ASBH Core Competencies for Healthcare Ethics Consultants, 3rd ed

DRAFT FOR REVIEW

Thank you for reviewing and providing constructive criticism of the attached draft 3rd edition of the ASBH Core Competencies for Healthcare Ethics Consultants.

Note: We are proposing a title change from "Core Competencies for Healthcare Ethics *Consultation*" to "Core Competencies for Healthcare Ethics *Consultants*" because we are proposing adding competencies for healthcare organizational ethics work (Chapter 3), which is not *consultation* per se but is still the work of healthcare ethics consultants. Also, due to formatting issues, we were unable to place citations in the footnotes; therefore, citations that will be included in the footnotes in the final version are currently listed in the text next to the footnote notation (e.g., "typical concerns that arise in healthcare ethics[vii 2-11]", where [vii] is the footnote and [2-11] are the citations in that footnote).

Please provide "big picture" feedback (areas not discussed that should be, areas discussed that should be removed, significant ideas/concepts, etc.). If you wish to provide feedback on specific text (e.g., definitions, processes, tables), please include the chapter and line number along with recommendations for specific verbiage changes. While you are free to include concerns of any type, concerns raised without constructive recommendations for improvement will be less helpful to the writing team and less likely to be incorporated into the 3rd edition.

If there are refences that you would like included in the volume, please provide the complete citation including the PubMed ID number (PMID) for any articles you would like added. If you do not provide the complete citation including PMID, it will be difficult for the writing team to find the reference and decrease the likelihood that the reference will be included. References for books or book sections must include the complete citation including authors, title, year, edition, (editors, book title and section pages for chapters), publisher, city/state (or city/country if not USA) where published (if any of these is missing, the reference will not be added).

Not included in this draft:
Introduction: An introduction will be added at a later time.
Appendix 3: Another appendix will be added detailing the history and process of the first, second, and third editions of the core competencies.

1
Chapter 1. The Nature and Goals of Clinical Ethics Case Consultation

2
3
Defining Clinical Ethics Case Consultation

4 Clinical ethics case consultations are consultations in response to questions from
5 patients,[i] family members,[ii] surrogate decision-makers,[iii] healthcare professionals,[iv]
6 hospital administrators, or other interested parties[v] who seek to resolve uncertainty or
7 conflict regarding value-laden concerns that emerge in the care of a specific patient in
8 real-time.[vi] The ethics consultation service provides clinical ethics case consultations at
9 the healthcare facility generally using either a small team approach or an individual
10 consultant model.
11
12
Goals of Clinical Ethics Case Consultation

13 The general goal of clinical ethics case consultation is to improve the quality of
14 health care through the identification, analysis, and resolution of ethical questions or
15 concerns in a specific, current patient encounter. Key to clinical ethics case
16 consultation is identifying and analyzing the nature of the value uncertainty or conflict
17 that underlies the consultation as well as facilitating resolution of conflicts in a respectful
18 atmosphere with attention to the interests, rights, and responsibilities of all those
19 involved.[1] It involves being attentive and responsive to dimensions of the clinical
20 encounter, such that the care delivered to each patient fits within the standards of the
21 healthcare professions and ethical norms while accounting for the goals, values, rights,
22 and responsibilities of involved parties. Clinical ethics case consultations are focused

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[i] The term “patient” throughout this volume is used broadly to include people receiving healthcare, residents of long-term care facilities, members of health plans, etc.

[ii] The term “family members” throughout this volume is used broadly to include any person with whom the patient has a close personal relationship. Such persons may include blood relatives; relatives through marriage, adoption, etc.; close friends and other loved-ones; and anyone whom the patient considers to be part of their “family,” however they define that term.

[iii] The term “surrogate decision-maker” throughout this volume is used to describe any person who is in the position of making choices on behalf of the patient. This may include someone holding a durable power of attorney for healthcare decisions, a court-appointed guardian, a legally designated agent, or any other person who is tasked with making choices for a patient who lacks the legal authority or cognitive capacity to make decisions for themselves.

[iv] The term “healthcare professional” throughout this volume is used as an umbrella category to refer to all those involved in patient care including clinicians (i.e., physicians, psychologists, and other independent licensed healthcare professionals), nurses, social workers, pharmacists, therapists, chaplains, nurses’ aides, technicians, and others.

[v] Interested parties is defined as patients, family members, surrogate decision-makers, healthcare professionals involved in the specific case, hospital administrators, and any other persons involved in, who have impact on, or who have a vested interest in, the care of the patient.

[vi] Regarding value, we realize that there are values embedded in many different domains (e.g., law, morals, professional practices, various communities, individual conceptions of the good). We use value as a general term to capture the various normative dimensions of issues that emerge in health care. Value uncertainty or conflict often arises because of competing values from these different domains (e.g., judgments about “best treatment” often differ depending on whether medical values or individual patient values are being considered).

on a specific case in real-time; however, such consultations can inform healthcare-institutional ethics support as well.

Typical Concerns that Arise in Healthcare Ethics[vii] [2-11]

- advocacy or social responsibility
- beginning-of-life decision-making
- caring for vulnerable or unrepresented persons
- communication issues or barriers
- conscientious objection
- death and postmortem
- determination of an appropriate decision-maker
- end-of-life decision-making
- general requirements for decision-making capacity
- goals of care
- limiting or withdrawing life-prolonging treatment
- medically provided nutrition and/or hydration
- moral distress
- professionalism
- refusal of life-sustaining interventions
- refusal of recommended treatment or testing
- religious, cultural, or ethnic belief/traditions and their application to healthcare
- research on human subjects and related issues
- resource allocation or stewardship
- resuscitation for cardiac arrest or do not attempt resuscitation orders
- requests for potentially inappropriate treatments or medical futility
- risks and benefits assessment(s)
- substitute or proxy decision-making for adults and minors
- uncooperative behavior

The Ethics Facilitation Model

During the course of a clinical ethics case consultation, there are several important steps that healthcare ethics consultants should take to responsibly support those engaged in ethical decision-making and fulfill the goals of clinical ethics case consultation. These steps are collectively referred to as the ethics facilitation approach of clinical ethics case consultation, which is the standard approach used in practice:

- Identify, clarify, and analyze specific ethical questions, concerns, dilemmas, or conflicts pertinent to the given situation.

[vii] Common ethical issues and concepts were sourced from popular publications that characterize common topics for healthcare ethics consultation (cited). Listed in alphabetical order are those ethical issues and concepts that were included in four or more of these representative documents.

60 61 62 63 64 65 66 67 68 69 70 71 72 73 74

- Gather relevant background information by examining medical records and other documents such as professional practice guidelines and policy statements, codes of ethics, books, and journal articles.
- Facilitate discussion with involved parties to gather and clarify factual information and relevant values, goals, and preferences.
- Introduce and clarify relevant ethical concepts and normative guidance.
- Identify ethically acceptable options and provide an ethically grounded rationale for each option.
- Facilitate mutual understanding of relevant facts, values, and preferences.
- Support ethically appropriate decision-making while respecting differing points of view, values, cultures, religions, and moral commitments of those involved.
- Synthesize the relevant medical and values-based information into an ethical analysis and assessment.
- Make ethical recommendations as appropriate.
- Apply mediation or other conflict resolution techniques as appropriate.

75 76 77 78 79 80 81 82 83 84 85 86

While the ethics facilitation approach recognizes that there are multiple styles of clinical ethics case consultation and is adaptable to a variety of consultation service models and practices, it grounds its validity in its commitment to professional and interpersonal norms. The contributions of healthcare ethics consultants to ethical discourse should be consistent with relevant bioethics, clinical, and scholarly literature including academic, professional, and practice standards (e.g., American Medical Association and American Nursing Association codes of ethics, professional society ethics-related guidelines and policy statements, etc.), as well as pertinent institutional policies. In faith-based healthcare settings, healthcare ethics consultants' work should also be consistent with relevant doctrine (e.g., the Ethical and Religious Directives for Catholic Healthcare Services).

87 88 89 90 91 92 93 94 95 96 97 98 99

Interpersonally, the clinical ethics case consultation process should be respectful and inclusive of all involved parties and their personal values and moral commitments with attention to fairness and an openness to the varied understandings and interpretations of each clinical encounter by different people. In doing so, the knowledge, skills, and facilitative strategies of the consultants employing the ethics facilitation approach improves the likelihood of building an ethically supportable plan of care with which all parties can agree. By encouraging and modeling open, inquisitive communication, the ethics facilitation approach helps involved parties identify and elucidate their values and moral commitments, including previously unarticulated values, so that they can be discussed openly and respectfully to generate creative and well-considered decisions. In addition, the healthcare ethics consultants' knowledge of ethical theory may help to name and frame the values underlying the different perspectives of those involved. Such naming and framing can often lead to a deeper

understanding of, and respect for, those perspectives and values, which can facilitate the development of an ethically justifiable plan of care.[viii] [12]

Sharing Expertise

Healthcare ethics consultants are sometimes called to answer factual questions ("What is our hospital's policy on X as it applies to this patient?") or for help obtaining ethics-related information ("What do professional organization guidelines say about Y?"). For example, a healthcare ethics consultant might be asked to help clarify who has decision-making authority when a patient lacks decision-making capacity. The answer might entail clarifying the role of a surrogate decision-maker and the substituted judgment and best interest standards, reviewing the state's legal hierarchy for decision-making proxies[ix] and applicable institutional policy, and identifying the locus of decision-making authority and responsibility. Alternatively, a healthcare ethics consultant may be asked to share his or her ethics knowledge and expertise as it relates to a broad ethics topic, such as terminal palliative sedation. These situations represent the use of the healthcare ethics consultant as a resource, expert, and educator, and are entirely consistent with an ethics facilitation approach for clinical ethics case consultations.

Making Recommendations

The ethics facilitation approach does not preclude making recommendations in a clinical ethics case consultation. On the contrary, specific recommendations are often very helpful, appropriate, and desired by the requestor of the consult. Most commonly, healthcare ethics consultants might give recommendations regarding the process of decision-making, such as "attempt to contact the patient's daughter," "conduct a clinical assessment of decision-making capacity," or "convene another family meeting in one week's time." In other cases, a proposed course of action may be unethical and the consultants should recommend against it. Finally, in some relatively simple cases only one of the proposed courses of action is ethically justifiable. When this is the case, healthcare ethics consultants should explain why alternative actions are not ethically justifiable.

However, healthcare ethics consultants should be careful about recommending a single course of action if more than one course of action appears to be ethically acceptable. Healthcare ethics consultants should remember that within the ethics facilitation approach, the "best" substantive decision is ultimately one that aligns with the

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[viii] This is consistent with Dubler and Liebman's concept of "Principled Resolution," a consensus that identifies "a plan that falls within clearly accepted ethical principles, legal stipulations, and moral rules defined by ethical discourse, legislatures, and courts and that facilitates a clear plan for future intervention." *See* Dubler and Liebman 2004, p.11

[ix] The healthcare ethics consultant should not give legal advice. If legal advice is requested or appropriate, the healthcare ethics consultant should refer such questions to legal counsel or risk management to decrease the risk of role confusion.

values, goals, and preferences of the patient as well as the best medical judgment of the treating clinicians within the constraints of the legal and institutional context. As such, an “ideal” ethical outcome might not be achievable, and the healthcare ethics consultants’ role is to facilitate discussion about these components and encourage involved parties to think more clearly about the ethical implications of their actions to discern an ethically supportable plan. For cases in which several options are consistent with prevailing ethical and legal norms, healthcare ethics consultants need to be aware of their own personal moral values and biases while remaining cognizant that they should not impose their own values, beliefs, and preferences on others. By modeling self-reflectiveness and humility, healthcare ethics consultants are less likely to unduly influence the outcome of the discussion and more likely to ensure that a fair, inclusive, and transparent discussion occurs that empowers and respects all involved parties.

Guiding Discussion Among Ethically Acceptable Options

Some cases will have a number of options that are all ethically justifiable and consistent with prevailing ethical and legal standards. This raises the question of what role healthcare ethics consultants may play in guiding discussion among these options, especially when they personally view one option as preferable to another. Suppose, for example, that a terminally ill patient with decision-making capacity clearly expresses the wish to have life-sustaining treatment withdrawn. The patient’s family is not willing to “give up” and pressures the patient to continue the treatment. The patient agrees to wait for a time before having treatment withdrawn based on the family’s concerns despite her own wishes.

It would appear that there are at least two ethically acceptable options in the case. The patient is the ethically appropriate decision-maker, and the healthcare ethics consultants may wish to discuss with the family the importance of having the patient’s values respected. The consultants may guide discussion here in a way that enhances the decision-making authority of the patient, which is informed by community values and law (and presumably by institutional policy as well) and confirmed in the bioethics literature. However, the consultants should refrain from unduly influencing the patient’s decision. There is a fine line between educating (which may involve some degree of persuasion) and exerting undue influence. Healthcare ethics consultants need to be sensitive to their personal moral values and should take care not to impose their own values on other parties. This requires that healthcare ethics consultants be able to identify and articulate their own views and develop self-awareness regarding how their views affect consultation. A clear facilitation processes can also help reduce the risk that healthcare ethics consultants will unduly influence the outcome of the discussion by ensuring that a fair, inclusive, and transparent discussion takes place that empowers the voices of all involved parties. For example, healthcare ethics consultants might use a structured agenda for formal meetings that includes opportunities for each party to

174 articulate their concerns and values. Summarizing the views of each party can also help
175 provide balance in a consultation.
176
177 **Negotiating Entrenched Conflict**
178 When asked to address an entrenched or intractable conflict, it is appropriate for
179 healthcare ethics consultants to utilize ethics facilitation to help interested parties reach
180 a mutually acceptable or integrity-preserving outcome. For example, conflict can
181 sometimes be managed by clarifying and better communicating the clinical facts to
182 ensure mutual understanding; bringing in content experts to elucidate and respectfully
183 engage cultural, social, or religious values; or convening the parties to brainstorm
184 creative solutions. Even when agreement cannot be reached and a solution cannot be
185 successfully negotiated, the ethics facilitation model can identify underlying values and
186 sources of disagreement through an inclusive and mutually respectful process, such
187 that all parties have an opportunity to express their values and moral commitments to
188 each other to reach shared understanding of the rationale behind the decision made.
189 Unfortunately, in some cases agreement cannot be reached. When agreement
190 cannot be reached, the proper course of action can sometimes be determined by
191 answering the question: "Who is the ethically appropriate decision-maker?" Societal
192 values often indicate who should be allowed to make the decision in the absence of
193 agreement. A well-informed patient with decision-making capacity may accept or refuse
194 any recommended treatment.[x] Such a patient has decision-making authority even if
195 some family members or healthcare professionals disagree with the decision. When the
196 patient lacks decision-making capacity, a legally authorized surrogate decision-maker is
197 generally allowed to make decisions on the patient's behalf. Healthcare professionals
198 are generally granted the authority to make decisions about certain matters, such as
199 which treatments are medically indicated and should be offered to patients, and how
200 medical procedures are performed. For some types of decisions, such as what types of
201 treatments will or will not be provided by the healthcare organization, a person of
202 authority who bears institutional responsibility for the care of patients (e.g., an
203 administrator) may be the appropriate decision-maker.
204 Not all cases, however, allow for the straightforward identification of an ethically
205 appropriate decision-maker. In cases in which the appropriate decision-maker is not
206 clear, the involved parties should have recourse to an established and fair mechanism
207 to resolve the dispute. This may include institutional procedures for dispute resolution.
208 As a last resort, involved parties may turn to the courts for adjudication.
209

[x] It is well established that although patients with decision-making capacity have a right to accept or refuse any recommended treatment, patients and surrogate decision-makers do not have the authority to demand interventions that are not deemed medically indicated or appropriate.

210 **Ethics Consultation Service Relationship to Other Services in a Healthcare**
211 **Organization**
212 The ethics consultation service is the service that provides clinical ethics case
213 consultations for the healthcare institution. As described above, clinical ethics case
214 consultation is a distinctive service that includes (at minimum) the following general
215 components: 1) It responds to a specific request for assistance with an active, current
216 patient case; 2) It focuses on addressing uncertainty or conflict regarding value-laden
217 concerns in a healthcare context; 3) It addresses value-laden concerns through an
218 ethics facilitation approach; and 4) It is conducted by those who have the requisite
219 competencies to perform clinical ethics case consultations appropriately.
220 Other professionals within a healthcare organization may provide services that
221 overlap with the responsibilities of healthcare ethics consultants. For example, social
222 workers may convene family care conferences to address questions or gaps in the
223 patient’s treatment plan, or chaplains might address family conflict stemming from
224 uncertainty regarding their religious obligations in specific circumstances. Certainly, the
225 specific knowledge, skills, and attributes required by competent healthcare ethics
226 consultants (detailed in Chapters 2 and 3) overlap with many of those in other
227 professions (e.g., palliative care specialists, mediation professionals, counselors).
228 Healthcare ethics consultants often have other roles in the organization such as
229 physician, nurse, social worker, or chaplain.[13] In such cases, that person would need to
230 meet the competencies required by both roles and be able to clearly distinguish (for self
231 and others) when he or she is performing each role.
232 In addition, there are many individuals, departments, committees, and services
233 that share with the healthcare ethics consultants responsibility for maintaining a sound
234 ethical climate in a healthcare organization such as patient services, risk management,
235 compliance, human resources, chaplaincy, and quality assurance, and others. The well-
236 functioning healthcare ethics service should be aware of the resources available in the
237 institution that may be relevant to requests that come to the service and establish
238 collaborative relations with them.
239
240 **Boundaries of Clinical Ethics Case Consultation**
241 The role of clinical ethics case consultation is to address uncertainty or conflict
242 regarding value-laden concerns that emerge in a specific, real-time patient case. In
243 general, if a requester thinks that a circumstance raises an ethical concern, the
244 assumption should be that it does. Requesters may sometimes contact the ethics
245 consultation service seeking assistance primarily with concerns that are better handled
246 by other established mechanisms within the organization, e.g. general complaints,
247 allegations of misconduct, requests for medical opinions or patient assessment, legal
248 advice, spiritual support, etc.[14] Requests that fall outside the scope of the ethics
249 consultation service should be referred to other institutional resources as appropriate.

250 There are three primary reasons for this. First, healthcare ethics consultants may not
251 have the requisite expertise to address these concerns. Second, healthcare ethics
252 consultation resources tend to be scarce and should be reserved for their intended
253 purpose. Third, the primary role of the healthcare ethics consultants should be protected
254 to avoid role confusion and to foster trust between the healthcare ethics consultant and
255 healthcare staff.
256 In rare circumstances, healthcare ethics consultants may be faced with parties
257 who are opting for a course of action that is clearly outside the parameters of what
258 would be ethically acceptable. Although the ethics consultation service should never
259 function as "the ethics police," the consultants should notify the involved parties that,
260 like others, they may be obligated to report egregious violations[xi] to supervisors or
261 oversight bodies. Healthcare ethics consultants should not investigate complaints or
262 allegations of misconduct, and should advise those who request clinical ethics case
263 consultation for these purposes to take their concerns to more appropriate institutional
264 resources, (e.g., hospital administration, compliance, patient affairs, equal employment
265 office, conflict of interest committee, institutional review board, human resources, legal
266 counsel). Additionally, if systemic factors within an institution are identified as
267 contributing to the conflict or concern that prompted the request for a clinical ethics case
268 consultation, the healthcare ethics consultants should work with administration to
269 improve such factors (through policy development or modification, providing education
270 for staff, developing an improved culture of safety, etc.).
271
272 **Process Standards for Clinical Ethics Case Consultation**
273 Standard operating procedures have become commonplace in healthcare. It is
274 now well-accepted that following standard protocols decreases variability and improves
275 outcomes in many aspects of healthcare. The use of standards, or standardization,
276 may have a negative connotation to some people; however, for any healthcare service,
277 a certain degree of standardization is essential to ensuring quality. Process standards
278 are especially important for services like clinical ethics case consultation, where quality
279 cannot be determined merely by assessing the final outcome or product.
280 Certain process standards are necessary for high-quality clinical ethics case
281 consultations; however, different types of healthcare ethics consultations require
282 different standards. Various taxonomies have been used to distinguish between types
283 of healthcare ethics consultations. Examples include "proactive" and "reactive," "formal"
284 and "informal," "preconsultation" and "consultation," "ethics advisement" and
285 "retrospective case review,"[15] and an organizational-clinical hybrid.[16] For the purpose of

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[xi] "Egregious violations" here refer to obvious violations of law, hospital policy, professional codes of ethics, or an organizational code of conduct or ethical norm (e.g., refusing to report a serious medical error, thus causing lack of needed follow-up care to the patient). Of note, institutions vary regarding where the line should be drawn for such reportable violations.

286 establishing process standards, the following two general categories of healthcare
287 ethics consultants work are used: (1) clinical ethics case consultations, and (2)
288 healthcare organizational ethics.[17] The standards outlined in this section are especially
289 relevant to clinical ethics case consultations.

290 For example, questions about whether it would be ethically appropriate to
291 deactivate an implanted pacemaker would be appropriate questions to pose to
292 healthcare ethics consultants regardless of whether the questions were about a specific
293 patient or the practice in general. To answer either type of question and develop a
294 response would require an understanding of the ethical concerns of the requesters, an
295 understanding of pacemakers, and critical thinking about the relevant ethics knowledge.
296 However, the consultation processes followed, and the form of the response, would
297 differ depending on whether the question was about deactivating a specific patient's
298 pacemaker (i.e., a clinical ethics case consultation) or the general practice of
299 deactivating pacemakers and potential implications for organizational practice and
300 policy (i.e., healthcare organizational ethics).

301 In most instances, a clinical ethics case consultation would require direct
302 communication with the patient or surrogate decision-maker and involved healthcare
303 professionals about the patient's specific clinical circumstances, values, and goals of
304 care, and documenting the outcome of the healthcare ethics case consultation in the
305 patient's medical record.[xii] In contrast, a question about the general practice of
306 deactivating pacemakers would involve discussions with involved parties, review of
307 pertinent medical and bioethics literature, discussion with key members of
308 administration, and consideration of development or modification of facility policy.
309 Some generally agreed-upon standards for ethics consultation services are described
310 below.[9,17]

311 1. Ensure patients, family members, surrogate decision-makers, and healthcare
312 professionals involved in the case all have access to request a consultation.
313 2. Establish a comprehensive ethics consultation service policy.
314 3. Create a thorough, systematic process for conducting clinical ethics case
315 consultations.

[xii] In rare cases, it may be appropriate to not inform the patient, family, or surrogate decision-maker of the clinical ethics case consultation; however, such cases are extremely rare and should be limited to only such cases in which disclosing the clinical ethics case consultation would negate the consultation. For example, if a care team requests a clinical ethics case consultation regarding a specific patient to ascertain whether it would be ethically permissible to not inform the patient of a specific treatment option, then it would be appropriate to not inform the patient of the consultation request because doing so would necessarily inform the patient of the treatment option in question and would therefore negate the ethical question raised since the patient would be thereby informed of this option. Such cases are extremely rare and should be considered a deviation from standard practice. As such, any clinical ethics case consultations in which the patient, family, or surrogate decision-maker was not informed of the consultation and/or included in the consultation process should be reviewed and scrutinized to ensure the standard of care for clinical ethics case consultation was met.

4. Develop standards for formal meetings conducted in the course of clinical ethics case consultations.
5. Provide notification of a clinical ethics case consultation to relevant parties.
6. Develop appropriate documentation.
7. Establish and maintain quality assessment and improvement processes.

Whether these standards are adequately addressed will help determine if an ethics consultation service can function effectively in particular healthcare institutions.

Ensure Access

Patients, family members, surrogate decision-makers, clinicians, clinical staff, and other involved parties should have open access to clinical ethics case consultation services. A general policy of open access is an important way of ensuring that the rights and values of all involved parties are respected. Requests for clinical ethics case consultation by patients, family members, surrogate decision-makers, or involved healthcare professionals should be accepted as a matter of policy. Importantly, the ethics consultation policy should articulate that such requests cannot be "vetoed" by others in positions of authority (e.g., an attending physician may not veto the clinical ethics case consultation request). The service should be available not only in acute care hospitals but in any healthcare institution. Exceptions to a general policy of open access, if any, should be carefully considered and clearly delineated in the institution's ethics consultation service policy. For example, an uninvolved hospital visitor should not be able to request a clinical ethics case consultation based on concerns he or she developed from something he or she inadvertently overheard.

Ethics consultation services should take steps to ensure that patients, families, and staff are aware of the ethics consultation service, what it does, and how to access it. The service should be publicized (e.g., through brochures, posters, newsletters, websites, and other media through which patients and staff regularly receive information about the facility). Increasing the presence and visibility of healthcare ethics consultants throughout the healthcare institution (by participating on morning rounds on various hospital units, participating on leadership committees, giving presentations at new employee orientation, presenting ethics grand rounds, etc.) can increase awareness of the ethics consultation service.[18] If ethics consultation services are presented as a valued resource that responsible healthcare professionals access to improve patient care, rather than a measure of last resort when the healthcare team "fails" to solve their own problems, it is more likely to be accessed by healthcare staff when needed.

Like most other healthcare services, the ethics consultation service should be available throughout normal working hours. This means that whenever someone attempts to contact the service, a healthcare ethics consultant will respond in a timely fashion (e.g., within one business day for routine requests and as soon as possible on

356 the same day for urgent requests). After-hours coverage arrangements may vary. In
357 facilities where the volume of consultation requests is high and resources sufficient, a
358 healthcare ethics consultant should be available at all times (weekends, nights,
359 holidays, etc.). In other facilities or settings where there are fewer ethics consultation
360 request, calls may be triaged by an administrator who has access to a competent
361 healthcare ethics consultant as needed;[17] however, an administrator who lacks the
362 requisite competencies should not attempt to provide ethics-related recommendations
363 or advice. Facilities that lack sufficient internal expertise to provide competent
364 healthcare ethics consultation should ensure that those tasked with providing healthcare
365 ethics consultation have access to an educated, trained, experienced, certified
366 healthcare ethics consultant to provide the necessary support to ensure all healthcare
367 ethics consultations meet minimum quality standards.
368
369 **Comprehensive policy**
370 One element of a sound consultation process is a clear policy for the ethics
371 consultation service. The following are suggested content areas that may be addressed
372 in an institution's ethics consultation service policy:
373 1. Structure and organization of the ethics consultation service: This may include:
374 a. Organizational structure of the ethics consultation service (leadership,
375 reporting requirements, etc.) including the relationship of the ethics
376 consultation service and the institution's ethics committee.
377 b. Roles and responsibilities of the ethics consultation service leaders and
378 members
379 c. Competencies required for healthcare ethics consultants and how those
380 competencies will be evaluated (see Chapters 2 and 3)
381 d. Model for clinical ethics case consultations
382 i. For a small teams model: Who comprises the small teams and how
383 does the service ensure each team meets all competencies (see
384 Chapter 2)
385 ii. For an individual consultant model: Who functions as an individual
386 consultant
387 iii. Which consultations will use a small teams model versus an
388 individual consultant model if both are available at the institution
389 iv. Under what circumstances should the institutional ethics committee
390 function as an adjudication body[xiii] [19-21]
391 e. Who may request a clinical ethics case consultation
392 f. How the ethics consultation service is contacted

[xiii] In general, the institutional ethics committee as a whole can be used as an adjudication body in cases of making decisions for unrepresented, incapacitated patients and in cases when a patient or surrogate decision-maker requests interventions that the care team believes are potentially inappropriate. Using the full institutional ethics committee for clinical ethics case consultations is no longer a supported model.

   g. Response time (for both urgent and non-urgent consultation requests)
2. Scope and purview of the ethics consultation service including what requests are appropriate and inappropriate for the ethics consultation service.
3. Process for clinical ethics case consultation, including:
   a. What approach or approaches are used and required or recommended steps in the clinical ethics case consultation process.
   b. How anonymous requests are handled (i.e., when the requester does not disclose his or her identity to the healthcare ethics consultant).
   c. How requests for confidentiality are handled (i.e., when the requester is known but does not want others to know he or she requested a clinical ethics case consultation).[xiv]
4. Documentation of the clinical ethics case consultation including who is responsible for documenting in the patient's healthcare record and what information will be documented. If the ethics consultation service maintains internal records of clinical ethics case consultations, who is responsible for documenting the consultation in the internal records, what information is maintained in the internal files, and how are those files used.[xv]
5. How healthcare ethics consultants provide healthcare organizational ethics support including how the healthcare ethics consultants are integrated into the broader healthcare organization structure.
6. Quality assessment and improvement (see Chapter 5)

Thorough and Systematic Process

To competently perform a clinical ethics case consultation, a thorough and systematic process is essential. A sound consultation process should include explicit stages: the initial contact of information gathering, processing, and analysis; description

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[xiv] Some organizations allow clinical ethics case consultation requests in which the requester does not disclose his or her identity, whether for fear of retaliation or other negative repercussions (i.e., "anonymous" consultation requests). Other organizations find anonymous requests problematic for several reasons; without an identified requester, the consultant has no one to respond to, and might be perceived as "meddling" or "the ethics police." In addition, anonymous requests typically amount to allegations of misconduct or requests for investigation that should be referred to the appropriate resources. However, individuals should always be able to talk with a healthcare ethics consultant confidentially, as long as they understand the limitations on what the healthcare ethics consultant can do if the requester insists that he or she not be identified to others as requesting an ethics consultation.

[xv] Some may be concerned that documentation of a clinical ethics case consultation in the medical record or in the ethics consultation service's internal records may increase the organization's legal liability risk. Because clinical ethics case consultations influence decisions on an active patient case, they are generally not considered part of the quality improvement process and are not protected from discovery. However, precisely because clinical ethics case consultations impact patient care, the standard practice in clinical ethics case consultation is to document the consultation in the patient's medical record. Failure to document consultations that impact patient care is below the standard of care in healthcare ethics consultation. If the ethics consultation service maintains internal files, all such files must be HIPAA compliant.

419 of the next stage of consultation; and retrospective review.[xvi] [17,22-24] After receiving a
420 request for a clinical ethics case consultation, the consultation team (or individual
421 consultant) should clarify the request and explain the process that will be followed.
422 Generally, this requires considering the preliminary information received at the time of
423 the request, confirming that the request is appropriate for clinical ethics case
424 consultation, setting reasonable expectations with the requester about what the
425 healthcare ethics consultants will and will not do, and developing an initial formulation of
426 the ethics question(s) that will be addressed. The ethics consultation service should
427 have clearly identified methods for these steps (triaging consultation requests,
428 assembling and facilitating a meeting of involved parties, etc.). Methods for protecting
429 the confidentiality of patients and family members involved in the consultation should be
430 clearly established (e.g., starting a meeting with a confidentiality reminder, maintaining
431 HIPAA compliance).
432 Of note, some ethics questions relating to an active patient case may seem
433 straightforward and too simple to warrant a formal clinical ethics case consultation.
434 However, even these questions should be addressed systematically and
435 comprehensively because clinical ethics case consultations are often more complex
436 than initially presented or perceived. For example: the information presented by the
437 requester may not be complete or accurate and may change once additional information
438 is collected, other parties involved may have morally relevant perspectives that are not
439 communicated by the requester but ought to be considered. Therefore, when healthcare
440 ethics consultants are asked to comment informally on an ethics question pertaining to
441 an active patient case (a "curbside" consultation request), in general, they should
442 decline such requests. When it seems necessary to respond to such "curbside"
443 consultation requests, healthcare ethics consultants should clarify that they can only
444 respond in general terms, and that their response is conditioned on the information as
445 presented. They should not give recommendations for a specific patient without
446 completing a formal clinical ethics case consultation process and should encourage a
447 clinical ethics case consultation request be placed. [17]
448
449 **Standard Procedure for Formal Meetings**
450 Part of a sound process for any clinical ethics case consultation includes
451 developing standard procedures for when and how to conduct formal meetings with
452 multiple involved parties with differing positions. Formal meetings can be especially
453 useful when the patient, surrogate decision-maker, or other parties are not confident
454 that their interests or views have been accurately represented or fully taken into
455 account; when the parties are having trouble understanding one another's point of view;

[xvi] Some ethics consultation services use a specific approach to ethical analysis in case consultations, such as Jonsen, Siegler, and Winslade's 4 box approach; Fletcher and Spencer's 4-step approach; Orr and Shelton's Process and Format; and the VA's CASES approach. (All cited in the text)

or when there are many different parties involved. [17,25] Formal meetings can be an efficient way to address conflict, build trust and empathy between members of the moral community of caregivers through face-to-face interaction, and generate agreement on appropriate options, goals, and plans.

In general, healthcare ethics consultants should meet with the patient or surrogate decision-maker; however, a formal meeting is not always necessary and, in some situations, may not be appropriate.[17] Formal meetings can be logistically difficult and time-consuming to arrange, which can delay the consultation process. In addition, such meetings utilize a large number of person-hours, making them inefficient in some situations compared to other alternatives. Another problem with formal meetings is that some people are uncomfortable speaking in front of a group; this is especially a problem for patients and family members who may be intimidated by the presence of multiple representatives from the facility. If consultants rely on formal meetings as their primary means of gathering information, key pieces of information may not be available during the meeting, and there is little opportunity to verify that the information presented is accurate. In addition, not all healthcare ethics consultants are experts in every ethics knowledge or skill area. Healthcare ethics consultants who enter a formal meeting “cold” or who fail to gather sufficient information in advance may find they are poorly prepared to discuss the relevant ethics knowledge in depth. [17] For these reasons, consultants should assemble relevant information before determining whether to convene a formal meeting with individuals outside the ethics consultation service.

If a formal meeting is needed, it may be arranged by the healthcare ethics consultants or by a member of the healthcare team. If possible, the healthcare ethics consultants should communicate with each key participant before the meeting. A prior private discussion can help the patient or surrogate decision-maker feel safer and more comfortable talking openly during the meeting. The healthcare ethics consultants’ premeeting preparation should include reviewing the ethical question, relevant information, and ethics knowledge; setting clear goals for the meeting; and anticipating biases and areas of potential conflict in advance.

After the group is assembled, following a consistent meeting protocol can help ensure that all relevant perspectives are voiced. Failing to recognize the power dynamics in a clinical ethics case consultation can make the situation worse by undermining the consultation process and eroding trust. [26] It should be clear who is leading the meeting. A healthcare ethics consultant should begin with introductions, explain the goals of clinical ethics case consultation and the role of the healthcare ethics consultants, and establish clear expectations and ground rules for the meeting (e.g., asking participants to respectfully allow one another to talk without interruption despite whatever strong feelings they may have).

Being able to recognize power imbalances and address them effectively, ensuring everyone has a chance to be heard, is an important skill (and included as a

496 core competency in Chapter 2). In any formal meeting, healthcare ethics consultants
497 should take steps to "level the playing field" (to the degree possible) to minimize
498 disparities of power, knowledge, skill, and experience that separate the clinician(s), staff
499 members, patient, and family members. This will help ensure that all parties involved,
500 especially those who hold less power, have an equal opportunity to express their views.
501 Healthcare ethics consultants should also help parties communicate effectively (e.g., by
502 helping to ensure that medical information is communicated clearly so that everyone
503 involved has a good understanding of the clinical situation and by acknowledging and
504 defusing strong emotions among involved parties). Making decisions under conditions
505 of uncertainty is difficult, and it is important that probabilities be expressed as clearly as
506 possible to avoid bias and misinterpretation.[27] The consultant should also help the
507 parties clarify and express their values and goals as these apply to the question at
508 hand. For example, focusing on the values fueling disagreements about a do-not-
509 attempt-resuscitation (DNAR) order for a patient (e.g., beneficence, respecting the
510 patient's wishes, loyalty) is more likely to lead to conflict resolution than focusing on the
511 DNAR order alone.

512 If conflict is a feature of a clinical ethics case consultation, in addition to
513 addressing power imbalances as described above, the following components of ethics
514 mediation may prove critical to coming to an ethically supportable resolution: [12]

515 - Identify the parties involved in the conflict, recognizing that most conflicts have
516 more than two sides.
517 - Understand the interests of the participants (both stated and latent).
518 - Help the parties define their interests.
519 - Help maximize options for a resolution of the conflict.
520 - Search for common ground or areas of consensus.
521 - Ensure that the consensus can be ethically justified.

522

523 When a healthcare ethics consultant who is also a healthcare professional (e.g.,
524 physician, nurse, social worker, chaplain) is playing the role of healthcare ethics
525 consultant in a formal meeting, he or she should introduce himself or herself as a
526 healthcare ethics consultant and explain that in that role he or she is not acting as
527 primary decision-maker, care provider, or clinical consultant. Even when the clinical or
528 professional expertise of the healthcare ethics consultant is relevant to the case, the
529 healthcare ethics consultant should refrain from providing clinical advice, but rather,
530 defer those decisions to the clinicians and professionals charged with caring for the
531 patient. Similarly, when a clinical ethics case consultation is requested for a patient
532 whom the consultant is caring for in his or her "other" professional capacity (e.g.,
533 chaplain), then he or she should enlist the involvement of another healthcare ethics
534 consultant and clearly explain to colleagues that he or she is there solely as a member
535 of the patient's care team (e.g., in this case, the patient's chaplain).

536
537
Notification

538 Patients or their surrogate decision-maker(s) should be notified if a clinical ethics
539 case consultation is being conducted. Notification includes giving the reason for the
540 consultation, describing the process of clinical ethics case consultation, and inviting the
541 patient or surrogate decision-maker to participate. There may be reasonable
542 exceptions to this standard of patient/surrogate decision-maker notification, such as
543 when there is a conflict between healthcare professionals only (e.g., staff disagree
544 about whether to inform a patient about his or her prognosis based on cultural beliefs,
545 or members of the healthcare team are experiencing moral distress over the plan for a
546 particular patient). The reasonable exceptions should be addressed in the formal
547 process or policy of the ethics consultation service. Further, any clinical ethics case
548 consultations in which the patient or surrogate decision-maker is not informed and
549 involved should be formally reviewed by the appropriate body (e.g., the full ethics
550 consultation service, the ethics consultation service leadership, the hospital ethics
551 committee), either in real time or retrospectively, to ensure that not informing the
552 patient or surrogate decision-maker is/was appropriate.
553 The attending physician should also be notified of a clinical ethics case
554 consultation involving one of his or her patients because the attending physician is
555 ultimately responsible for the care of the patient. Anyone (patient, surrogate decision-
556 maker, family member, or healthcare professional) can refuse to participate in a clinical
557 ethics case consultation, but a refusal is often a sign of a serious breakdown in
558 communication and trust. Although the attending physician should be notified of the
559 clinical ethics case consultation and may choose whether or not to participate, he or she
560 cannot stop the consultation from proceeding in response to another party's concerns
561 (which should be made clear in the ethics consultation service policy). Whether a
562 clinical ethics case consultation may go forward when the patient refuses to participate
563 is more controversial. In some cases, healthcare ethics consultants may be able to help
564 healthcare professionals think through the ethical dimensions of the case even when
565 patients or others refuse to participate.
566
567
Documentation

568 Documenting the clinical ethics case consultation is an important aspect of the
569 consultation process. Clinical ethics case consultations should generally be
570 documented in the patient's medical record to ensure healthcare professionals, patients,
571 and surrogate decision-makers have appropriate access. Further, some ethics
572 consultation services also maintain HIPAA-compliant internal records. Such services
573 may document clinical ethics case consultations in their HIPAA-compliant internal
574 records. Such internal records may be useful for improving performance, informing
575 future consultations, legal purposes, and tracking workloads. Some ethics consultation

576 services maintain detailed internal records including all clinical ethics case consultation
577 notes entered into patients' medical records, as well as additional information that does
578 not necessarily belong in the medical record, such as communications among
579 consultants, consultants' observations about the consultation process, logistical details,
580 and notes and references relating to the sources of ethics knowledge. [17,28] Clearly,
581 maintaining required patient confidentiality in such records may be challenging, and
582 many ethics consultations services do not maintain records separate from the medical
583 records of patients other than tracking patient identifiers, which may be done in the
584 electronic medical record system in a HIPAA-compliant manner.

585 All clinical ethics case consultations should be documented in the patient's
586 medical record, except in very rare circumstances. Not placing a note in the chart may
587 be reasonable if the patient or family were not informed of and involved in the clinical
588 ethics case consultation. For example, if the healthcare team asks the ethics
589 consultation service whether not informing the patient of one potential treatment option
590 is ethically justifiable, it would be reasonable to not place a note in the patient's chart
591 because the patient is legally entitled to access their medical record and placing a note
592 in the chart would negate the ethics consultation request because the patient would
593 learn of the not-offered treatment option. Such cases, however, are extremely rare.
594 Good documentation in the medical record, using non-judgmental language (e.g., not
595 describing the family as "difficult"), not only communicates relevant information to
596 involved parties, but it also promotes accountability and transparency for legal
597 purposes.[xvii] Standard forms or standardized electronic data entry are useful for
598 ensuring that all important components of clinical ethics case consultations are
599 consistently and thoroughly summarized in the patient's medical record. Institutions may
600 develop a standardized clinical ethics case consultation note template.

601 The following elements should be explored by healthcare ethics consultants,
602 documented in the patient's medical record, and, if appropriate, documented in the
603 ethics consultation service's internal records:

604 • information about the person requesting the consultation, including name and
605 role in the case[xviii] [30]
606 • date and time of the request

[xvii] Note: The healthcare ethics consultant should not offer legal analysis or opinion. That is not the objective, goal, or the appropriate stance of the ethics consultation note. When a healthcare ethics consultant has expertise in both ethical analysis and the law, legal analysis or opinion should be written in a separate note, which can be cited in the ethics consultation note. The role of the consultant (i.e., hospital counsel versus healthcare ethics consultant) should be clearly defined, with attention paid to conflicting obligations). *See* Dubler 2009. 29. Dubler NN, Webber MP, Swiderski DM, Faculty, the National Working Group for the Clinical Ethics Credentialing P. Charting the future. Credentialing, privileging, quality, and evaluation in clinical ethics consultation. Hastings Cent Rep 2009;39:23-33.

[xviii] Unless "anonymous" requests are allowed. *See* Bruce 2014.

- requester's description of the circumstances, including his or her ethical concern(s) and steps they have already taken to resolve them
- identifying information about the patient (name, medical record number, location, clinical service, etc.)
- patient's attending physician
- name(s) of healthcare ethics consultant(s) working on the case
- clear statement of the ethics question
- sources and summary of the relevant information, including
    - medical facts
    - patient's values, preferences, and interests, including relevant contextual factors (e.g., culture, religion/spirituality, social support, financial concerns, quality of life considerations)
    - other parties' values, preferences, and interests
    - information about patient's decision-making capacity
    - information about patient's advance directive or POLST, if applicable
    - information about authorized surrogate, if applicable
- ethics knowledge, including relevant policy statements and guidelines from healthcare professional organizations, codes of ethics, hospital policies, published literature, precedent cases, appropriate doctrinal directives if practicing in a faith-based healthcare setting, etc.
- description of any formal meetings held
- summary of the ethical analysis, including ethical issues/concerns/considerations and ethical reasoning, and ethical principles or theories in appropriately accessible language
- identification of the ethically appropriate decision-maker(s)
- options considered and whether they were deemed ethically justifiable
- explanation of whether agreement was reached
- recommendations and action plan(s)[xix] [17]

Quality Assessment and Improvement

Ethics consultation services, as any other healthcare service, must be subject to an evaluation process that is continuous, comprehensive, transparent, and accountable to the institution (see Chapter 5). Ethics consultation services should have a mechanism for consultation review and evaluation to promote accountability. [31-33] This process will also promote one of the goals of healthcare ethics consultation outlined above: to inform

[xix] *See* Fox 2006. Which of these elements are considered essential to a clinical ethics case consultation note may differ among healthcare organizations. Some ethics consultation services may document certain elements listed above in their internal ethics consultation service records rather than in the patient's health record. Each ethics consultation service should identify minimum documentation requirements to communicate relevant information to other healthcare professionals and to track ethics consultation service information for quality-improvement purposes.

642 institutional efforts aimed at policy development, quality improvement, and appropriate
643 utilization of resources.[xx] [1,17,34] The ethics consultation service policy should stipulate
644 how the quality of the ethics consultations will be assessed and ensured. [29]
645 Retrospective review of clinical ethics case consultations should be a regular part of the
646 process. It is important that the ethics consultation service clearly specify its procedures
647 and periodically reevaluate how they are meeting overall service and institutional
648 objectives and values. More formal evaluation methods should also serve this goal, and
649 a standard approach to quality assessment and improvement is discussed in Chapter 5.
650

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[xx] See Fletcher 1996. The importance of ethics consultation services for organizational efficiency and effectiveness is recognized in different ways in different institutions. Some organizations have added an "organization ethics" subcommittee reporting to the ethics committee to address such issues. Some health systems have a designated ethics officer (e.g., Catholic Health Care West's Vice President of Ethics and Justice Education) or a specific administrative committee. The VA's "integrated ethics" initiative involved clinical ethics, quality improvement or preventive ethics, and leadership ethics. *See* Fox 2006 and Fox 2007.

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1
Chapter 2. Core Competencies for Clinical Ethics Case Consultation
2
3 A clinical ethics case consultation is a consultation regarding a current, active
4 patient case in which one or more involved parties have raised ethical concerns or are
5 seeking guidance on resolving ethics-related issues. This chapter reviews the core
6 knowledge, skills, and attributes necessary for competent clinical ethics case
7 consultation. Of note, at times healthcare professionals may request informal
8 assistance regarding a specific patient in lieu of a formal clinical ethics case
9 consultation. When such a request is made, the healthcare ethics consultant should
10 decline to provide such informal recommendations and instead should provide a clinical
11 ethics case consultation as described in Chapters 1 and the current chapter. This is
12 important because there are often subtle issues at play in consideration of ethical issues
13 with a specific patient and an informal consult can lead to insufficient consideration of
14 the perspectives of various involved parties and insufficient consideration of the ethical
15 issues; therefore, an informal consult is generally suboptimal in such situations and a
16 full clinical ethics case consultation should be performed.
17
18 **Core Competencies: The Rationale**
19 Patients, families, surrogates, and healthcare professionals should be able to
20 trust that when they seek help regarding the ethical dimensions of care the team or
21 person providing the clinical ethics case consultation is competent to offer that
22 assistance. As such, the consultation team, or solo consultant, must possess certain
23 knowledge, skills, and attributes to provide competent clinical ethics case consultation.
24 The competencies required to perform clinical ethics case consultation may be
25 divided into 1) knowledge competencies, 2) skills competencies, and 3) professional
26 attributes. The knowledge competencies cover an array of clinical and bioethical topics,
27 and the skills competencies can be subdivided into assessment and analysis skills,
28 process skills, and interpersonal skills. The specific competencies are detailed in the
29 tables below.
30
31 **Core Competencies Using a Small Team Model**
32 At most facilities, clinical ethics case consultation is performed using a small
33 team model.[1] Utilizing this model allows team members to share expertise so that no
34 one person is required to have advanced knowledge and skills in all competency areas.
35 Every member of the ethics consultation team must possess at least a basic knowledge
36 in all core knowledge competencies (Table 1), at least a basic skill level in all core skill
37 competencies (Table 2), and all of the professional attributes (Table 3) (basic
38 knowledge and basic skill are defined below). This is necessary due to the dynamics of
39 team-based consultation and the importance of each team member being able to fully
40 participate in consultation discussions.
41 Further, competent clinical ethics case consultation requires that for all core
42 knowledge and skills competencies, at least one member of the ethics consultation
43 team has advanced knowledge and skill in that competency (advanced knowledge and
44 advanced skill are defined below). In the small team model, advanced knowledge and
45 skills may be provided by various members of the team. For example, one team
46 member may have advanced expertise in several core skills, another team member

may have advanced expertise in other core skills and some core knowledge, and a third may have advanced knowledge in other areas. As such, while no one healthcare ethics consultant on the team has all of the necessary advanced knowledge and skills, as a combined team, they have advanced knowledge and advanced skills in all core competencies described in Tables 1 and 2.

Core Knowledge for Clinical Ethics Case Consultation

Competent clinical ethics case consultation requires knowledge in multiple core domains including moral reasoning, ethical theories, healthcare systems, clinical care, national guidelines, health law, as well as institutional policies, local context, and the beliefs and perspectives of the local community (see Table 1). All members of the ethics consultation service must have at least a basic knowledge in all of these core domains.

Basic knowledge is defined as a general understanding of the specified area. For example, a basic knowledge of healthcare decision-making might include a general understanding of the requirements for informed consent, a basic understanding of the elements of decision-making capacity, and an overall understanding of the range of ethically permissible decision-making models. All members of the clinical ethics case consultation team should have at least this basic knowledge in all of the core knowledge areas enumerated in Table 1.[i]

For each core knowledge area, at least one member of the team must have advanced knowledge; however, different team members can (and often do) bring advanced knowledge of different areas so that together the team has advanced knowledge in all areas. *Advanced knowledge* is a thorough and detailed grasp of the specified area. For example, advanced knowledge of healthcare decision-making would include a deep understanding not only of the requirements for consent to be considered truly informed and all necessary elements of decision-making capacity, but also a deep understanding of the limits of consent, how healthcare professionals can facilitate patient comprehension, supported decision-making for those with compromised decision-making capacity, the differences between coercion, persuasion, and nudging, as well as appropriate uses of an informed decision-making model, a shared decision-making model, and an informed nondissent decision-making model including the benefits and potential risks of each model. The overall concept that all team members must have basic knowledge in all core domains and the team as a whole must have advanced knowledge in all core domains is unchanged from prior editions of these core competencies.[ii] [2,3]

There are many ways that healthcare ethics consultants can gain basic knowledge in the core domains. These include regional bioethics education programs, brief courses (e.g., one-week bioethics training courses hosted at various universities

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[i] Individuals who do not have at least the basic core competencies in each of these core knowledge areas and skills may participate as learners but should not be part of the actual clinical ethics case consultation team.

[ii] Some have proposed competency-based assessment for healthcare ethics consultants similar to other competency-based goals and assessments used in healthcare. See Sawyer 2021 and the Assessing Clinical Ethics Skills (ACES) Tool as examples. Such tools may be helpful in assessing whether healthcare ethics consultants possess the necessary basic knowledge and skills to participate in healthcare ethics case consultations, and to ensure that the team as a whole has the requisite advanced knowledge and skills.

annually), participation in bioethics conferences (e.g., the annual meeting of the American Society for Bioethics and Humanities or the International Conference on Clinical Ethics and Consultation), in-service presentations, seminar sessions and bioethics journal clubs, accessing and reviewing relevant literature (foundational books on bioethics and clinical ethics case consultation, national ethics-related guidelines, etc.), and self-education. The *ASBH Education Guide* and the *ASBH Case-Based Study Guide* are excellent resources for those seeking to improve their knowledge and skill.[4,5] All healthcare ethics consultants should be aware of their own limitations and, when appropriate, access others' specialized knowledge.

Table 1. Core Knowledge for Clinical Ethics Case Consultation
All members of the consultation team must have at least a basic knowledge in each of the following areas. For each core knowledge item, at least one member of the consultation team must have advanced knowledge in this area.

- **Moral reasoning and ethical theory as it relates to healthcare ethics consultation**, including, at a minimum:
    - Consequentialist and non-consequentialist approaches, including utilitarian approaches; deontological approaches such as Kantian, natural law, communitarian, and rights theories
    - Virtue, narrative, literary, and feminist approaches to ethics
    - Theological/religious teachings on morality and ethics
    - Principle-based reasoning and casuistic (case-based) approaches[6]
    - Related theories of justice, with particular attention to their relevance to resource allocation, triage, and obligations to provide health care
- **Ethical issues and concepts that typically emerge in healthcare ethics consultation**[iii]
    - Patients' rights, including rights to health care and disability rights and accommodation, self-determination, treatment refusal, and privacy; the concept of "positive" and "negative" rights and obligations
    - Decision-making models including informed consent, shared decision-making, and informed nondissent, and their relation to respect for autonomy, adequate information, voluntary and involuntary, competence or decision-making capacity, rationality, and paternalism
    - Surrogate decision-making, including for adults who never possessed decision-making capacity, and the related concepts of substituted judgment and best interests
    - Reasonable limitations to surrogate authorization for care provision over incapacitated refusal
    - Vulnerable populations including unrepresented patients, incarcerated patients, and undocumented patients
    - Parental permission and assent for children and adolescents, and the limits of parental decision-making authority, including children with

[iii] Not all of the above issues will be relevant to every health care organization; for example an ethics consultant in a nursing home likely does not require knowledge of reproductive ethics.

special healthcare needs, mental or physical impairments, or chronic illness[iv] [4]

- Fiduciary responsibilities of healthcare professionals, including confidentiality and exceptions to confidentiality, the duty to warn, and the right to privacy
- Disclosure and deception and their relation to patients' rights and confidentiality
- Dealing with patients difficult to care for and common barriers to "patient compliance"
- Social determinants of health
- Professionals' rights and duties, including the parameters of conscientious objection and the duty to care
- Understanding of how cultural and religious diversity affects moral intuitions and decision-making
- Understand how biases based on race, ethnicity, gender, gender identity, disability, education, socioeconomic status, etc. informs the context of a clinical ethics case consultation
- Advance care planning, including advance directives, durable power of attorney, healthcare proxy appointments, POLST/MOLST, etc.
- End-of-life decision-making, including an understanding of DNAR orders, forgoing life prolonging measures, limiting or withdrawing medically provided nutrition and hydration; concepts of "death," "person," "quality of life," posthumous gamete retrieval, euthanasia (including the concepts of "voluntary," "involuntary," "non-voluntary," "active," and "passive" euthanasia), and medical aid in dying
- Requests for potentially inappropriate treatments and medical futility, including the definitions of each[7]
- Beginning-of-life decision-making, including reproductive technologies, surrogate parenthood, in vitro fertilization, sterilization, maternal-fetal conflict, and abortion; best interest considerations for critically ill newborns, the concept of "person," the right to privacy, and the right to an open future[8]
- Genetic testing and counseling, including its relation to informed consent, paternalism, confidentiality, access to insurance, impact on non-tested family members, and reproductive issues
- Conflicts of interest involving healthcare organizations, healthcare professionals (including healthcare ethics consultants), and/or patients/family members
- Medical research, therapeutic innovation, or experimental treatment, and related issues of informed consent, benefit to patient, therapeutic misconception, benefit to society, and social responsibility
- Organ donation and transplantation, including procurement and allocation

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[iv] *See* Anderson-Shaw 2015 pages 54-67.

171 172
    - Resource allocation, including triage, rationing, and social responsibility or obligations to society

173
- **Healthcare systems as they relate to healthcare ethics consultation**
174
    - Managed care systems including alternative payment models
175
    - Medical home systems
176
    - Clinically integrated networks and Accountable Care Organizations
177 178
    - Relevant federal and state governmental systems (e.g., Medicare, Medicaid, state department of health)
179
    - Strengths and weaknesses of the national healthcare system
180
    - Influences on the development of health policy
181
    - Healthcare organization administration
182
    - Systemic oppression and marginalization

183
- **Clinical context as it relates to healthcare ethics consultation**
184 185
    - Terms for basic human anatomy and those used in diagnosis, treatment, and prognosis for common medical problems
186 187
    - Understanding how patients or their surrogate decision-makers interpret health, disease, and illness
188 189
    - Factors that influence the process of healthcare decision-making by patients, family members, and healthcare professionals
190 191 192
    - Awareness of basic clinical courses of commonly seen illnesses (e.g., that kidney disease may lead to kidney failure and need for dialysis or transplant)
193 194
    - Awareness of the grieving process and psychological responses to illness
195 196
    - Awareness of the processes that healthcare professionals employ to evaluate and identify illnesses
197 198 199
    - Familiarity with current and emerging technologies that affect healthcare decisions and distinctions between medical research and therapeutic innovation
200 201
    - Knowledge about different healthcare professionals and their roles, relationships, codes of ethics, and expertise
202 203 204
    - Basic understanding of how care is provided on various services such as intensive care, rehabilitation, long-term care, home care, palliative and hospice care, primary care, and emergency trauma care
205
    - Complex discharge issues
206 207 208 209
    - Understanding of historically disadvantaged groups including persons of lower socioeconomic status, those with limited health literacy, persons with disabilities, incarcerated persons, those who are targets of bigotry based on race, ethnicity, religion, sexual orientation, etc.

210 211
- **Healthcare institution in which the consultants work, as it relates to healthcare ethics consultation**
212
    - Mission statement
213 214
    - Structure, including departmental, organizational, governance, and committee structure
215
    - Decision-making processes or frameworks
216
    - Range of services and sites of healthcare delivery

217 - Healthcare ethics resources, including how the ethics consultation
218 service is financed; the working relationships between the ethics
219 consultation service and other departments, particularly legal counsel,
220 risk management, quality improvement, pastoral care, social work, and
221 (if applicable) the palliative care service; and qualifications of fellow
222 healthcare ethics consultants staffing the ethics consultation service
223 - Medical records system, including how to locate specific types of
224 information in a patient's health record; healthcare ethics consultants
225 involved in case consultations also need to know how to document in a
226 patient's health record

227 - **Local healthcare institution's policies relevant for healthcare ethics**
228 **consultation**
229 - Medical decision-making (informed consent, shared decision-making,
230 informed nondissent)
231 - Responding to requests for potentially inappropriate treatment
232 - Medical futility
233 - Decision-making for unrepresented patients
234 - Limiting and withdrawing life-sustaining treatment including medically
235 provided nutrition and hydration
236 - Pain management and palliative care
237 - Voluntary stopping eating and drinking
238 - Terminal palliative sedation
239 - Medical aid in dying
240 - Advance directives, surrogate decision-making, healthcare agents,
241 durable power of attorney, and guardianship
242 - Do Not Attempt Resuscitation (DNAR)/Do Not Resuscitate (DNR)
243 orders
244 - Determination of death (including death by circulatory criteria and
245 death by neurological criteria)
246 - Confidentiality and privacy
247 - Organ donation and procurement
248 - Conflicts of interest
249 - Disclosure of adverse events or errors
250 - Admissions, discharge, and transfer criteria
251 - Impaired professional
252 - Conscientious objection
253 - Reproductive technology

254 - **Beliefs and perspectives of patient and staff population where one**
255 **practices healthcare ethics consultation**
256 - Important beliefs and perspectives that bear on the healthcare of
257 racial, ethnic, cultural, and religious groups served by the facility
258 - Resource persons for understanding and interpreting cultural and faith
259 communities
260 - Perspectives of those with physical, mental, cognitive, or other
261 disability and their family members or support persons.
262 - In faith-based care settings, religious rules guiding care

263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292

- **Ethics-related policy statements and guidelines promulgated by healthcare professional organizations, codes of ethics and professional conduct, and guidelines of accrediting organizations.**[v]
    - Ethics-related guidelines, policy statements, and codes of ethics from relevant professional organizations (e.g., medicine, nursing, healthcare administration)
    - The healthcare ethics consultant code of ethics[9]
    - Local healthcare facility's code of professional conduct
    - Other important professional and consensus ethics guidelines and statements (e.g., presidential commission statements)
    - Patients' bill of rights and responsibilities
    - Relevant standards of The Joint Commission and other accrediting bodies (e.g., patient rights and organizational ethics standards)
- **Relevant health law.** Although healthcare ethics consultants should not provide legal advice, healthcare ethics consultants may legitimately interpret the ethical implications of health law and how they may inform ethical decision making. Healthcare ethics consultants should be knowledgeable about relevant laws, precedent cases, and regulations including those governing the following:[vi]
    - End-of-life issues such as advance directives (including living wills and proxy appointment documents such as durable powers of attorney for health care), nutrition and hydration, and determination of death
    - Surrogate decision-making, including who is authorized to determine decision-making capacity, appointment of and legally defined order of precedence of proxy decision-makers, and use of proxy appointment documents
    - Decision-making for patients lacking decision-making capacity without family or other identifiable surrogates (unrepresented patients), including the process for assessing decision-making capacity and for obtaining medical guardianship and other mechanisms

[v] All team members should have at least basic knowledge in each of these areas. At least one member of the team must have advanced knowledge of relevant professional guidelines, codes of conduct, etc. specific to the case. For example, in a case of an adult patient requesting treatment that the clinical team believes is potentially inappropriate, at least one of the consultants must have advanced knowledge of professional guidelines defining futile and potentially inappropriate treatment and professional guidelines detailing how healthcare professionals and facilities should address such conflicts. However, it would not be necessary for a member of the team to have advanced knowledge of other areas of professional guidelines and codes of conduct that are irrelevant to the specific case. All healthcare ethics consultants should be able to find relevant professional guidance for any case on which they are consulting, should locate and review such guidance, and should share such guidance with all members of the clinical ethics case consultation team as well as with appropriate healthcare professionals and other involved parties in the consultation.

[vi] All team members should have at least basic knowledge in each of these areas. At least one member of the team must have advanced knowledge of relevant health law specific to the case. For example, in a case of an adolescent refusing treatment, at least one of the consultants must have advanced knowledge of relevant health law regarding minors' rights to consent and decline treatment. However, it would not be necessary for a member of the team to have advanced knowledge of other areas of health law that are irrelevant to the specific case.

293 ○ Decision-making for minors, including emancipated minors and specific
294 conditions that allow minors to make their own medical decisions,[vii]
295 limits on parental authority, mandated reporter requirements, and rights
296 of an adolescent to refuse treatment
297 ○ Medical decision-making and informed consent
298 ○ Organ donation and procurement
299 ○ Confidentiality, privacy, and release of information
300 ○ Reproductive decision-making
301 ○ Reporting requirements, including child, spouse, or elder abuse and
302 communicable diseases
303 ○ Limiting or withdrawing life-prolonging interventions (including ordering
304 DNAR/DNR status) over the objection of the patient or surrogate
305 decision-maker
306 ○ Medical aid in dying
307

308 **Core Skills for Clinical Ethics Case Consultation**

309 Competent clinical ethics case consultation requires skill in multiple core domains
310 including assessment and analysis skills, process skills, and interpersonal skills (see
311 Table 2). All members of the ethics consultation service must have at least a basic skill
312 level in all of these core domains. *Basic skill* is defined as the ability to use the skill at a
313 beginner level in case consultations. *Advanced skill* is defined as the ability to use the
314 skill at a higher, more expert level or in an adept manner in case consultations. For
315 example, for the skill "identify and justify a range of ethically acceptable options and
316 their consequences:" a basic level of skill would entail listing the ethically supportable
317 options, whereas an advanced level of skill would include weighing the appropriateness
318 of various options and clearly linking them to an ethical rationale or justification. All
319 healthcare ethics consultants should have at least a basic skill level in all core
320 competencies listed in Table 2.

321 For each core skill competency, at least one member of the consultation team
322 must have an advanced level of skill in that area; however, different team members can
323 (and often do) bring advanced level skills in different areas so that together the team
324 has advanced skill levels in all areas. The overall concept that all team members must
325 have at least a basic level of skill in all core domains and the team as a whole must
326 have advanced skills in all core domains is unchanged from prior editions of these core
327 competencies.

328 Gaining the necessary skills for clinical ethics case consultation can be more
329 challenging than gaining the required knowledge. Because building skills requires
330 training and practice, healthcare ethics consultants who lack some of the necessary
331 skills should find ways to build those skills to at least a basic level. All healthcare ethics
332 consultants should be aware of their own limitations and, when appropriate, call on
333 others' specialized skills.

[vii] Statutes regarding minors' legal authority to consent to treatment vary by state and country. For example, in some U.S. states, a minor who is herself a parent is granted the legal authority to consent to her own treatment; however, in other states minors who are parents do not have this legal status. Healthcare ethics consultants should know the specific laws and court rulings in their state, province, or country that govern the age of majority for healthcare decisions and exceptions based on patients' medical conditions and other factors.

It is particularly important for healthcare ethics consultants trained in another professional discipline, such as medicine, law, nursing, or philosophy, to ensure that they do not rely too heavily on skills honed in their primary professions and neglect other essential skills when performing clinical ethics case consultation to the point that they confuse their roles when performing clinical ethics case consultation. For example, when a physician is performing clinical ethics case consultation, it is not his or her role to develop a differential diagnosis. When a lawyer is performing clinical ethics case consultation, it is not his or her role to provide legal counsel.

Table 2: Core Skills for Clinical Ethics Case Consultation

All members of the consultation team must have at least a basic skill in each of the following areas. For each core skill item, at least one member of the consultation team must have advanced skill in this area.

Assessment/analysis skills

- Identify the nature of the value uncertainty or conflict that underlies the need for clinical ethics case consultation, which requires the ability to:
    - Discern and gather relevant data (e.g., clinical, psychosocial)
    - Assess the social and interpersonal dynamics of the consultation (e.g., power relations, racial, ethnic, cultural, and religious differences, principles of trauma informed care)
    - Distinguish the ethical dimensions of the consultation from other, often overlapping, dimensions (e.g., legal, institutional, medical)
    - Clearly articulate the ethical concern(s) and the central ethics question(s)
    - Identify various assumptions that involved parties bring to the consultation (e.g., regarding quality of life, risk taking, institutional interest, unarticulated agendas, what health and illness means to the patient or surrogate)
    - Identify relevant beliefs and values of involved parties
    - Identify the consultant's own relevant moral values and intuitions and how these might influence the process or analysis

366 • Access and appropriately apply relevant internal guidance including
367 institutional policies and standards
368 • Access and appropriately apply relevant external guidance including
369 professional guidelines and policy statements, codes of ethics, and ethics
370 literature
371 • When practicing in a faith-based healthcare setting, access and appropriately
372 apply relevant religious teachings and guidance
373 • Access and appropriately apply relevant statutes and case law without
374 providing legal advice
375 • Clarify relevant ethical concepts (e.g., confidentiality, privacy, informed
376 consent, substituted judgement, best interest standard, professional duties,
377 etc.[viii] [10])
378 • Identify and justify a range of ethically acceptable options and their
379 consequences
380 • Evaluate evidence and arguments for and against different options
381 • Recognize and acknowledge personal limitations and possible areas of
382 conflict between personal moral views and one's role in clinical ethics case
383 consultation (e.g., accepting group decisions with which one disagrees, but
384 which are ethically and legally acceptable)
385 • Address issues involving diversity among patients, staff, and institutions
386
387 **Process skills**
388 • Establish clear expectations for the clinical ethics case consultation
389 • Identify which individuals (patient, healthcare professionals, family members,
390 etc.) should be involved in the consultation process
391 • Determine whether other services should also be involved (risk management,
392 legal, social services, etc.) and communicate and collaborate effectively with
393 other responsible individuals, departments, or divisions within the institution
394 • Utilize institutional structures and resources to facilitate the implementation of
395 the chosen option
396 • Communicate and collaborate effectively with other responsible individuals,
397 departments, or divisions within the institution
398 • Facilitate formal meetings, including:
399 o Effectively begin a meeting by introducing members, clarifying
400 participants' roles and expectations, identifying the goal of the meeting,
401 and establishing expectations for equal involvement and confidentiality
402 of what is discussed
403 o Keep parties focused to reach a meaningful conclusion or stopping
404 point
405 o Establish a timeline for implementing agreed-upon tasks or "next
406 steps"
407 o Discern the need for additional meetings

[viii] Ackerman referred to this as the "reflective social dialog" embodied in "a myriad of academic journals, books, newsletters, government publications, and public discussions."

408 • Document the consultation clearly and thoroughly in the patient's healthcare
409 record[ix]
410 • Communicate the results of the clinical ethics case consultation to the patient,
411 the clinical team, and whomever requested the consultation
412 • If the ethics consultation service maintains internal records, document
413 consultations in appropriate internal records ensuring HIPAA compliance
414 • Identify underlying systems issues and refer such issues to appropriate
415 bodies or leaders[x]
416 **Interpersonal skills**
417 • Listen well and communicate interest, respect, support, and empathy to
418 involved parties
419 • Recognize and attend to various relational barriers to communication present
420 among those involved in a consultation, particularly suffering, moral distress,
421 limited health literacy, and strong emotions
422 • Educate involved parties regarding the ethical dimensions of the consultation
423 • Elicit the moral views of the involved parties
424 • Represent the views of the involved parties to others in a balanced and fair
425 manner
426 • Enable the involved parties to communicate effectively and be heard by other
427 parties
428 • Recognize and attend to various relational barriers to communication
429
430 **Attributes, Attitudes, and Behaviors of Healthcare Ethics Consultants**
431 Professional attributes remain foundational in healthcare professions.[xi] [11] Like all
432 areas of development, a professional's attributes may evolve over time with mentorship
433 and through experience. These attributes, attitudes, and behaviors can be nurtured,
434 and these qualities in healthcare ethics consultants should be taught and modeled.[4,12]
435 ASBH's *Code of Ethics and Professional Responsibilities for Healthcare Ethics*
436 *Consultants*[9] outlines foundational professional attributes that healthcare ethics
437 consultants must possess to be successful while navigating ethical problems.
438

[ix] In rare cases, it may be appropriate to not document the consultation in the patient's medical record. For example, if it is determined that the patient or family will not be informed of the consultation (e.g., if the clinical team asks if it would be ethically permissible to not inform the patient of one potential treatment option, and therefore informing the patient of the consultation would necessarily negate the reason for the consultation), then it may be appropriate to forego documentation in the healthcare record because patients have access to such records. Any case in which the patient or family is not informed of the consultation, the consultation and the decision to not inform the patient or family should be reported to the ethics consultation service leadership and formally reviewed.

[x] For some systems issues, the ethics committee may be the most appropriate body to develop or modify institutional policy to address concerns.

[xi] There remains debate on appropriate word choice for this concept. The first edition of the *Core Competencies* referred to "character," the second edition to "attributes, attitudes, and behaviors," and other scholars recommend "virtue" (see, for example, Baylis 2000). For the purposes of this edition, we settled on attributes because it seemed value neutral.

439 **Table 3: Attributes, Attitudes, and Behaviors of Healthcare Ethics**
440 **Consultants**
441 *All members of the consultation team must have all of these attributes, attitudes,*
442 *and behaviors.*
443 ● Ability to act with integrity, even when doing so poses risk[xii] [11,13,14]
444 ● Compassion to navigate crisis, tragedy, and grief
445 ● Courage to attend to and address power dynamics
446 ● Honesty, forthrightness, and self-knowledge of one's uncertainty and
447 limitations
448 ● Humility to honor and respect the stories of patients, families, and healthcare
449 team members
450 ● Prudence to respect one's scope of practice and mindfulness of potential
451 conflicts of interest
452 ● Respectful curiosity to explore and unpack what is at stake
453 ● Tolerance and patience to welcome all viewpoints and awareness of one's
454 own emotional response to different viewpoints
455 ● Trustworthiness and the ability to create a moral space[15] in which involved
456 parties, especially those in vulnerable positions, feel comfortable participating
457
458 Programs that educate and train healthcare ethics consultants should help
459 learners develop these attributes, attitudes, and behaviors. Programs should
460 encourage reflection about attributes and their development and explore the possible
461 relationship between attributes and clinical ethics case consultation. They should
462 ensure that program faculty and mentors model these important attributes and
463 behaviors and are willing to reflect with students on whether and how attributes
464 contributed to past successful or unsuccessful consultations. Programs must hold
465 learners accountable for their behavior and should include evaluation of attributes in
466 performance evaluations of all healthcare ethics consultants.
467
468 **Core Competencies using an Individual Consultant Model**
469 In other facilities, clinical ethics case consultation is performed using an
470 individual consultant model. The core knowledge, skills, and attributes required for the
471 individual consultant are the same as those for the small team model (see Tables 1, 2,
472 and 3 above); however, the individual consultant must have advanced knowledge in
473 each of the core knowledge areas and advanced level skills in each of the core areas
474 listed. This level of advanced knowledge and skills in the full array of competencies
475 requires significant education, training, and experience. As such, an individual
476 healthcare ethics consultant should have completed dedicated education and training in
477 clinical ethics consultation (through fellowship training in healthcare ethics, mentored
478 real-world experience, etc.), should be able to demonstrate sufficient proficiency to
479 respond to healthcare ethics consultation requests, and should be officially recognized
480 within their institution as being competent to, and responsible for, performing clinical
481 ethics consultations alone and at a level sufficient for the institution.
482

[xii] Understood as moral courage; see, for example see Baylis 2000, Freedman 1996, and Sullivan 2004.

483 **Comparison of Models**
484 The small team model and the individual consultant model each have strengths
485 and weaknesses.[16-19] An individual consultant model may facilitate rapid response to
486 ethics consultation requests; however, an individual healthcare ethics consultant
487 providing such services must have the necessary education, training, and experience to
488 respond to the consultation requests and ethics needs of the institution. Many
489 institutions lack the resources to employ a healthcare ethics consultant who has all of
490 the advanced knowledge, skills, and attributes required for a competent individual
491 consultant. A team-based clinical ethics consultation approach may be less able to
492 rapidly respond compared with an individual consultant model; however, because there
493 are multiple people on the team, no single team member needs to possess all
494 necessary advanced knowledge and skills required to perform the consultation with
495 competence. Different team members may contribute different expertise and together
496 can provide competency for clinical ethics case consultation. Local resources and
497 contextual realities influence which ethics consultation service model(s) are most
498 practical for a given organization and some facilities will use a mix of small team and
499 individual consultant models because each has benefits.[1,20-23]
500 Although the second edition of the *Core Competencies* supported a full
501 committee approach for clinical ethics case consultation as a third acceptable model,
502 the full committee model for clinical ethics case consultation is no longer supported.
503 The individual or small team providing the clinical ethics case consultation must
504 possess the competencies described in the current chapter; however, some facilities
505 have relied on a full committee model when those at the facility lack the necessary
506 competencies either individually or as a small team, relying instead on the sheer
507 number of people involved in the consultation despite the lack of necessary core
508 knowledge and skills of the committee members. Further, a full committee approach
509 does not allow for timely responses nor the intimate atmosphere necessary in most
510 clinical ethics case consultations. For these reasons, this approach fails to meet the
511 minimum standard in the field and is therefore no longer supported.
512 There are times when the law or policy requires that an adjudication body review
513 and approve decisions, for example, for cases in which the patient or family requests
514 interventions that the treating team deems potentially inappropriate or when making
515 decisions for an unrepresented patient.[7,24,25] In such cases, the full ethics committee
516 may be used as the adjudication body if the committee has sufficient diversity,
517 community representation, experience, and size to function appropriately.[24-26] In such
518 cases, the full committee is not performing a clinical ethics case consultation but rather
519 is acting as an independent decision-making body. Further, there may be times when
520 the individual consultant or consultation team wishes to confer with the full committee or
521 specific committee members prior to making recommendations. This may be most
522 appropriate when the consultation concerns a novel issue for which there is insufficient
523 guidance in the bioethics and medical literature and the individual consultant or
524 consultation team is uncertain as to the which options are ethically permissible. In such
525 cases, the full committee is again not performing the clinical ethics case consultation,
526 but rather is acting as an advisory body to the individual consultant or consultation
527 team.
528

529 **Ethics Consultation Services**

530 Ethics consultation services are comprised of the people who provide clinical
531 ethics case consultations. At some facilities, this may be a large number of people who
532 all possess at least the basic knowledge, skills, and attributes required for all members
533 of the ethics consultation team (see Tables 1, 2, and 3) who come together in small
534 teams to perform individual clinical ethics case consultations. For example, the service
535 may have several teams, each comprised of three or four service members who each
536 have the requisite basic knowledge, skills, and attributes and combined have the
537 requisite advanced skills and knowledge outlined in Tables 1 and 2. Under such a
538 system, each team may be on call for a month at a time on a rotating basis. Of note,
539 under such a system it is essential that each team possesses all of the necessary
540 advanced knowledge and skills to perform competent clinical ethics case consultation.
541 Having a large number of healthcare ethics consultants (who all have the required basic
542 knowledge, skills, and attributes) and asking for whomever is available to come together
543 to perform a clinical ethics case consultation is suboptimal because the ad hoc team
544 may not possess all of the necessary advanced knowledge and skills necessary for
545 competent clinical ethics consultations. The ethics consultation service leadership
546 should ensure that any team providing a clinical ethics case consultation has the
547 requisite advanced knowledge and skill to perform the consultation competently.
548 At other institutions, there may be a single expert healthcare ethics consultant
549 who has completed the necessary education and training in healthcare ethics
550 consultation who performs all clinical ethics case consultations at the facility as an
551 individual consultant. At large institutions, there may be several expert healthcare
552 ethics consultants who rotate call for clinical ethics case consultations as individual
553 consultants. There is no "one size fits all" for ethics consultation services. The only
554 essential component is that all clinical ethics case consultations are conducted by either
555 a small team who together have the necessary advanced-level competencies, or by an
556 individual who possesses all of the necessary advanced-level competencies.
557

558 **Facilities that Lack Sufficient Expertise in Clinical Ethics Case Consultation**

559 Many facilities lack personnel who have the requisite knowledge and skills and
560 therefore rely on external ethics consultation services. Models include joint or shared
561 ethics consultation services (e.g., two or more institutions share an external ethics
562 consultation service, or a nursing home refers cases to a nearby hospital's ethics
563 consultation service), extramural ethics consultation services (e.g., facilities refer cases
564 to a free-standing ethics consultation service that responds to consultation requests
565 from any of the member facilities, or a facility contracts with an expert healthcare ethics
566 consultant who works with local ethics committee members to ensure all competencies
567 are covered and mentors local members to provide education and support).[27-29] Other
568 models include ethics consultation provided at the regional or headquarters level of a
569 healthcare system, which functions as a tertiary referral service for particularly difficult
570 clinical ethics case consultations,[xiii] or an independent ethics consultant who serves

[xiii] The VA's National Center for Ethics in Health Care and Catholic Health Care West's Vice President of Ethics and Justice Education provide examples.

571 multiple institutions. Advantages include ensuring access to qualified clinical ethics
572 case consultation services without overburdening facilities with insufficient resources to
573 staff their own ethics consultation service and providing protections against intra-
574 institutional bias in certain cases.[27-29] Regardless of the model employed, all healthcare
575 facilities should have a mechanism to provide competent clinical ethics case
576 consultation.
577
578 **Remote Consultations**
579 It is most desirable for healthcare ethics consultants to work on site, but in some
580 facilities this may not be possible. This situation is most often the case in rural settings
581 where healthcare ethics consultants may provide services across a broad geographic
582 range.[xiv] [30] In such circumstances, healthcare ethics consultants must rely on
583 technology (videoconferencing, teleconferencing, email, remote medical record access,
584 etc.). Such methods may be unavoidable for geographically remote facilities but must, in
585 all cases, be HIPAA-compliant. Healthcare ethics consultants who work off site must
586 make a special effort to overcome the variety of obstacles. For example, it can be
587 challenging to establish trusting relationships in clinical ethics case consultations
588 without face-to-face meetings.[31] Further, without being physically present, the
589 healthcare ethics consultant may seem less available and more impersonal compared
590 to an in-person consultant who is better able to develop connections with clinical teams.
591 Meeting patients, family members, and clinical team members face-to-face is generally
592 preferable; however, remote options can be essential in order to provide competent
593 clinical ethics case consultation services.
594

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Chapter 3: Healthcare Organizational Ethics

As noted in the prior chapters, clinical ethics case consultation is the primary work of healthcare ethics consultants. However, while clinical ethics case consultation is focused on one specific current patient case, healthcare ethics consultants impact the care of all patients who receive care at the organization through broader work. The core functions of healthcare ethics consultants beyond clinical ethics case consultation is termed healthcare organizational ethics defined as: "First, [healthcare organizational ethics] relates to the organization's creation of its core mission and values and seeks to embed such into the organization's decision-making, administrative and clinical practices, policies, and culture. Second, [healthcare] organizational ethics also seeks to identify, analyze, and resolve conflicts between organizational values through an ethical reasoning process that is fair and transparent."[1] In this chapter, four core functions are discussed: policy and procedure work, ethics inquiries, teaching, and serving on committees and working groups. This work, along with clinical ethics case consultation, is core to the work of healthcare ethics consultants and therefore all healthcare ethics consultants must have at least a basic level of skill in these areas.

The core knowledge and attributes discussed in Chapter 2 related to clinical ethics case consultation serve as the core knowledge and attributes for healthcare organizational ethics as well. However, the skills necessary for each of the four domains within healthcare organizational ethics differ. As such, this chapter provides the specific core skill competencies necessary for healthcare ethics consultants in their healthcare organizational ethics work (see Table 4).

Policy and Procedure Work

In the course of clinical ethics case consultations, healthcare ethics consultants often become aware of complex issues that will likely impact other patients (e.g., multiple cases of patients who lack decision-making capacity and do not have anyone to make decisions on their behalf). When healthcare ethics consultants learn of such issues, developing policy or standard operating procedures is often extremely helpful. Within this topic of policy and procedure work is included other forms of guidance as well such as reports, checklists, etc. that clinical teams can use in providing ethically supportable care to patients and families. Development of such guidance has many benefits. Research shows that certain patients and families often receive biased care (e.g., those who are of minority status, those with lower health literacy, those of lower socioeconomic status, etc.), and creating policies and procedures (e.g., having a specific, defined protocol for handling certain types of requests, conditions, etc.) can promote the fair treatment of all patients and families. Further, such guidance allows healthcare professionals to handle similar situations in the future without necessarily involving healthcare ethics consultants because an ethically supportable policy or procedure has already been developed. Policies and procedures also have the benefit of being developed over time with significant input from a broad and diverse group of interested parties and without the time pressures of clinical ethics case consultations. As such, policy and procedure work is core to the function of healthcare ethics consultants.

46 Healthcare ethics consultants may serve different roles in the development and
47 updating of policies. A healthcare ethics consultant may serve as the primary author for
48 policies that are primarily ethical in nature (e.g., a hospital policy on decision-making for
49 unrepresented, incapacitated patients). For other policies, where ethical issues are
50 important but perhaps not primary (e.g., a hospital policy on visitation) a healthcare
51 ethics consultant may serve as a contributor. Many healthcare facilities include a
52 healthcare ethics consultant on their committee or board that reviews all hospital
53 policies so that during the regular course of policy review the healthcare ethics
54 consultant can raise ethics-related concerns and recommend referral to the appropriate
55 body for consideration (to the hospital ethics committee, the ethics consultation service,
56 etc.). How policies are developed and maintained varies at different healthcare
57 facilities; however, the involvement of a healthcare ethics consultant in all policies that
58 have ethical implications is imperative.
59 When developing such policies and procedures, healthcare ethics consultants
60 must ensure that appropriate ethics knowledge is brought to bear. Such knowledge
61 includes all the areas presented in Table 1. In the development and updating of policies
62 and procedures, healthcare ethics consultants must specifically research and consider
63 relevant policy statements and guidelines from healthcare professional organizations,
64 relevant statutes and case law, relevant guidelines of accrediting organizations, relevant
65 religious or doctrinal guidance if practicing in a faith-based organization, and relevant
66 ethics literature (both normative and empirical).
67 Some policies may provide guidance on well-established, generally non-
68 controversial topics. For example, when developing or updating a policy regarding
69 resuscitation status in the operating room, healthcare ethics consultants should
70 research and share relevant guidance from professional organizations such as the
71 American Society of Anesthesiologists,[2] the American College of Surgeons,[3] the
72 American Medical Association,[4] and any other relevant organizations; applicable federal
73 and state statutes such as the Patient Self Determination Act;[5] guidance from
74 accrediting bodies,[6] and relevant ethics literature on the subject. Alternatively, policies
75 may cover emerging or more controversial subjects, in which case such guidance is
76 critical. For example, in developing a policy on care of gender non-conforming youth,
77 the healthcare ethics consultant should consider applicable guidance from the American
78 Academy of Pediatrics,[7] the American College of Obstetricians and Gynecologists,[8] and
79 the American Medical Association;[9] relevant state or federal statutes and case law
80 (which will vary state to state); guidance issued by accrediting bodies;[10] religious
81 guidance if practicing in a faith-based healthcare system; and relevant ethics literature.[i]
82 When developing or updating policies and procedures, especially for controversial
83 topics, it is essential that healthcare ethics consultants base their recommendations on
84 such guidance rather than on their own personal values and beliefs. Healthcare

[i] Guidelines and policy statements from professional organizations generally review major ethics literature, are often written by experts in the field, undergo significant review, and are endorsed by major professional organizations. As such, articles that contradict such guidance should generally be given significantly less weight than the guidance from professional organizations.

professionals, patients, family members, and healthcare ethics consultants may have strong personal beliefs on healthcare-related topics; however, the role of the healthcare ethics consultant is to bring to bear ethics knowledge and professional guidance rather than advocating for their personal values and beliefs. Knowing how to research, locate, and obtain external guidance, and sharing such guidance with others collaborating on policy development is a core function of healthcare ethics consultants (see Table 4).

Ethics Inquiries

Ethics inquiries[ii] are questions from healthcare professionals regarding a general ethics-related question for which the response is not informed by any patient-specific information (i.e., should generally not involve an active patient case because questions regarding an active patient case should typically receive a full clinical ethics case consultation). Appropriate questions for ethics inquiries include those that are not influenced by any case-specific factors such as: “Do we have a policy regarding patients’ authority to decline recommended life-saving treatment?” “In general, is it okay to transfuse a child of Jehovah’s Witness parents over the parents’ objection if the child is at imminent risk of death?” “I would like to use informed nondissent for my patient, can you share some resources with me on that topic?” Such ethics inquiries can be appropriate because the healthcare ethics consultant is acting as a resource and is not giving advice or making recommendations about a specific case. The healthcare ethics consultant can discuss the topic with the healthcare professional, make general recommendations regarding how to handle such issues in clinical practice, and direct the healthcare professional to the relevant local policy, external guidelines, ethics literature, etc. (see Table 4).

Teaching

Healthcare ethics consultants often provide education for healthcare professionals. Such education may take many forms including, but not limited to: didactic sessions (Grand Rounds presentations, noon lectures, etc.), small group discussions, case presentations, new hire orientation, ethics rounds on specific patient-care units,[11-13] development of online asynchronous ethics-related education, development and maintenance of ethics-related content resources on patient-care units. Again, the core knowledge necessary for providing such education is provided in Tables 1 and 4.

Serving on Committees and Working Groups

It is essential for healthcare ethics consultants to serve on committees and working groups for the healthcare organization. This is necessary to ensure that someone with appropriate ethics knowledge is “at the table” when decisions are made. Healthcare ethics consultants can provide real-time ethics analysis and education to leaders to ensure decisions are informed by relevant ethics literature and appropriate consideration is given to ethical issues. Healthcare ethics consultants can also raise

[ii] Various terminology has been used for this work including: “information ethics conversations,” “informal ethics inquiries,” “curbside ethics conversations,” etc. The term “ethics inquiries” is used and defined here to capture all these concepts and terms.

127 practical concerns or considerations given their experience with, and exposure to,
128 ethical issues through their clinical ethics case consultation work. In healthcare,
129 decisions are complex, and leaders must consider a wide range of sometimes
130 conflicting values (needs and preferences of individual patients and families, needs of
131 the community, preferences of facility staff and clinicians, financial considerations and
132 profitability, public perception and marketing, etc.). Ideally, healthcare ethics
133 consultants should also be involved in "big picture" decision making at the highest levels
134 (decisions regarding adding or eliminating a service line, significant changes to
135 organizational structure, etc.) to ensure that the values at stake are clarified and that the
136 ethical implications of such decisions are articulated and considered; however, the skills
137 required to participate in these high-level leadership discussions often take significant
138 time and experience to acquire and are therefore considered advanced healthcare
139 ethics consultant skills and more junior healthcare ethics consultants may not be
140 prepared to provide such services. While the ethical arguments of the healthcare ethics
141 consultant may not always be determinative, providing ethical insight is key to help
142 leaders make ethically grounded decisions.
143 Further, by serving on committees and working groups, healthcare ethics
144 consultants may gain greater insight into the decision-making of leaders and others at
145 the facility. If a healthcare ethics consultant is knowledgeable (Table 1), skillful (Tables
146 2 and 4), and has the necessary attributes (Table 3), over time, others will seek out the
147 healthcare ethics consultant's counsel making them significantly more impactful at the
148 facility.
149
150 **Table 4. Core Skills for Healthcare Organizational Ethics**
151 *In addition to the skills listed in Table 2, all healthcare ethics consultants must*
152 *have at least a basic level of skill in each of the following areas.*
153 **Policy and Procedure Work**
154 • Research and access external guidance (including ethics-related policy
155 statements and guidelines promulgated by healthcare professional
156 organizations, codes of ethics and professional conduct, guidelines of
157 accrediting organizations, ethics literature, and relevant health law)
158 • Communicate clearly, openly, honestly, and concisely using verbiage that
159 is appropriate (not overly intellectualized nor overly simplified)
160 • Demonstrate understanding of the healthcare organization's operations,
161 catchment area, services to the community, and relevant legal and social
162 constraints on policy change.
163 • Manage time effectively, set and meet goals and deadlines
164 • Problem-solve with focus on tangible outcomes and products
165 • Listen actively, making others feel heard and respected
166 • Lead effectively (when placed in leadership position)
167 • Foster mutual respect
168 • Engage in conflict resolution
169 • Take accountability for projects and outcomes
170 • Delegate work as appropriate

171 - Keep an open mind and respect others' perspectives and opinions
172 - Communicate with empathy and sensitivity
173 - Demonstrate self-awareness
174 - Speak honestly and build trust among collaborators

175 **Ethics Inquiries**

176 - Clarify the limits of ethics inquiries
177 - Access and share relevant policies and procedures, professional policy
178 statements and guidelines, ethics literature, and appropriate statutes and
179 case law

180 **Teaching**

181 - Establish learning objectives
182 - Plan and prepare lessons
183 - Demonstrate adaptability
184 - Engage learners
185 - Practice patience
186 - Use technology as appropriate
187 - Hone public speaking skills
188 - Solicit feedback

189 **Serving of committees and working groups**

190 - See skills listed above under Policy and Procedure Work heading

191
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Chapter 4: Healthcare Ethics Consultation as a Professional Practice

In the past decades, there has been significant advancement in the professionalization of the field of healthcare ethics consultation. Research published in 2022 suggests that more than 95% of U.S. hospitals with at least one hundred beds have an ethics consultation service whereas approximately 76% of hospitals with fewer than one hundred beds have such services. Similarly, 98% of urban hospitals, but only 82% of rural hospitals, have such services. Most hospitals (65%) generally rely on a small team model for clinical ethics case consultations, whereas the individual consultant model is less prevalent (19%);[i] however, most hospitals use different models for different consultations. It is estimated that across the United States there are approximately 68,000 clinical ethics case consultations performed annually by approximately 27,000 healthcare ethics consultants.[1]

Most healthcare ethics consultants have other primary duties at the healthcare organization. Research indicates that approximately 24% of healthcare ethics consultants are physicians, 23% nurses, 11% social workers, 10% chaplains, 9% administrators, 9% other healthcare professionals, 4% lay people, 3.5% attorneys, 3% philosophers, 2% ethicists, and 4% "other."[1] Further, 8% of healthcare ethics consultants have completed a fellowship or graduate degree program in bioethics, 40% learned to perform clinical ethics case consultations with formal, direct supervision by an experienced member of an ethics consultation service, and 41% learned independently, without formal, direct supervision. Larger hospitals, academic hospitals, and urban hospitals are all more likely to have healthcare ethics consultants who have completed a fellowship or graduate degree program in bioethics. Over the past two decades, there has also been an increase in the number of healthcare ethics consultants who have completed advanced training. Data from 2000 demonstrated that only 5% of healthcare ethics consultants had completed a fellowship or graduate degree program in bioethics in contrast to 8% in 2018.[1]

The broader field of healthcare ethics consultation has been moving towards professionalization. Ozar describes four key features of a profession: 1) Important and Exclusive Expertise – the group must "provide its clients with something the larger community judges extremely valuable". This expertise has cognitive and practical components which bring about benefits for those served. 2) Internal and External Recognition – the expertise of the group is recognized by its members and the larger community and can be informal or formal, e.g. through certification or licensure. 3) Autonomy in Matters of Expert Practice – those served by the profession accept the professionals' judgements as determinative on matters within their expertise. Professional autonomy extends to determining the specific needs of the client in areas within the professional's expertise; determining the likely outcomes of various actions taken in response to these needs, and; judging which possible action is most likely to best meet these needs. 4) Obligations of Professionals and Professionals

[i] This research also demonstrates that 16% of hospitals use a full committee model for clinical ethics case consultations; however, as noted in Chapter 1, the full committee model is no longer supported as an appropriate model for clinical ethics case consultation.

42 – "membership in a profession implies the acceptance by its members of a set of ethical
43 standards of professional practice."[2]
44 The American Society of Bioethics and Humanities (ASBH) published the first
45 edition of these core competencies in 1998, the second edition in 2011, and now this
46 updated third edition. Further, ASBH publishes an education guide for healthcare ethics
47 consultants which is now in its second edition[3] as well as a case-based study guide.[4] In
48 2014, ASBH published the first-ever Code of Ethics and Professional Responsibilities
49 for Healthcare Ethics Consultants.[5] This code specifies the obligations and
50 responsibilities of healthcare ethics consultants to ensure those in the practice meet
51 these ethical standards.
52 Further, in 2017 ASBH created the Healthcare Ethics Consultant (HCEC)
53 Certification Commission, which began certifying healthcare ethics consultants in 2018
54 and established the Healthcare Ethics Consultant-Certified (HEC-C) designation for
55 certificants. The HEC-C certification is designed to certify healthcare ethics consultants
56 who possess at least the minimum necessary competencies to function as a qualified
57 healthcare ethics consultant on an ethics consultation team (i.e., a basic level of
58 knowledge and skill[ii] in the core competencies discussed in this volume). In 2022, the
59 HEC-C certification program became accredited by the National Commission for
60 Certifying Agencies.[iii] At the time of the writing of these core competencies, there is
61 also a new effort underway to accredit healthcare ethics consultant fellowship programs
62 by the Commission on Accreditation of Allied Health Education Programs. These
63 progressive steps have led to an increased professionalization of the practice of
64 healthcare ethics consultation.
65 While these core competencies are designed for all healthcare ethics consultants
66 who provide clinical ethics case consultation services as part of a team, an increasing
67 number of hospitals and organizations are employing advanced-level healthcare ethics
68 consultants who are competent to provide clinical ethics case consultations as an
69 individual consultant. As note in Chapter 2, such individual consultants must have
70 advanced knowledge and skills in all of the competency areas. In general, such
71 qualified individual consultants have completed advanced training in healthcare ethics
72 (e.g., through a fellowship program) or have significant expertise and many years of

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[ii] Although the certification multiple choice examination does not directly assess the candidate's skills, the examination is designed to test the knowledge that forms the basis for the core skills, which is separate from the core knowledge that is tested. As such, both knowledge and, to some extent, skill are assessed through the examination.

[iii] Certification programs in healthcare-related fields are generally accredited by several different federally recognized certifying bodies. Medical board certification programs are accredited by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA). Nursing certification programs are accredited by the Accreditation Board for Specialty Nursing Certification (ABSNC). Other healthcare professional certification programs are accredited by the National Commission for Certifying Agencies (NCCA). These federally recognized accreditation bodies ensure that certification programs meet rigorous standards to ensure those who are certified are indeed qualified. Accreditation of certification programs is separate from accreditation of educational and training programs, which are accredited by different federally recognized bodies (such as the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), the Accreditation Commission for Education in Nursing (ACEN), the Commission on Accreditation for Respiratory Care (CoARC), the Commission on Accreditation of Allied Health Education Programs (CAAHEP), etc.).

experience in the field. While advanced knowledge can often be gained through educational programs (e.g., Master's degree in bioethics, Certificate programs in bioethics), individual consultants must also have advanced skills which generally require dedicated training to learn and perfect.

Using a standard Accreditation Council for Graduate Medical Education (ACGME) approach to competency assessment can be helpful in advanced training in healthcare ethics. ACGME uses milestones based on the Dreyfus Stages: 1) Novice, 2) Advanced beginner, 3) Competent, 4) Proficient, and 5) Expert. Some educators have used this ACGME model to design specific milestones for healthcare ethics consultants, suggesting that all healthcare ethics consultants should have reached at least milestone 2 (advanced beginner) in all core knowledge and skills areas, and individual consultants (including those who have completed fellowship training in healthcare ethics consultation) should have reached at least milestone 4 (proficient) in all areas. Milestone 5 (expert) would generally be considered a higher level of knowledge and skill, obtained by healthcare ethics consultants over many years of practice.[6]

Because there are clear standards in the practice of clinical ethics case consultation, healthcare ethics consultants have significant influence on patient care decisions (often life-and-death decisions), and there is now broad recognition that all members of the healthcare team must not only be competent to perform their duties but must also be able to demonstrate their competence, it is essential that healthcare ethics consultants possess at least the minimum necessary knowledge, skills, and attributes described in these core competencies. Obtaining and maintaining such knowledge and skills requires practice, ongoing continuing education, and routine evaluation and quality assessment as outlined in Chapter 5. Organizations may use the HEC-C credential to verify that potential healthcare ethics consultants have at least the minimum necessary core competencies, and/or they may design their own assessment criteria to ensure those providing clinical ethics case consultations are competent to do so.

Because the work of healthcare ethics consultants requires specific competencies; has significant impact on patients, families, healthcare professionals, and the organization as a whole; and requires dedicated time and effort to perform the duties competently, healthcare organizations must provide sufficient support for the ethics consultation service. Such support includes, but is not limited to, administrative support, funding for healthcare ethics consultants (either dedicating a specific portion of their FTE to ethics work with commensurate decrease in other duties, or paying an hourly wage for their ethics work time), appropriate recognition by organization leadership, inclusion of healthcare ethics consultants in key decision-making meetings, etc. One approach supports delineation of ethics staffing models in three categories: necessary, recommended, and conditional. Factors included in such analysis include ratios of ethics consult volume to total bed, ICU bed, and admissions data.[7] While this taxonomy may provide standard vocabulary for staffing models, the diversity of training, degree type, and employment models for healthcare ethics consultants all contribute to the diversity of professional roles held by those performing healthcare ethics consultation services. Indeed, most healthcare ethics consultants are employed primarily in a clinical role rather than specifically as a healthcare ethics consultant.[1,8]

Although the field of healthcare ethics consultation continues to evolve, it is clear that this important clinical area will continue to move towards greater professionalization. With time, an increasing number of organizations will move towards employing healthcare ethics consultants with advanced training. While the shift towards "professional healthcare ethics consultants" will surely take time, it is clear that that is the direction for the future.

Considerations for Cultivating and Maintaining Professionalism in Clinical Ethics

The professional role of a healthcare ethics consultant requires the distinct competence to navigate and resolve conflicts of values present in the course of clinical ethics case consultations and healthcare organizational ethics. The professional role of a healthcare ethics consultant may demand the activity of "holding space" to learn what is important to each stakeholder and allow for all to share their perspectives.[9,10] When holding space, a healthcare ethics consultant must be able to recognize and, when necessary, set aside their own views, utilizing professional attributes and managing conflicts of interest. Healthcare ethics consultants must also maintain privacy and confidentiality, seek assistance when needed, and promote progress in the field of healthcare ethics consultation.

However, as with any domain of expertise, few practitioners have all the necessary competencies when undertaking their professional role. Further, once acquired, if not practiced regularly, competencies can weaken over time. Additionally, healthcare is an ever-changing landscape of information and practice, and up-to-date information and practice standards must be maintained. Therefore, healthcare ethics consultants have a responsibility to the profession to cultivate and maintain the competencies necessary for high-quality healthcare ethics consultation.

Professional Background

Since healthcare ethics consultants often have varied disciplinary backgrounds, supplemental knowledge will be needed prior to the ability to perform clinical ethics consultation competently.[3,11,12] Consider the following examples:

- Clinicians might have to supplement their professional strengths with advanced knowledge of moral reasoning and skills in ethical analysis.
- Lawyers with expertise in health law might need to acquire knowledge of common concepts and issues in healthcare ethics, clinical practice, and health systems.
- Philosophers and theologians may need to acquire basic knowledge of clinical practice and health systems as well as knowledge of ethics-related health law.

Each healthcare ethics consultant should assess their experiential or educational gaps based on the core competencies presented in this volume.

Ongoing Engagement with the Field

Healthcare ethics consultation takes place in the context of a shifting landscape of scholarship, healthcare practice, and law. Continued engagement with the broader field of healthcare ethics (through continuing ethics education, participation in regional or state ethics networks, participation in national organizations like the American

Society for Bioethics and Humanities and its annual conference, etc.) is imperative for healthcare ethics consultation practice to reflect up-to-date information about healthcare ethics, healthcare broadly, and relevant health law.

Knowledge Acquisition and Integration

It is impossible for any healthcare ethics consultant to possess all knowledge needed for every possible healthcare ethics consultation request. For example, as medical knowledge and technologies advance, ethical analysis must adapt and expand to incorporate new knowledge of available therapies and interventions.[13-15] Additionally, although there are enduring moral philosophies, healthcare ethics consultants should continue to engage with innovations in theoretical and applied ethics that impact healthcare ethics consultation practices.[iv] [16,17] Furthermore, shifting societal and cultural values may require similar shifts in clinical ethics case consultation and healthcare organizational ethics. Yet, recognizing what one does not know is a key feature of expertise.

Due to the field's constant evolution, it is essential that healthcare ethics consultants demonstrate the ability to acquire and integrate knowledge. Knowledge acquisition requires that a healthcare ethics consultant be information literate, meaning they "must be able to recognize when information is needed and have the ability to locate, evaluate, and use effectively the needed information."[18]

Knowledge acquisition requires that healthcare ethics consultants be able to draw from multiple sources for balanced and up-to-date information. This may include:

- accessing applicable guidelines and policy statements from professional organizations as well as codes of ethics
- accessing available library resources, including performing literature searches of peer-reviewed journals
- continuing their education through webinars, conferences, workshops, podcasts, and other relevant content
- engaging persons with expertise in other knowledge areas relevant to a given clinical ethics case consultation
- seeking knowledge from bioethics peers and other healthcare ethics consultants
- recognizing patients and families as sources of knowledge, including relevant cultural or personal values and perspectives.

A healthcare ethics consultant should be able to integrate new information into their existing knowledge framework to facilitate appropriate retrieval and use in future consultations.

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264 http://www.ala.org/acrl/publications/whitepapers/presidential)
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266

Chapter 5: Quality Assessment and Improvement

Healthcare facilities use standard approaches to quality assessment and continuous quality improvement;[i] therefore, healthcare ethics consultants should use these same well-established processes. For a brief history of quality assessment and improvement in healthcare, see Appendix 1. The Agency for Healthcare Research and Quality (AHRQ) has established standards in quality assessment and improvement. Perhaps the most widely used approach to quality improvement in the healthcare setting today is the Plan-Do-Study-Act (PDSA) method;[ii] however, healthcare ethics consultants should use whatever standard approach is used at their organization by other services.

The necessity of quality assessment in healthcare ethics consultation rests on three ethical principles: a duty to care, non-maleficence and beneficence. Healthcare ethics consultants are part of a healthcare organization that provides care to patients. Part of that duty of care involves ensuring that the quality of services provided is at least minimally competent. Ideally, services are above minimally competent; however, minimal competency is the most basic level of competence that meets standards set in these Core Competencies. Therefore, the knowledge and skills of those providing healthcare ethics consultation services must be assessed to ensure they meet minimal competency, and the quality of the ethics consultation service must be assessed to ensure the service as a whole meets the minimum level of competence as well. A failure to do so could cause harm to patients, families, clinical staff, and others.[1] For example, a healthcare ethics consultant who provides inaccurate information could lead a patient to make a decision they later regret. Failing to treat all parties respectfully in the consultation could lead to emotional harm. Beyond non-maleficence, ensuring quality in ethics consultation also contributes to beneficence toward those involved, e.g. helping them reach consensus on how to move forward in the care of a dying patient.

Quality assessment is necessary to ensure that the service meets established standards, including ensuring healthcare ethics consultants are competent in their role (i.e., the meet the requirements of these Core Competencies), clinical ethics case consultations meet the standards presented in these Core Competencies, and errors in ethics recommendations are minimized. Because healthcare ethics services often involve high-risk (sometimes life-and-death) situations, poorly managed healthcare ethics services can have devastating effects on patients, families, healthcare professionals, and the organization as a whole. On-going assessment and quality improvement ensures the healthcare ethics service identifies gaps in quality and addresses aspects of performance that need improvement.

Ongoing quality assessment and improvement are also required for accountability. The healthcare ethics service needs to monitor and maintain the competence of those providing the service, the quality of all aspects of the service

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[i] Quality assessment is generally understood as a baseline measure of quality. Continuous quality improvement is generally understood as the practice of improving the quality of service usually through repeated cycles of quality measurement, planning, and intervention.

[ii] For more information, see https://www.ahrq.gov/evidencenow/tools/pdsa-form.html, https://edhub.ama-assn.org/steps-forward/module/2702507, https://www.ihi.org/resources/tools/plan-do-study-act-pdsa-worksheet

(clinical ethics case consultation, education, policy, etc.), and assess the impact of the service. Healthcare ethics services should be able to assess and demonstrate their value to the recipients of the service, as well as to hospital leadership who support the service by providing funding, administrative support, etc. Value may be measured qualitatively (improved satisfaction with the consultation process as reported by patients and families, decreased burnout of healthcare professionals, etc.), or quantitatively (decreased response time for consultation requests, decreased length of stay, etc.), or both. Indeed, research has demonstrated that clinical ethics case consultations are associated with increased satisfaction among both family members and healthcare professionals, and also decreases length of stay.[2,3] Such data support the ongoing funding and resource support of the healthcare ethics service.

In assessing and improving quality for any healthcare service (including healthcare ethics), one key component is identifying appropriate outcome measures. An ideal outcome measure has two primary features: it is both measurable and meaningful. Identifying appropriate outcome measures in healthcare ethics has posed a challenge to the field. Some proposed outcome measures may be meaningful but difficult to measure (e.g., concordance between the values of the patient and the treatment decisions). Other proposed outcome measures may be measurable but are not widely considered a meaningful outcome for healthcare ethics (e.g., cost of care). Ideally, services measure specific outcomes; however, at times measurement of a desired outcome is challenging and the measurement of specific processes may be appropriate. An example from intensive care quality assessment and improvement may be illustrative. It is well-established that ventilator-associated pneumonia (VAP) increases morbidity, mortality, and length of stay; therefore, decreasing the rate of VAP is a key outcome measure in the intensive care unit (ICU) setting. Historically, VAP rates were low; however, with significant focus over the past two decades VAP rates have been lowered significantly with a goal of zero VAPs. Given that VAP rates are now extremely low (North American hospitals report rates as low as 1-2.5 VAP cases per 1000 ventilator days;[4] however, the goal is zero VAP occurrences), assessing the VAP rate in a specific ICU is not conducive to quality improvement projects. Research has demonstrated that one reliable intervention an ICU may implement to bring their VAP rates closer to zero is compliance with a VAP bundle.[iii] Further, because the VAP bundle components are performed routinely throughout the day and charted by nursing, compliance with a VAP bundle can be easily measured. As such, for VAP quality improvement projects, it is common to measure compliance with the process (i.e., compliance with VAP bundle, which is easily measurable and is also meaningful because it has been demonstrated to be correlated with VAP incidence) in addition to VAP rates (which are extremely rare). In the case of healthcare ethics, process measures are appropriate for quality improvement projects if they are measurable and have been demonstrated to be correlated with a meaningful outcome (e.g., one can easily measure the length of a clinical ethics case consultation note; however, because

[iii] There are multiple VAP bundles in wide use. These bundles generally include routine care of the intubated patient to minimize risk of VAP. Some bundle components may include: elevating head of bed 30º, q3hr oral care, maintaining endotracheal tube cuff inflated to $20cmH_2O$, changing ventilator tubing only when visibly soiled, etc.

there is no evidence that note length is correlated with the quality of the consultation, note length would not be an appropriate outcome measure for quality work).

As yet, the field of healthcare ethics has not established meaningful and measurable quality outcomes. Work in this area is ongoing and should remain a focus of bioethics research to better allow healthcare ethics consultants to measure the outcome of their work and improve the quality of the service. Currently, there are several outcomes (discussed below) that, although they are not ideal, are widely used in healthcare ethics and should be considered for assessment at local healthcare facilities.

Ethics Consultation Service Structure

While the field lacks evidence that specific structures improve the quality of clinical ethics case consultations, there are several widely agreed upon standards that should be measured. These measurable standards include:

- All members of the ethics consultation service have at least a basic level of knowledge (Table 1) and skill (Tables 2 and 4), as well as the necessary attributes (Table 3), required for all healthcare ethics consultants. Ethics consultation services should assess the competency of all members to ensure they meet minimum necessary criteria. Of note, because the healthcare ethics consultant certification program certifies that healthcare ethics consultants have at least the minimum necessary core competencies, facilities may use certification (the HEC-C) as one method for assessing the competencies of their healthcare ethics consultants.[iv] When assessing the competence of individual healthcare ethics consultants who are not certified, facilities may use widely available tools such as the Neiswanger Institute for Bioethics' Assessing Clinical Ethics Skills (ACES) Tool.[5] or the Veteran's Administration Ethics Consultation Proficiency Assessment Tool.
- All clinical ethics case consultations are performed by a team that has the necessary advanced knowledge and skill required for the consultation (i.e., for all core knowledge (Table 1) and skills (Table 2), at least one member of the team has advanced knowledge/skill in that area). When consultations are performed by an individual consultant, that consultant has advanced knowledge/skill in all core areas. Some institutions may have the ability to assess advanced-level knowledge and skill (e.g., healthcare ethics consultant training programs); however, many facilities lack such expertise. Therefore, it may be reasonable rather that assessing the advanced knowledge and skill of individual healthcare ethics consultants to instead assess the quality of the consultation itself. One proposed assessment tool for consultations is the Veteran's Administration Ethics Consultation Quality Assessment Tool, which assesses consultation quality through review and assessment of the consultation chart note.[6]

[iv] Although the certification multiple choice examination does not directly assess the candidate's skills, the examination is designed to test the knowledge that forms the basis for the core skills, which is separate from the core knowledge that is tested. As such, both knowledge and, to some extent, skill are assessed through the examination.

121 • There are sufficient resources to ensure the ethics consultation service is able to
122 provide quality service. Resources should include at a minimum: Administrative
123 support for the service, funding for healthcare ethics consultants for their time
124 and effort used to provide clinical ethics case consultations and healthcare facility
125 ethics work, and funding for a service leader who is qualified to supervise the
126 ethics consultation service.
127 • There is a clear and specific policy regarding how clinical ethics case
128 consultations shall be performed. It is advisable to also distinguish ethics
129 inquiries from clinical ethics case consultations. Such policies should include
130 reference to standard practices such as the CASES approach promoted by the
131 National Center for Ethics in Health Care,[7,8] the Four Topics Method initially
132 developed by Jonsen, Siegler, and Winslade,[9] the GRACE method of
133 consultation,[10] the SFNO approach,[11] or other well-established approaches to
134 clinical ethics case consultation.
135 • There is a clear policy regarding access to the ethics consultation service that
136 specifies that any person involved in the care of a patient (including, but not
137 limited to, the patient, the patient's family member, or any member of the
138 healthcare team) may request a clinical ethics case consultation. There are also
139 clear practices in place to ensure patients and families are made aware of the
140 ethics consultation service and are given information on how to request a clinical
141 ethics case consultation.
142 • There is a policy identifying the role of healthcare ethics consultants in healthcare
143 organizational ethics work including how the healthcare ethics consultants
144 contribute to policymaking, the general types of committees and working groups
145 the healthcare ethics consultants may participate in, and the general
146 responsibilities of the healthcare ethics consultants regarding other roles (e.g.,
147 teaching).
148 • The ethics consultation service and the organizational ethics work are reviewed
149 regularly to ensure compliance with policies and procedures, and to identify any
150 ethics needs at the facility. Such review may be performed by the ethics
151 consultation service leadership, the hospital ethics committee, or another
152 appropriate body.
153
154 **Clinical Ethics Case Consultation Process**
155 There are several specific processes that are widely accepted as standard
156 practice and may be objectively measured. While these processes have not been
157 shown to be correlated with improved quality of clinical ethics case consultation, many
158 services continue to use the following processes as measurable standards to be
159 assessed, tracked, and improved upon. These include:
160 • Response time for clinical ethics case consultation requests
161 • Formulation of the ethics question, and referral to other services if appropriate

162 • Notification of involved parties (e.g., the attending physician,[v] the patient and/or
163 family)
164 • Reviewing the medical record
165 • Meeting with the patient (or with the family if the patient is unable to participate in
166 the clinical ethics case consultation)
167 • Meeting with involved parties
168 • Gathering ethics knowledge (guidelines and policy statements, facility policies
169 and procedures, ethics literature, etc.)
170 • Determining if a formal meeting is appropriate, and leading such a meeting
171 • Facilitating moral deliberation
172 • Identifying the ethically appropriate decision-maker
173 • Synthesizing and communicating information
174 • Identifying the range of ethically appropriate options, identifying options that are
175 not ethically supportable, and making recommendations as appropriate
176 • Documentation of the clinical ethics case consultation in the patient's healthcare
177 record
178 • Recording data from the consult for use in assessment and quality improvement
179
180 **Clinical Ethics Case Consultation Outcomes**
181 As noted at the beginning of this chapter, the goal in quality assessment and
182 improvement is to identify objectively measurable, meaningful outcomes; however, the
183 field of healthcare ethics as yet has not identified such outcome variables. Instead, the
184 following outcome variables have been widely used and should be considered for
185 quality assessment until the field has developed more reliable outcomes.[vi] [12]
186 • ***Ethicality***: The degree to which clinical practices conform to established ethical
187 standards (using ethically appropriate decision-making models, respecting a
188 patient's stated choice to stop life-prolonging interventions, assisting the
189 surrogate decision-maker in the appropriate use of substituted judgement or best
190 interest assessment, informing the patient of a medical error that caused harm,
191 etc.). To date, there are no widely available tools to assess ethicality of clinical
192 ethics case consultation. One way in which many ethics consultation services
193 measure ethicality is to present all clinical ethics case consultations to the
194 hospital ethics committee post hoc to receive feedback and allow the full
195 committee to weigh in on the ethicality of the recommendations and final
196 outcome. While such a method is necessarily subjective, it can still be an
197 important outcome measure for ethics consultation services.
198 • ***Experience of those involved in the consultation process:*** Ethics
199 consultation services may solicit feedback from patients, family members, and
200 healthcare professionals who were involved in clinical ethics case consultation to
201 gauge their experience with the consultation process. Focusing on satisfaction
202 may be suboptimal because some people may not be satisfied (with the

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[v] Of note, while it is widely agreed that the attending physician should be notified of the consultation request, it is also well-established that no one, including the attending physician, should have the authority to "veto" or cancel a clinical ethics case consultation request.

[vi] For a good discussion of quality improvement based on the outcomes presented here, see: Bliss 2016.

outcome, etc.) despite a robust and appropriate process. Questions that assess whether participants believe that the ethical question(s) was adequately addressed, whether they felt heard (even if their preference was not the ultimate outcome), whether they believe the process was fair, etc. may be better questions than those that focus on satisfaction. There are experience survey tools widely available that may be used or modified for local use.[13] While qualitative methods for assessing experience have been employed and can provide more robust data,[14] the use of quantitative surveys can provide data that can be tracked and used in PDSA quality improvement cycles.

- ***Conflict resolution:*** Ethics consultation services may solicit feedback from patients, family members, and healthcare professionals who were involved in clinical ethics case consultations that featured a conflict in values or opinions to gauge their perception whether the conflict was appropriately addressed. Again, survey tools that include appropriate questions are widely available.[13]
- ***Education***: While a core function of healthcare organizational ethics work includes education, the impact of clinical ethics case consultations on healthcare professionals' ethics knowledge should not be underestimated. When a clinical ethics case consultation is performed well, healthcare professionals often gain significant knowledge on ethics-related topics, and often gain significant insight regarding how to handle similar cases in the future. Soliciting feedback from healthcare professionals to gauge their knowledge acquisition through the consultation process is an important and meaningful outcome measure.

Note: The following section (in different font and color) is provisional. Please provide feedback regarding whether the following is helpful and should be included in the Core Competencies 3rd edition.

Five Questions to Support High-Quality Ethics Consultation

While there is no consensus on quality criteria and standards that are mandatory, obligatory, or necessary for evaluating healthcare ethics consultation practices, many emerging standards have been advocated for in recent years. Synthesizing the literature's emerging best practices in a way that offers concrete, practical advice for ethics consultation services, program directors, and administrators, ASBH offers five quality questions that can help guide the development of quality assessment and quality improvement metrics for an ethics consultation service:

1. Are clinical ethics consultations performed using an appropriate process?
2. How many clinical ethics consultations does the ethics consultation service perform?
3. Is the ethics consultation service adequately accessible?
4. Is the ethics consultation service adequately staffed?
5. Does the ethics consultation service have sufficient institutional support and integration?

Each question represents a quality target for ethics consultation services. These quality questions can be used together or independently to support high-quality ethics consultation.

Quality Question 1: Are Clinical Ethics Consultations Performed Using an Appropriate

Process?

While there has been considerable debate about the overall process for performing clinical ethics consultations and what an acceptable degree of variation from that process would be, there are at least minimum activities necessary to engage in any clinical ethics consultation (Berkowitz et al., 2015; Bliton, 1999; Fletcher & Moseley, 2003; Lipman & Powell, 2016; Orr & Shelton, 2009). Chapter 1 provides examples of practices that may be assessed on an ongoing basis; for example, clinical ethics consultation intake, information gathering (from clinicians, patients, families, other stakeholders, and the medical record), ethical analysis, recommendation development and communication, documentation, and case closure.

Clinical ethics consultation processes should be measured according to best practices reported in the literature. One quality indicator for the clinical ethics consultation process is the existence of an institutional policy that describes how healthcare ethics consultants will respond to requests for clinical ethics consultations. The policy should specifically describe these expectations by reference to appropriate, nationally recognized references, such as the CASES approach delineated in the IntegratedEthics framework promoted by the National Center for Ethics in Health Care (Berkowitz et al., 2015), the Four Topics Method initially developed by Jonsen (Jonsen et al., 2022), or the GRACE method of consultation (Hester, 2022). The ethics consultation service should then assess how closely actual clinical ethics consultations conform to the policy. A prerequisite for such review is adopting a method for retaining access to chart notes and reviewing them for quality assurance purposes (Bramstedt et al., 2009). In addition, ethics consultation services should consider measuring how often a formal clinical ethics consultation note is written in the medical record; the percentage of cases for which the healthcare ethics consultant participates in care conferences or family meetings; and whether the consultants' recommendations are relevant, easy to understand, and actionable.

Clinical ethics consultation policies can be evaluated through an audit (potentially by organizational leaders or outside consultants). It is important to assess the practicality of the guidance in the policy given the characteristics of the institution. The existence of a policy describing the ethics consultation service practices, the alignment with best practices in the field, and the practical feasibility of implementing the policy are all indications of a high-quality policy. Monitoring the quality of clinical ethics consultation policies is likely best performed as a retrospective exercise. Examples of how to practically implement such an audit are provided by the Department of Veterans Affairs (Pearlman et al., 2016) and the Catholic Health Association of the United States (CHA & Ascension Health, 2014). The quality monitoring cycle includes periodic review of chart documentation, how the clinical ethics consultation process was implemented, self-assessment, peer observation, and stakeholder feedback.

Ethics consultation services should have a formally adopted ethics consultation policy covering the content described above, which should be reviewed at regular intervals.

Quality Question 2: How Many Clinical Ethics Consultations Does the Ethics Consultation Service Perform?

The activity of responding to requests for clinical ethics consultation is an essential function of ethics consultation services. However, volume, or the number of clinical ethics consultations performed over a given duration of time, is not an indicator of consultation service quality alone. What is important is that an ethics consultation service performs enough clinical ethics consultations to meet the needs of the hospital or health system.

Researchers estimate that 102,000 clinical ethics consultations are performed annually in

295 U.S. hospitals each year (Fox et al., 2022). Although there are reports in the literature that some
296 ethics consultations services observe zero annual requests for clinical ethics consultations, the
297 majority of ethics consultations services report at least some volume (Fox & Duke, 2022).
298 Clinical ethics consultation volume is significant because it provides a quantitative measure of
299 how frequently the service performs its essential function, allowing for comparisons to be made
300 between past and future service performance in addition to comparisons between service
301 performance and goals for service volume or comparisons with ethics consultation services at
302 other hospitals or health systems.
303 When measuring consultation volume, it is also imperative to not only report how many
304 clinical ethics consultations were performed but also to distinguish between types of clinical
305 ethics consultations. For example, the ethics consultation service may track the number of
306 inpatient clinical ethics consultations; outpatient clinical ethics consultations; formal clinical
307 ethics consultations regarding an active case; healthcare ethics consultations involving general
308 guidance or recommendations not specific to a particular patient; and retrospective healthcare
309 ethics consultations, when a consultation is requested to review a patient care experience or
310 clinical team experience retrospectively, without the goal of influencing a particular patient's
311 near-term future care. In addition to counting the number and type of clinical ethics consultations
312 performed, it is helpful to compare the clinical ethics consultation volume to hospital size
313 (clinical ethics consultation to bed ratio) and hospital admission numbers (clinical ethics
314 consultation to admission ratio) and to compare these results to national data (Feldman et al.,
315 2020; Glover et al., 2020).
316 Monitoring ethics consultation service volume requires at least a method for consultants
317 to document that they performed a clinical ethics consultation in a way that can be tracked over
318 time. This may include using a word-processing document where individual narratives of case
319 summaries are recorded, a spreadsheet where information about cases is recorded, a database
320 program where information may be entered by consultants (Harris et al., 2009; Harris et al.,
321 2019), or a way of extracting summaries of clinical ethics consultations documented in the
322 electronic medical record.
323 Clinical ethics consultation volume should be reported and reviewed annually in a
324 manner consistent with reporting approaches described in other quality questions.
325

326 ***Quality Question 3: Is the Ethics Consultation Service Adequately Accessible?***
327 A goal of a well-functioning ethics consultation service is to meet the need for clinical ethics
328 consultations across the institution, which requires that individuals have access to the service
329 when they perceive a need for it. An ethics consultation service will be ineffective if it is not
330 accessible to healthcare professionals, patients, family members, and other stakeholders. This
331 includes being readily available and providing a timely response to clinical ethics consultation
332 requests. Clinical ethics consultation services should be accessible to healthcare team members,
333 patients, or family members who perceive ethical issues.
334 Monitoring the accessibility of an ethics consultation service can be accomplished by
335 tracking who requests clinical ethics consultations (doctors, nurses, patients, family members,
336 etc.), where clinical ethics consultations occur (which inpatient units, which clinics, etc.), and
337 what ethical issues the ethics consultation service responds to. These data and other variables
338 about an institution, patients served by the ethics consultation service, and the service itself
339 support evidence-based inferences about whether there are likely to be unmet needs in the
340 hospital or health system. Although some ethical issues are largely ubiquitous regardless of
341 patient location in a hospital, other issues are likely to occur uniquely to specific areas of care.
342 Moreover, some ethical issues may occur with the same (or similar) frequency across all units;
343 others—perhaps because of acuity in a unit—will occur with greater or lesser frequency
344 depending on location. Also, while the range of ethical issues that could arise in an institution is
345 theoretically limitless, there are patterns in the types of issues that generally arise (Gorka et al.,
346 2017; Harris et al., 2021; Johnson et al., 2012; Milliken et al., 2020; Robinson et al., 2017).[23]
347 Data related to location should include specific unit and unit type. All units in the hospital
348 or system served should be captured, even if never having consulted the ethics consultation
349 service, so that assessment of need compared to utilization can be made accurately. To measure
350 distribution across requester types, ethics consultation services need to capture some descriptive
351 information about those who are requesting consultation. Basic descriptors such as patient or
352 family, nurse, attending physician, trainee physician, social worker, case manager, chaplain, and
353 so forth are appropriate for this aspect of measuring access.
354 It also may be helpful to capture additional data points when recording information about
355 ethics consultation service access, such as additional stakeholders involved, types of encounters
356 during a consult (e.g., team meetings, family meetings, bedside conversations), and total time for
357 consult activities (in both hours and days), to aid in more robust quality assessment.
358 Monitoring access requires that information about clinical ethics consultations be
359 regularly recorded (using a tracking log, a spreadsheet, or a more sophisticated method discussed
360 above). There is no consensus taxonomy for describing requester types or hospital locations,
361 although there are commonly used terms for describing them (e.g., intensive care unit, neonatal
362 intensive care unit). For clinical ethics consultation themes encountered, since there is no
363 standard taxonomy for describing them (deSante-Bertkau et al., 2018), it is recommended that
364 healthcare ethics consultation services adopt the taxonomy proposed in chapter 2 (see "Issues
365 and Concepts Frequently Arising in Clinical Ethics Consultation") or an alternative they are
366 already familiar with. For ethics consultation services with low volume (e.g., fewer than 12 cases
367 per year), qualitative methods for identifying ethical themes may be more convenient than a
368 taxonomy.
369 Tracking data is a necessary but insufficient step for thoroughly assessing ethics
370 consultation service access. Given that access is a complex quality indicator, it can also be
371 helpful to perform calculations to understand relationships between components of the tracked

information, such as descriptive statistical analysis to determine frequencies, central tendencies, and variability across the core measures of unit, requester type, and ethical issue(s) if the ethics consultation service has sufficient resources to do so. To assess relationships between measures, cross-tabulations should be sufficient. Examination of correlations between unit of origin, requester type, and ethical issue(s)—as well as other measures, if captured—will give an ethics consultation service deeper insight into its current breadth of service and enable refinement of approaches in consultation activities.

Ethics consultation services should assess accessibility annually (or potentially more frequently for high-volume services). Data should be compared to historical data for the service (e.g., comparing accessibility factors for the past 5 years) to assess trends. Further, data may be compared to similarly constituted healthcare ethics consultation services within the health system or to those outside the system where internal comparisons are unavailable or inappropriate. These analyses may be reviewed by ethics consultation service personnel, hospital leadership, and other key institutional stakeholders.

Ethics consultation services may also track and trend other measures for quality assurance, including additional stakeholders involved, types of encounters during consultations, total time dedicated to consultation activities, and clinical information about patients who received ethics consultations.[24]

Quality Question 4: Is the Ethics Consultation Service Adequately Staffed?

Without sufficient staff, ethics consultation services will experience significant challenges performing consultations following an appropriate process, observing sufficient volume, or ensuring the service is accessible to appropriate stakeholders. Adequate staffing of healthcare ethics consultants, administrative staff, and support personnel are essential to responding to clinical ethics consultation requests and may also contribute to the functioning of the healthcare ethics program that supports the ethics consult service, if one exists. Adequate staffing refers not only to the quantity of healthcare ethics consultants but also the quality; healthcare ethics consultants must be qualified to perform their work competently, in accordance with the guidelines laid out in chapter 2.

Ethics consultation service staffing needs vary across hospitals and organizations; this variation might be related to such factors as hospital size, level of acuity, and the scope and breadth of responsibilities given to the ethics consultation service at an institution (Fox & Duke, 2022; Weaver et al., 2023). Consequently, a range of measures are applicable for assessing staffing needs and should be tailored to fit the hospital or health system's particular environment of care. When a target has been established, an estimated level of staffing to meet volume goals may be calculated using the consultation-to-bed ratio (CBR, described above), consultation-to-admission ratio (CAR, described above), Case Mix Index,[25] acuity, and other methods for measuring staffing needs (Gremmels, 2020; Repenshek, 2021). Research suggests that measures including staff competencies, number of staff available for clinical ethics consultation, frequency of time available to spend on the ethics consultation service annually, and the level of complexity of clinical ethics consultations performed may be used to develop a data-driven monitoring cycle that includes a description of the needs-based target for clinical ethics consultation volume, based on institutional characteristics and constitution of available staff, as well as to determine what gaps in staffing exist, although it is important to acknowledge that data on the utility of these specific measures are only beginning to emerge.

Because each environment of care will have its own particular needs for clinical ethics

418 consultation activities, determining needs and then staffing to fit them requires a combination of
419 methods. Legal analysis and literature review may demonstrate a need for clinical ethics
420 consultation services in some jurisdictions, for example, to assist clinical teams in determining
421 appropriate surrogate decision makers for incapacitated patients or to respond to the ethical
422 ramifications of changes in laws covering reproductive rights. Institutional characteristics such as
423 hospital bed count, annual admissions, academic affiliation or status as a teaching hospital, and
424 other variables may be collected by reviewing publicly available information, such as through
425 the American Hospital Directory. Information about bed count by acuity or specialty and
426 information about patient demographics often may be procured by collaborating with a hospital
427 or health system's quality department or similar group. Information about ethics consultation
428 service characteristics such as consultant model in use, access to ethics expertise within an
429 organization, administrative and ancillary support and staffing levels, clinical ethics consultation
430 volume, educational responsibilities, policy guidance and review responsibilities, and
431 administrative tasks (e.g., evaluations, supervision, management, and organizational obligations)
432 may be gleaned through auditing and interviews of key stakeholders.
433 Ideally, every healthcare institution or hospital would employ at least one individual who
434 is certified to perform healthcare ethics consultation (the HEC-C), possesses the necessary
435 knowledge and skill to perform clinical ethics consultations independently, and who has some
436 amount of dedicated time for responding to requests for clinical ethics consultation. Since this
437 goal may be unrealistic for some facilities, institutions that are unable to fund staff with protected
438 time specifically to serve as ethics consultation service staff should perform regular assessments
439 of whether available staff who lack protected time are able to perform minimum volume
440 thresholds consistent with the goal of having the service be accessible.[26] When facilities lack
441 personnel with sufficient education, training, and protected time to provide competent clinical
442 ethics consultation services, facilities should contract with other organizations to ensure access to
443 certified healthcare ethics consultants who can provide competent clinical ethics consultation
444 services or supervise local personnel to ensure clinical ethics consultations meet professional
445 standards.
446 High-acuity settings with cutting edge or high-complexity interventions, such as solid
447 organ transplantation, extracorporeal membrane oxygenation (ECMO), children's hospitals,
448 inpatient psychiatric care, and Level I trauma, are more likely to encounter novel or complex
449 ethical issues and therefore have greater need for multiple certified healthcare ethics consultants
450 who have formal education (ideally an advanced degree in a field relevant to healthcare ethics),
451 training (ideally fellowship training that meets minimum standards set by the Association of
452 Bioethics Program Directors [2017]), and experience. A healthcare ethics consultant may need
453 additional training in consultation specialties depending on the needs of the institution, for
454 example, pediatric, transplantation, or psychiatric ethics needs. Ethics consultation services in
455 high-acuity settings should have adequate staff to cover the additional oversight, training, and
456 support needed for supervised and independent healthcare ethics consultants by those with
457 advanced ethics expertise to meet their increased demands for ethics consultation services in a
458 sustainable fashion.
459
460 ***Quality Question 5: Does the Ethics Consultation Service Have Sufficient Institutional***
461 ***Support and Integration?***
462 In addition to expenses for personnel to staff a healthcare ethics consultation service, institutions
463 should anticipate incurring other expenses to attain and maintain the functioning of a quality

464 service. Since ethics consultation services typically do not generate revenue, institutions should
465 provide both financial and nonfinancial support of the ethics consultation service. Leadership
466 that identifies clinical ethics consultation as a valued service and an institutional culture that
467 regularly utilizes clinical ethics consultations are prerequisites for an effective ethics consultation
468 service. As these quality indicators are difficult to directly monitor, the following ways an
469 institution may support an ethics consultation service may serve as a proxy for an ethics
470 consultation service's perceived value (Miles & Purtilo, 2003).
471 Institutional support for an ethics consultation service can be measured most simply in
472 terms of funding. Alongside direct financial support for ethics consultation service staff salaries,
473 institutions can fund other staff who have nonconsultation responsibilities (e.g., administrative
474 assistants, project managers), educational programming (e.g., outside speakers, education for
475 ethics committee meetings, other educational sessions), ancillary services (e.g., computer
476 software, biostatistical support), and expenses related to ongoing staff education (e.g., books,
477 access to journal articles, attendance at scholarly conferences). Nonfinancial support and
478 integration are less straightforward to measure than financial support and will vary based on the
479 unique features of a particular ethics consultation service and its institution. Measures of
480 nonfinancial support include appointments on impactful hospital committees; regular
481 engagement in discussions about hospital policies or strategic planning efforts; inclusion in
482 regulatory review of hospital activities (e.g., Joint Commission surveys or Magnet Recognition
483 by the American Nurses Credentialing Center); and participation in clinical decision-making
484 forums, such as transplant committees or tumor boards. Volunteer, or nonprotected, time
485 allocated to healthcare ethics consultation by persons with primary appointments that are not
486 ethics related may be a nonfinancial indicator of institutional support. An ethics consultation
487 service's position within organizational reporting structures may also be an indicator of presence
488 or absence of nonfinancial support, such as whether the institution recognizes a healthcare ethics
489 program with a formal relationship to the consultation service or whether ethics consultation
490 service staff report to managers who lack knowledge and skill in ethics consultation practices.
491 As with staffing, ethics consultation services should track the amount of financial support
492 they receive, detailed in annual contracts, summarized each year in annual reports, or both. These
493 data can be reviewed longitudinally to assess changes over time. Nonfinancial support and
494 integration into the institution can also be tracked through annual reports. Committee
495 appointments, opportunities for institutional engagement, and recognitions should all be included
496 in annual summaries of activities and contributions. Feedback on the ethics consultation service
497 may also be obtained from surveying users of the service, institutional leaders, and other
498 stakeholders (Pearlman et al., 2013; Bliss et al., 2016; Volpe, 2017).[27] Both qualitative and
499 quantitative assessments can be useful. For example, quantitative surveys can help to assess
500 stakeholders' knowledge about the existence of an ethics consultation service and its overall
501 value. Qualitative assessments through interviews or surveys can supplement these data in
502 assessing stakeholders' insights regarding opportunities for the ethics consultation service's
503 improvement or growth. Importantly, no validated measures are available for such assessments,
504 so future research and quality assurance activities are needed to standardize them.
505 Ethics consultation services in all hospitals or health systems should be able to
506 demonstrate that they receive some of the types of financial and nonfinancial support described
507 above from their institution. All ethics consultation services should track both financial and
508 nonfinancial support through annual reports and audit these over time. At minimum, institutions
509 should dedicate annual funding necessary to support ethics consultation service staff in receiving

510 education and training needed to attain and maintain HEC-C designation.
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Chapter 6: Other Work of Healthcare Ethics Consultants

Chapters 1, 2, and 3 provide detailed descriptions of the practice of clinical ethics case consultation and healthcare organizational ethics, the core functions of healthcare ethics consultants, and the competencies required to perform these functions capably. In this chapter, other optional functions of healthcare ethics consultants are presented. No competencies are provided in these areas because these are not core functions of healthcare ethics consultants; many healthcare ethics consultants will not have the education, training, or experience to work in these areas; these are outside the healthcare ethics consultants scope of practice; or the healthcare ethics consultant lacks the bandwidth to expand into these non-core areas.

Moral Distress Services

Moral distress was first defined in 1984 by Andrew Jameton as occurring when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."[1] This definition has been both debated and refined over the years. Measuring moral distress and implementing targeted interventions to address morally distressing situations in healthcare require a definition that distinguishes moral distress from other concepts (e.g., moral uncertainty, moral injury, compassion fatigue, and ethical dilemma). A definition close to Jameton's original definition resonates with healthcare professionals and provides a foundation for targeted interventions: "Moral distress is the experience of a) believing one knows a correct ethical action to take or professional obligation to meet, and b) being unable to take action due to constraints beyond their immediate or individual control."[i]

This definition draws attention to the emotional sense that one cannot do right by a patient, family, or team and to the recognition that one has little power or influence to act differently or change the situation on one's own. While there is some disagreement over the precise characterization of moral distress,[2,3] all accounts include both an emotional component and an ethical component, the latter of which places it within the scope of practice of healthcare ethics consultation. Further, there is broad agreement that moral distress negatively impacts patient care due to its association with healthcare professional burnout (which leads to leaving specific patient-care units and potentially leaving the healthcare profession as noted in studies of nurses, physicians, social workers, and many other healthcare professionals[4-13]).

The root causes of moral distress occur at three levels; patient, unit/team, and organization.[14] At each level, the causes are those that tend to recur as embedded issues within systems rather than with specific patients. For example, a patient-level cause such as feeling pressured to order or carry out unnecessary tests or procedures may occur for a particular patient, but also has occurred before with other patients and will occur again with future patients. Examples of team-level causes are witnessing compromised care due to lack of clinician continuity, lack of consistent messaging to patients, or poor team communication. At the system level, being required to care for more patients than is safe, having excessive documentation requirements, and lacking adequate equipment or beds are commonly cited causes of moral distress.

[i] This definition was provided by Elizabeth G Epstein, PhD, RN, HEC-C and colleagues.

Each situation that healthcare professionals find morally distressing may have a different mix of patient, team, and system causes and therefore requires an approach that helps teams decipher the causes and identify strategies that will work for that situation. The moral distress consultation model was developed in 2006 with the purpose of assisting healthcare teams in identifying the causes of moral distress with regard to a particular clinical situation and collaborating to develop strategies to address the causes.[15,16] Moral distress consultation is integrated as a sub-service into some ethics consultation services and requires additional training of healthcare ethics consultants as well as education and buy-in of organizational leaders.

Research and Publications

Many healthcare ethics consultants publish papers in academic journals. Such articles may be normative, empirical (including qualitative and/or quantitative research), or a mix of both. Some also participate in the creation of guidelines or policy statements from professional organizations (such as these core competencies). Such activities generally fall under the categorization of academic bioethics and health humanities scholarship. While such endeavors are common for healthcare ethics consultants at academic institutions (particularly those with a primary academic appointment), most healthcare ethics consultants in non-academic centers do not generally participate in research and publication.

The knowledge and skills necessary for such scholarship often requires advanced training. Those doing empirical research must have advanced knowledge of study design, human subject protections, appropriate methodology (which can vary significantly between different types of research such that an expert in one type of research may have little knowledge of methodology for other types of research), responsible conduct of research, and other core knowledge and skills necessary. Similarly, those writing normative papers must have adequate education and training in analysis to produce meaningful work.

Academic faculty are often expected to publish papers, book chapters, and books, and publication record is generally a key consideration in promotion and tenure decisions. In many healthcare-related schools (medical schools, schools of nursing, etc.), obtaining grant funding for such research is also a frequent expectation. In contrast, those at non-academic institutions may face significant barriers to writing and publishing (lack of an office that can accept and manage grants, lack of adequate research infrastructure, lack of access to an IRB, lack of access to journals, lack of academic freedom, etc.).

The decision of whether to participate in research endeavors and authorship is complex; however, at a minimum, healthcare ethics consultants should read ethics-related publications to ensure that they maintain current knowledge in the field.

Research Ethics

Some healthcare ethics consultants focus significantly on research ethics. This may include work in the responsible conduct of research, participation on a human

88 subjects research ethics review committee,[ii] serving on an animal research ethics
89 review committee (such as an Institutional Animal Care and Use Committee (IACUC)),
90 serving on a research ethics consultation service,[17-19] or other involvement in research
91 ethics. Some healthcare ethics consultants also perform empirical research on various
92 topics in research ethics (informed consent for research, appropriate remuneration
93 versus undo inducement for study participants, etc.), or write normative papers on
94 research ethics topics.
95 It should be noted that the knowledge and skills necessary for work in research
96 ethics is significantly different than those required for clinical ethics. For example,
97 healthcare ethics is built upon a foundation in which the healthcare professional has a
98 fiduciary responsibility to the patient, and the patient's interests are always the primary
99 focus of the patient-clinician encounter. In contrast, the fundamental goal of research is
100 to develop generalizable knowledge, and the interests of the greater community are the
101 primary goal. In some cases, the interests of the human subjects are subjugated to the
102 interests of society. As such, the fundamental principles of clinical ethics and research
103 ethics differ in important ways, and those working in research ethics must have a clear
104 understanding of both clinical and research ethics, and the differences in these
105 disciplines. Of note, competence in clinical ethics does not equate to competence in
106 research ethics, nor does competence in research ethics equate to competence in
107 clinical ethics.
108
109 **Public Health, Health Policy, and Advocacy**
110 Many healthcare ethics consultants work in areas that allow them to have an
111 impact on the health of populations such as with local, state, or federal health
112 departments or agencies. Such work allows the healthcare ethics consultant to use
113 their specialized knowledge and skills to advocate for change to improve the health and
114 wellbeing of society broadly, in addition to the population served by their respective
115 institution. Although the education and training of healthcare ethics consultants and
116 public health and public policy experts differ, there are certainly overlaps as well.
117 Indeed, many view advocacy as an important role for healthcare ethics consultants.[20-22]
118 Although not universally accepted, many healthcare ethics consultants consider it
119 part of their professional role to serve as advocates for patients, families, healthcare
120 professionals, organizations, or healthcare more broadly.[23] During a clinical ethics case
121 consultation, healthcare ethics consultants often are in a position to help identify and
122 address moral distress of healthcare professionals, highlight unrepresented or
123 underrepresented perspectives, and level harmful power dynamics.[7,24,25] At times,
124 these clinical ethics consultations may lead to advocacy that supports organizational
125 change to promote an ethical institutional culture.
126
127 **Classroom Teaching**

[ii] In the United States, these are referred to as an Institutional Review Board (IRB). In Canada, these are generally called a Research Ethics Board (REB). In Europe, the term Research Ethics Committee (REC) is widely used. In Japan, there are different types of bodies including Research Ethics Committees, Certified Review Boards, and Ethics Committees that review different types of research.

128 While teaching healthcare professionals in the patient care setting is a core
129 function of healthcare ethics consultants (see Chapter 3), many healthcare ethics
130 consultants also teach outside the clinical setting. For example, many healthcare ethics
131 consultants participate in university courses for undergraduate, graduate, postgraduate,
132 and professional students. Such participation is common for healthcare ethics
133 consultants with primary academic appointments and is not uncommon for those
134 employed at academic institutions. There is wide agreement that learners should
135 receive education in bioethics and health humanities; therefore, the participation of
136 healthcare ethics consultants in such educational programs is imperative.
137
138 **Professional Presentations and Engagement**
139 Many healthcare ethics consultants, particularly those at academic institutions,
140 provide education beyond the local context. Such endeavors may include lectures at
141 professional meetings, at other universities and healthcare organizations, for the
142 general public, etc. Further, some healthcare ethics consultants give interviews with
143 news outlets, or may even produce their own podcasts or other publicly available
144 content. Such activities can help educate a broad audience and improve the ethical
145 care of patients and populations on a wide scale. Further, providing publicly available
146 education not only serves to educate the general public on healthcare ethics issues, but
147 such activities can also help educate people regarding who healthcare ethics
148 consultants are and why the involvement of healthcare ethics consultants is essential in
149 high-quality healthcare and public policy.
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Appendix 1: A Brief History of Healthcare Quality Assessment

In 1990, the Institute of Medicine defined quality of care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”[1] The Healthcare Research and Quality Act of 1999 established the Agency for Healthcare Research and Quality (AHRQ), the U.S. federal agency charged with improving the quality and safety of the U.S. healthcare system.[2] Meanwhile, the Committee on the Quality of Health Care in America was convened in 1998 to identify ways to improve the quality of U.S. health care. Their work resulted in two seminal publications in healthcare quality assurance: To Err Is Human: Building a Safer Health System,[3] which focuses specifically on patient safety, and Crossing the Quality Chasm: A New Health System for the 21st Century,[4] which examines how the healthcare system can be improved to provide care that is safe, effective, patient-centered, timely, efficient, and equitable and has been especially influential for hospitals and health systems today.

These changes were occurring against the backdrop of a long history of quality in other industry sectors such as the well-known PDSA (Plan-Do-Study-Act) Cycle developed from the work of W. Edwards Deming.[5] This and other frameworks find their way into the work of AHRQ when formalizing measures for healthcare quality such as Inpatient Quality Indicators, Patient Safety Indicators, and other metrics. Although these outcomes and measures fit well in direct patient care, their fit and application in the context of healthcare ethics consultation is less obvious. This represents an important gap that ASBH begins to bridge, although future research is necessary to continue developing sophisticated quality assessment methods for healthcare ethics consultation services and to align them with broader, well-established quality assurance methods used elsewhere in health care.

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Appendix 2: American Society for Bioethics and Humanities History

The American Society for Bioethics and Humanities was formed in 1999 when three leading ethics-related organizations—the Society of Health and Human Values (SHHV), the Society of Bioethics Consultation (SBC), and the American Association of Bioethics (AAB)—merged.

SHHV was established in 1969 as a membership organization for persons committed to human values in medicine. SHHV was a professional organization whose primary objective was to encourage and promote informed concern for human values as an essential, explicit dimension of education for health professionals. To accomplish this objective, the Society sought, through a variety of endeavors, to facilitate communication and cooperation among professionals from diverse disciplines who share such an objective and to support critical and scholarly efforts to develop knowledge, concepts, and programs dealing with the relation of human values to education for health professionals. SHHV archives were moved to the Moody Medical Library in February 1998.[1]

SBC was established in 1986. Its mission was to study clinical ethics consultation and to support those who provided ethics consultation services. SBC was the first specialty group to focus on clinical ethics consultation. Its archives were transferred to the Moody Medical Library in early 2001.

AAB was formed in 1994. It promoted the exchange of ideas among bioethics scholars, which enhanced the clinical activities of bioethicists, encouraged discussion and research in bioethics, and encouraged teaching and development of new scholars and participants in the field. The AAB archives were transferred to the Moody Medical Library at the University of Texas Medical Branch (UTMB)–Galveston in early 2001.

Today, the ASBH is an educational organization whose purpose is to promote the exchange of ideas and foster multidisciplinary, interdisciplinary, and interprofessional scholarship, research, teaching, policy development, professional development, and collegiality among people engaged in all of the endeavors related to clinical and academic bioethics and the health-related humanities. These purposes may be advanced by the following activities:

- encouraging consideration of issues in human values as they relate to health services, the education of healthcare professionals, and research
- conducting education meetings dealing with such issues
- stimulating research in areas of such concern
- soliciting and receiving grants, gifts, and bequests and otherwise acquiring and accumulating, holding, and investing assets to be used for such purposes in accordance with ASBH's bylaws
- fostering the interests of persons engaged in these endeavors
- contributing to the public discussion of these endeavors and interests, including how they relate to public policy
- conducting other activities consonant with ASBH's purpose and bylaws.

ASBH specifically seeks to foster dialogue, collegial endeavors, and membership with persons from diverse cultural, ethnic, and racial backgrounds.

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