

Ethics Consultation Redux

In the Fall, 2009 issue of HCEUSA, this section noted the attention given to “ethics consultation and quality” in some of the recent bioethics literature. The current issue of HCEUSA offers a feature article on ethics consultation (“Attempting to Establish Standards in Ethics Consultation for Catholic Health Care: Moving Beyond a Beta Group”) by ethicist Mark Repenshek, along with responses by three Catholic health care ethicists. In his article, Repenshek observes that Catholic health care seems “to be lagging behind the constructive dialogue outside Catholic health care on the matter of ‘standards for medical ethical consultation’ despite the prescriptive language found in Directive #37.” He also notes that, in part, the purpose of the *Beta* group was to “develop broader consensus on standards for the practice of ethics consultation along with measures for quality and effectiveness, and to spur dialogue on what criteria should constitute qualifications for practitioners within Catholic health care.” In his article, Repenshek underscores the need for greater attention within the ministry to the various dimensions of ethics consultation.

CHA is likely to launch a project to address these issues, but in the meantime Catholic health care systems and facilities might do well to devote time to discussing the proposals of the Clinical Ethics Credentialing Project that appear in the November-December, 2009 issue of *The*

Hastings Center Report (“Charting the Future: Credentialing, Privileging, Quality, and Evaluation in Clinical Ethics Consultation,” pp. 23-33). Among the topics covered in the article are *fundamental elements* of clinical ethics consultation and *standards* for clinical ethics consultation. With regard to the former, the working group, drawing upon the bioethics literature and the experience of the members of the working group, proposes that “clinical ethics consultation is an intervention in which a trained clinical ethics professional:

- Responds in a timely fashion to the request for a CEC from any member of the medical care team, patient, or family member;
- Reviews the patient’s medical record;
- Either interviews relevant medical stakeholders or gathers the clinical care team and other consultants to discuss the case;
- Visits the patient and family whenever possible;
- As a preliminary matter, identifies the ethical issues at play and any sources of conflict;
- Involves the patient or family with care providers to promote communication, explore options, and seek consensus, when appropriate;
- Employs expert discussion of bioethical principles, practices, and norms and uses reason,

- facilitation, negotiation, or mediation to seek a common judgment regarding a plan of care going forward;
- Attends to the social, psychological, and spiritual issues that are often at play in disagreements about the proper course of care;
 - Triggers a further process with hospital medical leaders or a bioethics committee to resolve the situation, if a resolution is not reached;
 - Follows up with a patient and family after the initial consultation (although this feature of CEC varies, since in some systems follow-up is a task solely for the medical team);
 - Records the process and substance of the consultation, including the consultant's recommendations and their justification as part of the patient's medical record;
 - Reviews the consultation with others on the CEC service as a basic level of evaluation and peer review; and
 - Utilizes a formal and rigorous quality improvement process" (p. 25).
- family members (or other patient representatives);
 - A clear process for gathering information and making appropriate arrangements to make sure all relevant stakeholders are heard;
 - A formal note in the medical record;
 - A standard format for writing in the chart;
 - Recognition of CEC as one of many collaborating services that must be integrated and transparent in its functioning;
 - Institutional and peer oversight;
 - Ensuring the qualifications and competency of CE consultants;
 - Measures for credentialing CE consultants;
 - Participation in a formal training program and verification of qualifications,
 - Completion of an apprenticeship;
 - A robust quality improvement process" (pp. 26-32).

With regard to *standards* for clinical ethics consultation, the group identifies the following:

- "Easy access to CEC and a plan for responding to requests for CEC from staff, patients, and

Each of these receives explication in the article. Also in the article, the authors offer elements of a tool for assessing the quality of ethics consultations (pp. 30-31). Finally, a task force of the American Society for Bioethics and Humanities (ASBH) has revised its "Core Competencies for Health Care Ethics Consultation." The new draft is available at www.asbh.org for review and comment.

The HCR article and the ASBH competencies provide ample resources for consideration and for efforts at improving the quality of ethics consultation and the preparedness of those who carry it out. While Catholic health care may be “lagging behind” in these discussions and initiatives, there is no excuse for its being “left behind.” The resources are available for achieving greater clarity about various aspects of ethics consultation and for making needed improvements.

R.H.

As we begin our fourth year of the *Health Care Ethics USA* newsletter, we invite you to take a brief survey to let us know what you think and help us serve you better. The survey will take only five to ten minutes. We value your time and insights and would greatly appreciate responses by February 22, 2010. Thanks in advance for your cooperation.

<http://www.surveymonkey.com/s/35SSYB3>

If you have any difficulty with the above link, please copy and paste the link into your web browser.