ask questions to assess those skills; i.e., 10 - 20 skills, questions for assessing them, & examples of good/bad answers) Develop a Top 10 list of quality problems ("HCEC don'ts") Develop a model process for HCEC retrospective review Provide resources on ASBH website – ongoing communication & education demonstration (e.g., retrospective review moderated by someone w/expertise; wiki where members could submit consults that exemplify excellence in HCEC that could be critiqued …) Develop a basic ethics literacy knowledge test for individuals involved in HCEC akin to the Collaborative Institutional Training Initiative (CITI) modules for human subjects research protection; (wouldn't be called a "certification," so as not to confuse with advanced certification) Train-the-trainer continuing medical education or CEU courses in HCEC (like Education on Palliative and End-of-life-care [EPEC]/End-of-Life Nursing Education Consortium [ELNEC])?

Standards Outside of Certification/Accreditation Process

We agreed that not all standards of HCEC practice are "testable," and other measures such as the Code of Ethics for HCE Consultants would address other competencies and attributes of those providing good quality HCEC. Also, certain procedural standards for an HCEC and standards for the consult service may not be "tested" at the level of individual certification or program accreditation, but are still important measures of quality. We discussed the full scope of practice of a "clinical ethicist" as not being the main focus of this Committee, although some of our work will address efforts toward professionalization of the field, such as the Code of Ethics for HCEC.

The task of this Committee related to the Code of Ethics and CC is to ensure the quality of these products before endorsing for Board approval. Since the Board is not comprised solely of experts in HCEC, it is the role of this Committee to endorse HCEC-related products for Board approval. Bob Baker and Ken Kipnis are working on the Code of Ethics. We agreed that they should present a summary of their work on the Code at the next Committee teleconference.

Another charge of this Committee is to inform the Program Committee related to how to evaluate and select HCEC-related content for the annual meeting pre-conference workshops and conference sessions. We agreed to restore a competitive process to how the pre-conference workshops are selected. (There was a deviation from this at the 2009 meeting based on a direction from the President.) One member pointed out that a competitive process can result in repetition of workshops presented in prior years (e.g., if a pre-con is very popular and gets excellent reviews, it could be selected again the following year if submitted) and this is not necessarily a bad thing. There is some tension here in wanting to present diversity but also ensuring quality, recognizing that pre-conference workshops generate revenue for ASBH, so popular programs with higher attendance are favored for that reason. We agreed that the workshops should be interactive, interdisciplinary, consistent with the CC standards, and—to promote fairness and provide an objective basis for comparison—those submitting proposals should provide a list of previous workshops they have facilitated with evidence of positive attendee evaluations. We agreed that a request for proposals should be announced for two preconference workshops – one that is directed toward an advanced level of HCEC practice, and one toward a basic level. One suggested pre-conference workshop topic might be what to avoid in HCEC. The process for selecting HCEC-relevant general conference sessions should be the same – we should encourage those with HCEC expertise to submit proposals and perhaps consider criteria for choosing among submissions when quality is high among many. Individuals from the Committee or others with HCEC expertise should evaluate pre-con and general session proposals. One member wondered if we could ask for more clinical ethics sessions, or a representative number based on number of total program submissions. Anita will check with the Program Committee chairs about this.

2. Structure of the Committee.

We discussed whether the sub-committee structure of the group needs to be changed, and agreed that instead of a sub-committee for standards and one for accrediting/credentialing, we would have a sub-committee for certifying advanced-level providers of HCEC, and a sub-committee to develop resources to improve competencies of those with basic levels of core competencies.

The following is the new sub-committee structure. Colleen agreed to serve as Committee Co-Chair. Anita will chair the "basic competencies" sub-committee, and Colleen will chair the "certification" for advanced competencies sub-committee. Sub-group membership is as follows:

IMPROVING BASIC COMPETENCIES (Anita)		**CERTIFICATION OF ADVANCED HCEC PRACTICE (Colleen)**	
Autumn Fiester	John Moskop	Armand Antommaria	Christine Mitchell
Joseph Carrese	Terry Rosell	Mark Aulisio	Nneka Mokwunye
Ellen Fox	Millie Solomon	Jeffrey Berger	Kayhan Parsi
Jack Gallagher	Lucia Wocial	Nancy Berlinger	Bob Pearlman
Paula Goodman-Crews		Art Derse	Marty Smith
Tracy Koogler		Colleen Gallagher	Jeffrey Spike
		Steve Latham	

3. **Workload/Timeline**

We agreed to meet monthly as a sub-group, and quarterly with the whole group via teleconference. Sub-committee chairs will schedule sub-group teleconferences. Anita will schedule the quarterly full committee teleconference. One member asked if we have a capacity for live web-based meetings. Anita will check on this.

The meeting was adjourned at 4:53 PM.