Bylaws for Clinical Ethics Consultation at the Providence Center for Health Care Ethics

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At Providence in Oregon, our ethicists accompany caregivers, patients, and their families as they wrestle with complex and value-laden issues that often impact life and death decisions. Rooted in the notion of clinical ethics as professional practice, our ethics consultation service is staffed by professionally trained ethicists.[1] While best practices, standards, and competencies required to do the work of health care ethics are emerging and professionalizing at large, we found it incumbent to make a statement to our institution and our colleagues about our accountability to excellence as professionals.[2] At present, the Bylaws for Clinical Ethics Consultation is being vetted by and socialized with institutional partners. These bylaws are predicated on a number of pertinent presuppositions on the work of health care ethics in Catholic ministries, and they establish the formative documents of the service, guidelines and practice commitments of professional practitioners (ethicists), and acknowledge the intra-institutional accountabilities of ethicists and an ethics consult service.

WHY BYLAWS?

While there is no binding set of standards or practices for ethicists as professionals, in the setting of emerging standards (cf. *Striving for Excellence in Ethics* and the American Society for Bioethics and Humanities [ASBH] *Core Competencies for Health Care Ethics Consultation*) and the employment of multiple ethicists, we desired a way to inform the practice of clinical ethics consultation in a reliable, consistent, and professional manner. Therefore, we drew upon the analogy of the professional staff bylaws operative in our institution. Whereas many health care organizations articulate clinical ethics consultation policies that establish norms of conducting a consult, we did not believe that was the appropriate institutional mechanism. By comparison, policies do not dictate the practice of medicine or nursing as professional practices; so too we believe the same should apply to clinical ethics.

PRESUPPOSITIONS

Five major presuppositions shape the impetus and form of the bylaws:

1. Ethics consultation is a professional practice performed by ethicists.
2. Clinical ethics *praxis* is aimed at supporting and empowering the principal moral agents in patient care situations, not supplanting them. Therefore, there are implications for how to organize and to integrate ethicists qua professionals with *fiduciary responsibilities*.
3. The ASBH guidelines and competencies are compatible within the Catholic health care context.
4. An operating policy does not and should not define ethics consultation. Such policies ought not undermine the professional autonomy of ethicists. (Therefore, in our context, our ethics consultation policy defines *how to request* a consult and *what one can expect* in the consultation.)
5. Such bylaws (vetted, socialized, and endorsed appropriately) demonstrate *transparent self-regulation* of a profession.

In our context, we envision the integration of clinical ethics along the lines of primary, secondary, and tertiary integration. Primary ethics occurs directly in the sacred provider-patient encounter (or directly between caregiver and patient/decision-maker). The exercise of primary ethics by a caregiver is predicated on the possession of sufficient proficiency of the ethical components of correlative professional competencies.[3] Secondary ethics happens when those directly involved in the care of a patient need additional support to address basic questions or policy clarifications. We use the term *ethics liaison* to describe this role, but most often it is a member of the ethics committee. In smaller ministries (e.g., critical access hospitals), these caregivers may also be part of the care team. Finally, tertiary ethics is the availability and performance of a professional consultation service by specialists with expertise in the field (aka, ethicists or attending ethicists in our context).

FUNCTIONS AND PURPOSES

As currently written, our bylaws state four functions:

i. To characterize the practice of clinical ethics consultation by a professionally trained ethicist;
ii. To establish the role and function of an "attending ethicist" in providing clinical ethics consultation;
iii. To outline the operations of the Ethics Consultation Service as they pertain to clinical ethics consultation; and
iv. To clarify the expectations of the attending ethicist in performing clinical ethics consultation.

More broadly, the seven purposes of the bylaws are as follows:

1. To describe the major dimensions and features of clinical ethics consultation and its assessment as operationalized by our Center;
2. To set forth the general expectations of the professional practice of clinical ethics consultation on the Ethics Consultation Service as operated by our Center;
3. To be accountable for emerging professional norms in clinical ethics and to stakeholders or relevant interested parties whether internal or external to the organization;

4. To support the dimensions of a culture of high reliability and patient safety as they apply to the practice of clinical ethics consultation;
5. To strive toward excellence in all aspects of clinical ethics consultation;
6. To maintain lateral accountabilities with local institutional entities (e.g., leadership, ethics committees, professional staff, etc.); and
7. To be engaged in continuous quality improvement and self-care.

CONTENT OUTLINE

The bylaws are divided into two broad sections: articles and appendices. Articles contain the theological, philosophical, and professional standards, norms, and guidelines of clinical ethics consultation. Appendices contain the reference documentation and communication resources in operationalizing the Ethics Consultation Service in general and clinical ethics consultation in particular. In general, we do not anticipate or intend for the articles to change much over time (though we do expect some iterative revisions, especially as the bylaws are reviewed by others). Yet, we do expect that the appendices will change more rapidly in response to the changing health care environment and organizational contexts within which we practice.

While a summary of each article is outside the scope of this paper, the following eleven articles constitute the bylaws, narrowly speaking.

i. Preamble
ii. Purposes of the Bylaws
iii. Definitions
iv. A Natural History of Ethical Issues in Health Care
v. Health Care Ethics Praxis
vi. The Nature of Clinical Ethics Cases
vii. Personnel & Functional Roles
viii. Consultation Guidelines
ix. Functional Products: Interventions and Outcomes
x. Professional Practice Quality Improvement
xi. References

At present (February 2020), the appendices to these bylaws include the following items:

A. General Operating Policy: Clinical Ethics Consultation (regional policy)
B. Clinical Ethics Consultation Process (conceptual map of the process of clinical ethics consultation)
C. Message for Clinical Ethics Consultation Orders in Oregon (states in scope, out of scope, business hours, etc.)
D. Clinical Ethics Support: C.A.S.E.S. Approach (for circumstances when an ethicist is not available or not necessary: a function of secondary ethics integration)
E. Providence Model for Health Decision-Making in Clinical Settings (a visual disclosure model to assist with exploration and explanation of ethical thinking)
F. Clinical Ethics Case SBAR Form (a tool for caregivers to use to organize relevant case information)
G. Clinical Ethics Triage Screening Tool (to help determine whether to escalate an issue to the attending ethicist)
H. Perinatal Ethics Team Letter (to communicate resources for high-risk obstetric cases, neonatal cases, and other

maternal-fetal medicine issues)

I. Clinical Ethics Consultation | Clinical Ethics Alert (a one-pager on consultation; a communication tool for caregivers)
J. Ethics Liaison | Clinical Ethics Alert (a one-pager on the role of ethics liaisons, who are embedded resources who may be able to provide clinical ethics support when an ethicist is not available)
K. Evaluation Framework for Clinical Ethics Consultation (the conceptual framework for the summative and formative metrics of the consultation service)

ITERATIVE DESIGN AND EVOLUTION

Over time, we anticipate revisions to the current iteration of our bylaws. On the one hand, institutional parties will have additional insights and feedback to integrate into the document. Moreover, our ongoing formation and ministry as ethicists will bring new perspectives to the vocation of ethics that in turn will shape the document. On the other hand, external forces such as Church teaching, developments in the ethics literature, and research and other scholarship in the field will mold the content as well. Overall, while the bylaws are a testament to our commitment to the professional practice of clinical ethics consultation, like other professions, we seek to be faithful to our fiduciary responsibilities and core commitments as we adapt and respond to the signs of the times.

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ENDNOTES

1. Nicholas Kockler and Kevin Dirksen, "Integrating Ethics Services in a Catholic Health System in Oregon," *National Catholic Bioethics Quarterly* 18(1) (Spring 2018): 113-134.
2. The first iteration of our bylaws was co-authored by N. Kockler and Kevin M. Dirksen, M.Div., M.Sc., HEC-C.
3. John Tuohey and Nicholas Kockler, "Ethics Education Enhances Skills of Doctors in Training," 93(3) (Spring 2012): 29-37.